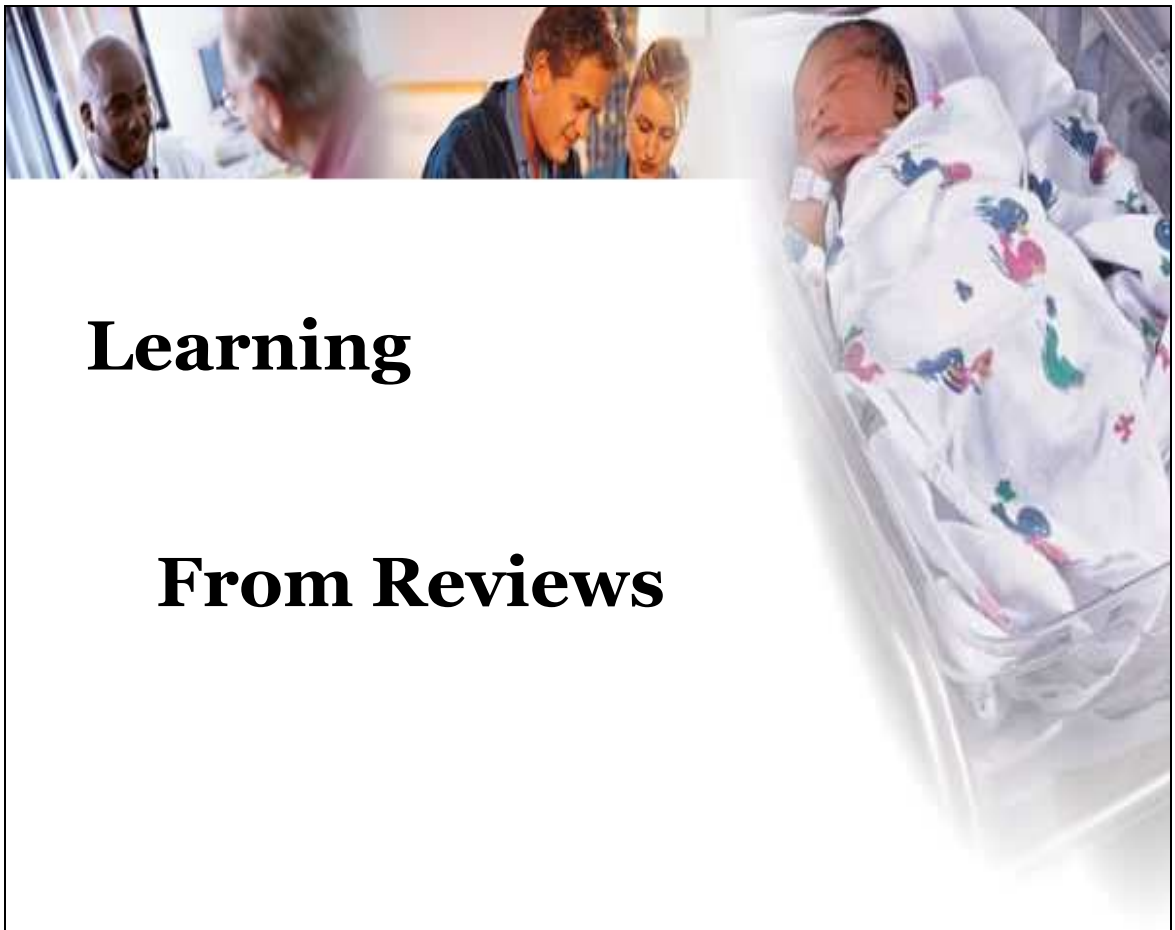
IRP

INDEPENDENT RECONFIGURATION PANEL



Learning From Reviews

AN OVERVIEW

Second Edition – December 2009

FOREWORD

To the second edition of *Learning from Reviews*

The IRP has now completed sixteen full reviews. Our reviews have covered settings and populations of widely differing scales, from major conurbations such as Greater Manchester and north London to highly ruralized communities in north Yorkshire and the Forest of Dean. The services involved have varied greatly, from large-scale frontline services such as maternity and emergency care to highly specific but no less vital services like pathology. One thing, however, is consistent everywhere – the passion people have for the NHS and for their local services.

The IRP has, I believe, been a success story. The Secretary of State for Health has, to date, accepted in full all of our recommendations in every report that we have submitted. I am committed to maintaining this record though recognising that we cannot be complacent and that this will only be achieved through continued hard work. I remain hugely grateful to the Panel membership for their dedication in hearing many hours of oral evidence and sifting through hundreds (if not thousands) of pages of written evidence – all in their spare time while maintaining "day jobs".

It is pleasing to see that a number of the IRP's recommendations have found their way into mainstream guidance on reconfiguration. The five principles contained in the Department of Health report, *Next Stage Review: Leading Local Change* (see page eight of this report) echo many of the sentiments expressed in the advice we have provided to the Secretary of State.

Our success can, equally, be measured on the ground. Recommendations from our reviews have now been implemented in a number of places and the benefits are there to see. This is evidenced by the experience in west Yorkshire where the midwife-led maternity units in Calderdale and Huddersfield are proving extremely popular. A recent IRP follow-up visit to Sandwell and Birmingham NHS Trust found that their proposals for emergency surgery had now been fully implemented and are working successfully.

It may be a source of some frustration, but it is, nevertheless, a fact that reconfiguration can be a long process. The long time spans involved are most evident where proposals have been

referred to us. The Panel does its best to review contested proposals in as timely a manner as possible. For those in a hurry, the best advice we might offer is to get it right first time. The best way to achieve that is to be mindful of, and learn from, the experiences of others. I hope that this report is of use in that respect.

Despite scepticism at times from politicians and the public alike, reconfiguration is, I believe, a force for good. One final thought though. Reconfiguring services, and in particular relocating them, is *not always* the right answer. In some areas the IRP has examined, the maintenance of a service for local people weighed far more heavily than other factors. As I said in the foreword to the first edition of this report, the NHS operates in an environment of rapidly changing medical treatments and demography. We are always at a point in a journey. Change is inevitable and we must plan for it. But in doing so, the NHS should never lose sight of the importance of retaining services locally wherever possible.

Dr Peter Barrett CBE
Chair
Independent Reconfiguration Panel

FOREWORD

To the first edition of *Learning from Reviews*

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[1] 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.

[1] As at November 2008, now 16 reviews.

The critical list

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

- **inadequate community and stakeholder engagement in the early stages of planning change**
- **the clinical case has not been convincingly described or promoted**
- **clinical integration across sites and a broader vision of integration into the whole health community has been weak**
- **proposals that emphasize what cannot be done and underplay the benefits of change and plans for additional services**
- **important content missing from reconfiguration plans and limited methods of conveying information**
- **health agencies caught on the back foot about the three issues most likely to excite local opinion – money, transport and emergency care**
- **inadequate attention given to the responses during and after the consultation**

INTRODUCTION

Since it started work in 2003, the IRP has published sixteen 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[2] have dealt with maternity or children's services (or both) and seven with emergency treatment and care - Accident & Emergency (A&E) services, inpatient emergency trauma (treatment of serious injuries), surgery and medical care. The other three covered general care for older people, services for older people with mental health problems and the provision of microbiology services (further details are included in Appendix A).

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

In addressing these questions, we have drawn on our published reports, on a range of NHS guidance material, and on interviews with 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.

[2] Additionally, three of the referrals categorised under emergency treatment and care also included maternity and children's services.

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 the Secretary of State for decision.

Its establishment was part of a package of changes to the arrangements for patient and community engagement in healthcare services first set out in the NHS Plan in 2000. The Health and Social Care Act 2001, and subsequently the NHS Act 2006, give councils with social care responsibilities the power to scrutinise matters relating to the health of local people. This is done by local authority **health overview and scrutiny committees (HOSC)**. HOSCs have a general monitoring role and must also be consulted by local NHS bodies about proposals for substantial developments or variations in services provided. Under the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002, a HOSC has the right 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 also provides informal advice to health bodies, HOSCs and other stakeholders where reconfigurations were being planned or debated. The IRP has provided advice on proposals or the development of proposals in numerous locations throughout England.

The organisation and working methods of the IRP are summarised in Appendix B. Our terms of reference are included in Appendix C.

Most referrals to the IRP have arisen when proposals have been put forward to alter the range of services provided between hospitals serving different communities. In these circumstances, one or another community may be - or may perceive itself to be - the ‘loser’ of healthcare services that 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 focus is on the patient and quality of care within the context of safe, sustainable and accessible services for local people.

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 Care Quality[3] 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.
- publication of a new strategic framework as set out in ***High Quality Healthcare for All*** (June 2008).

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.

Leading Local Change requires that all reconfiguration proposals be subject to independent clinical and management assessment through the Office of Government Commerce *Gateway*

[3] Formed following the merger of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Commission.

Review process and assessment by the National Clinical Advisory Team (NCAT). It states, *"there will be a high clinical bar for change everywhere in the NHS, so that change is always for the benefit of patients"*.

The context for the immediate future is created by the economic downturn and impending pressure on NHS resources. Rapid and large scale change to deliver services for patients more efficiently and effectively will be required to meet the challenge of finding £15 - 20bn across the NHS over the next five years. Service reconfiguration, appropriately driven by the needs of patients and the quality of services they receive, will have an important part to play.

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

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

- 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'
- the proposals are **not consistent with Government policies** about providing services nearer to patients - they will be much further away.
- 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 proposals take **no strategic view** for the wider locality – they are just local tinkering
- 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 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
- no evidence that the proposals will lead to **improvements** for local people

- 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
- the proposals are purely **financially** driven
- people will be compelled to make long and/or expensive **journeys** that may deter patients from attending and reduce the opportunities for visiting
- **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

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

- 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
- no account was taken of opposing views expressed during the consultation – **it was a done deal**

The list above describes the most common objections made in formal referrals to the Secretary of State. It does not, however, tell the whole story. The IRP's reviews have revealed other factors that play a role and highlight a number of problems which generate or allow mistrust and cynicism to develop and make an impasse more likely. The following passages pick up both on the objections made and on the subsequent Panel's findings.

Engaging the public in developing proposals

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 Section 244 of the NHS Act 2006 (which supersedes the NHS Health and Social Care Act 2001). However, most referrals did include some adverse comment 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. Engagement with local stakeholders from the outset is not only a highly desirable and effective means of smoothing the future path for reconfiguring services, it is also a legal requirement under Section 242 of the NHS Act 2006.

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.

Big issues - such as the *right* of communities to a local DGH offering key inpatient services close to home – deserve to be discussed openly before any change is considered. 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. These issues need to be aired from the outset. Early engagement at the start of the process can save time in the long run.

The critical list No.1

Inadequate community and 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.

Making the clinical case for change

The way in which the clinical case is presented, and the evidence used to support it, is a key factor in making the case for change. In most cases reviewed by the IRP, the principal arguments put forward for change have 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 needed to meet the requirements of the European Working Time Directive 2003, which reduced the working hours of junior doctors and further limited them in 2009
- advances in technology and clinical techniques that 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 often 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, where the most expert diagnosis and care for each patient can be provided and where best use can be made of 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. But they also need to do this to see enough cases to maintain and develop their expertise. Junior doctors, too, need to 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. Understandably, this causes the strongest reaction in services where immediate treatment is needed, such as 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.

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. Credible clinical leadership and opinion is essential for all parties – NHS, HOSC and the public.

The critical list No.2

The clinical case has not been convincingly described or promoted

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.

Who consults and what to consult on?

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 meant that proposals were often 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.

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."***

The critical list No.3

Clinical integration across sites and a broader vision of integration into the whole health community has been weak.

The absence of an effective strategic plan – for the PCT area or the wider region – for the services affected makes proposals look like local tinkering. This has limited flexibility and encouraged site-based solutions. It has also limited the integration of acute services with primary healthcare and social care.

Presenting the benefits

In attempting to make the case for change, how well has the NHS fared in presenting the potential benefits? Too often, the message describes what the NHS cannot do in its present configuration rather than what it should and will do in the future.

This is seen mostly evidently in responding to medical manpower concerns and in particular the implications of the European Working Time Directive. National standards and guidance are developed for good reason – to enhance services. While some reconfigurations may, indeed, involve moving services from one location, they often also involve the introduction of new and improved services. But, if people are unable to see the benefits to them personally of changing services, they will draw their own conclusions as to the motives for change.

The critical list No. 4

Proposals that emphasize what cannot be done and underplay the benefits of change and plans for additional services.

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 reconfigurations frequently end up costing more.

The formal consultation process

Engagement with stakeholders and the public is a legal requirement under S242 of the NHS Act 2006. Section 244 of the Act requires NHS bodies to consult their local HOSCs on any proposals for substantial changes of local health services. The same legislation does not determine whether or not a formal public consultation is required though a plethora of Cabinet Office and DH guidance exists on the subject. The simplest piece of advice may be that if the proposals are big and/or are potentially controversial - and most particularly if the local HOSC considers that it is necessary - formal public consultation should be undertaken.

Guidance also offers many helpful hints on how to conduct a good consultation. However, it has not always been immediately obvious to the IRP whether any account has been taken of the guidance.

> ***"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."***

Some consultation documents 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. Others still, have failed to provide convincing detail to the local community that the proposed changes are either affordable and/or capable of being implemented. In a small number, statements about travel times between sites have defied the best efforts of the IRP subsequently to undertake the journey within the assumed time.

The NHS has, in some instances, been criticised for being over-reliant on the internet and/or lengthy, highly technical consultation documents to disseminate information. Publishing documentation, either in paper form or on a website, is not a substitute for continued personal engagement with stakeholders. Guidance suggests many different methods for maintaining effective communications and it is likely that a range of methods will be required to ensure maximum coverage to the local population.

"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."

The critical list No. 5

Important content missing from reconfiguration plans and limited methods of conveying information.

Local communities want to know what services will be provided, where and how they will access them. They also want reassurance that the changes are based on realistic assumptions and are achievable.

The three big issues

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. This is most keenly felt with regard to *emergency care*, for example, ambulances responding to an emergency callout being 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.

The critical list No. 6

Health agencies caught on the back foot about the three issues most likely to excite local opinion – money, transport and emergency care.

These issues are common to nearly all reconfigurations and public concern is both predictable and entirely understandable. Failure to anticipate such concern inevitably gives the impression of ill-considered proposals regardless of how well thought through they may otherwise be.

Post-consultation

Reconfiguration is rarely a short cut. Indeed, it is frequently a lengthy process. Sustaining stakeholder engagement throughout the transition to consultation and subsequently to decision-making and beyond requires careful planning. The end of the formal consultation phase should not be seen as the end of the need to keep people informed. On the contrary, this may be the point at which people are most anxious to know what happens next.

Legal judgements confirm what should be obvious to everyone – consulting people on proposals is only of any value if appropriate account is then taken of the views that emerge. This also means *being seen* to take account of views received.

> ***"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."***

Independent validation of consultation responses is important. Equally, modification or refinement of proposals as result of consultation helps to show that local people's opinions count. Moving too quickly from end of consultation to decision-making without adequate reflection time in between demonstrates the opposite.

> ***"....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."***

The critical list No. 7

Inadequate attention given to the responses during and after the consultation.

This compounded problems where early stakeholder engagement was limited. Pressure to make a quick decision should be resisted. Taking time to consider responses is important.

What was the contribution of the HOSCs?

As mentioned previously, none of the reconfigurations reviewed by the IRP were referred to the Secretary of State because the HOSC itself had not been properly consulted. This is encouraging and it is to be hoped that the trend continues. The scrutiny process exists for good reason and is not to be taken for granted. Adherence to national guidance and local protocols help to avoid false assumptions and accusations of complacency.

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.

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 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.

> ***"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."***

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.

Maternity, obstetrics and paediatrics - a service perspective

Six* of the 16 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.

* Three other referrals covering general hospital services also included maternity and children's services

** 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, four of the 16 reviews have supported the proposals, seven have supported them in principle but placed conditions on their implementation, one was supported with conditions *and* amendments to the proposals and four have not supported them - of which two recommended alternative proposals.

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 interviewed for the first edition of this report had been involved with the first ten 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.

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.

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"*.

Since the first edition of this report was published in November 2008, we have continued to seek feedback about what has happened following publication of IRP reports. Summaries of five reviews of interest and their outcomes are highlighted below:

- **Review: Maternity services in Calderdale and Huddersfield**, **August 2006**

  Issue: Consolidation of obstetric services between Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) at CRH. Midwife-led units (MLU) to be available on both sites.

  Outcome: *The IRP supported the proposals. Since opening in March 2008, the Huddersfield MLU has now seen more than 900 births to August 2009 and anticipates up to 700 births in 2010. The MLU at CRH is proving equally popular with more than 700 births in the last 12 months.*

- **Review: Inpatient mental health services for older people in Gloucestershire, July 2007**

  Issue: Centralisation of specialist inpatient beds from four locations across Gloucestershire to one centre in Cheltenham, with intermediate care provided at the other locations.

  Outcome: *The IRP supported the proposals subject to conditions. Conversion work on the facility is proceeding well and set to open in April 2010. Length of stay in specialist beds has been reduced considerably, intermediate care has improved and good transport arrangements have been put in place.*

- **Review: Emergency surgery services in Sandwell and West Birmingham, November 2007**

  Issue: Concentration of the majority of emergency surgery at Sandwell Hospital and inpatient elective surgery at City Hospital, Birmingham as an interim measure prior to a move to a single site hospital.

  Outcome: *The IRP supported the proposals subject to conditions. The new arrangements have been in place since March 2009 and are operating well with the transfer of patients between the hospitals fewer than anticipated. This has enabled the Trust to turn to other pressing issues, not least its plans for a new single site hospital by 2015.*

- **Review: Orthopaedic and general surgical services in West Kent, November 2007**

  Issue: Interim proposals to consolidate the majority of emergency and orthopaedic surgical services at Kent and Sussex Hospital with elective surgery at Maidstone Hospital, prior to completion of new hospital at Pembury.

  Outcome: *The IRP supported the proposals subject to conditions. In light of changes to senior management, operational performance requirements and managing the new hospital build (first services due to move in January 2011) the Trust opted, ultimately, not to implement the interim changes. The first services are due to move into the new Pembury Hospital in 2011.*

- **Review: Paediatric services, obstetrics, gynaecology and special care baby unit at Horton General Hospital, Banbury, February 2008**

  Issue: Transfer of inpatient paediatrics, consultant-led obstetrics, the special care baby unit and the gynaecology ward from Horton Hospital to the John Radcliffe Hospital in Oxford.

  Outcome: *The IRP did not support the proposals because they did not provide an accessible or improved service for local people. The Panel recommended that further work be carried out to set out the arrangements and investment necessary to retain and develop services at the Horton Hospital. Since the Panel's report, much effort has been put into re-establishing relationships with the local community – underlining the importance of creating good community and stakeholder engagement from the outset of planning change. A "Programme Board" has been established to develop proposals for appropriate models of care. A report to the Oxfordshire PCT Board in November 2009 identified a potential model of care subject to further planning and evaluation.*

A complete list of full IRP reviews is included at Appendix A and all reports are available on the IRP website www.irpanel.org.uk in the *Completed Reports* section.

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 FULL REVIEWS

IRP reports on each of the reviews listed below can be found on the IRP website www.irpanel.org.uk in the *Completed Reports* section.

	Location	**Date Submitted**	**Services reviewed**	**IRP advice on proposals**	**Current position**
1	East Kent (Canterbury, Ashford, Margate)	12 June 2003	General hospital services incl. maternity paediatrics and emergency care	Not supported, IRP endorsed alternative proposals	Alternative proposals endorsed by IRP fully implemented
2	West Yorkshire (Calderdale, Huddersfield)	31 August 2006	Maternity	Supported	Proposals fully implemented
3	North Teesside (Stockton on Tees, Hartlepool)	18 December 2006	Maternity, paediatrics and neonatology	Not supported, IRP recommended alternative proposals	IRP alternative interim proposals fully implemented. Work on longer term recommendations proceeding. New hospital planned to open 2015 subject to funding approval from DH/Treasury.
4	Greater Manchester *(Making it Better)*	26 June 2007	Maternity, paediatrics and neonatology	Supported with conditions	First transfer of services due to take place in Jan 2010. Implementation expected to be completed winter 2011/12.
5	North east Greater Manchester *(Healthy Futures)*	26 June 2007	General hospital services incl. emergency care	Supported with conditions	Work proceeding on implementation, expected to be complete by 2011
6	Gloucestershire (Gloucester, Cheltenham, Stroud, Cinderford)	27 July 2007	Older people's inpatient mental health	Supported with conditions	Building work for new inpatient facility on schedule to be completed April 2010
7	West Midlands (Sandwell, West Birmingham)	30 November 2007	Emergency surgery	Supported with conditions	Proposals fully implemented. Preparatory work for

					new hospital proceeding, expected to open in 2015
8	West Kent (Maidstone, Tunbridge Wells)	30 November 2007	Orthopaedic and general surgery	Supported with conditions	Trust opted not to implement interim changes. Building work for new hospital at Pembury proceeding with first services due to move in 2011.
9	West Suffolk (Sudbury)	31 December 2007	Community services	Supported with conditions	Admission prevention service and intermediate care teams in place Dec 2009. Approval for outline business case for new healthcare hub ongoing.
10	North Oxfordshire (Banbury, Oxford)	18 February 2008	Maternity, paediatrics, neonatology and gynaecology	Not supported	Recommendations for obstetrics and paediatrics considered by PCT in November 2009.
11	North Yorkshire (Scarborough)	30 June 2008	Maternity	Supported	Facilities ready, recruitment ongoing, Scarborough MLU expected to open in early 2010.
12	North London (Barnet, Enfield Haringey)	31 July 2008	General hospital services incl. maternity, paediatrics and emergency care	Supported with conditions	Implementation of first phase – women's and children's services – to be completed spring 2011. Second phase – urgent care, emergency inpatients and planned care – expected to be implemented in 2013.
13	East Sussex (Hastings, Eastbourne)	31 July 2008	Maternity, neonatology and gynaecology	Not supported	Maternity services strategy for East Sussex agreed and implementation plan being taken forward with stakeholders for consultant-led care on two sites and

					enhanced community services by 2012.
14	North Yorkshire (Bridlington)	31 July 2008	Cardiac care and acute medical services	Supported	Proposals fully implemented
15	Southeast London (Lewisham, Bromley, Bexley, Greenwich)	31 March 2009	General hospital services incl. maternity, paediatrics and emergency care	Supported with conditions and amendments	Workstreams and planning ongoing. Business case to Trust Board in January 2010 with implementation expected to be complete March 2011.
16	Lincolnshire (Lincoln)	29 May 2009	Microbiology	Supported	Proposals fully implemented

APPENDIX B

The IRP Review Process

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, s/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 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. We have no responsibility for the implementation or the monitoring of the implementation of the Secretary of State's decision.

APPENDIX C

Terms of Reference for Independent Reconfiguration Panel

A1. To provide expert advice on:

- Proposed NHS reconfigurations or significant service change
- Options for NHS reconfigurations or significant service change

referred to the Panel by Ministers.

A2. In providing advice, the Panel will consider whether the proposals will provide safe, sustainable and accessible services for the local population, taking account of:

i. clinical and service quality

ii. the rigour of involvement and consultation processes

iii. the wider configuration of the NHS and other services locally, including likely future plans

iv. other national policies, including guidance on NHS service change

v. any other issues Ministers direct in relation to service reconfigurations generally or specific reconfigurations in particular

A3. The advice will normally be developed by groups of experts not personally involved in the proposed reconfiguration or service change, the membership of which will be agreed formally with the Panel beforehand.

A4. The advice will be delivered within timescales agreed with the Panel by Ministers with a view to minimising delay and preventing disruption to services at local level.

B1. To offer pre-formal consultation generic advice and support to NHS and other interested bodies on the development of local proposals for reconfiguration or significant service change – including advice and support on methods for public engagement and formal public consultation.

C1. The effectiveness and operation of the Panel will be reviewed annually.