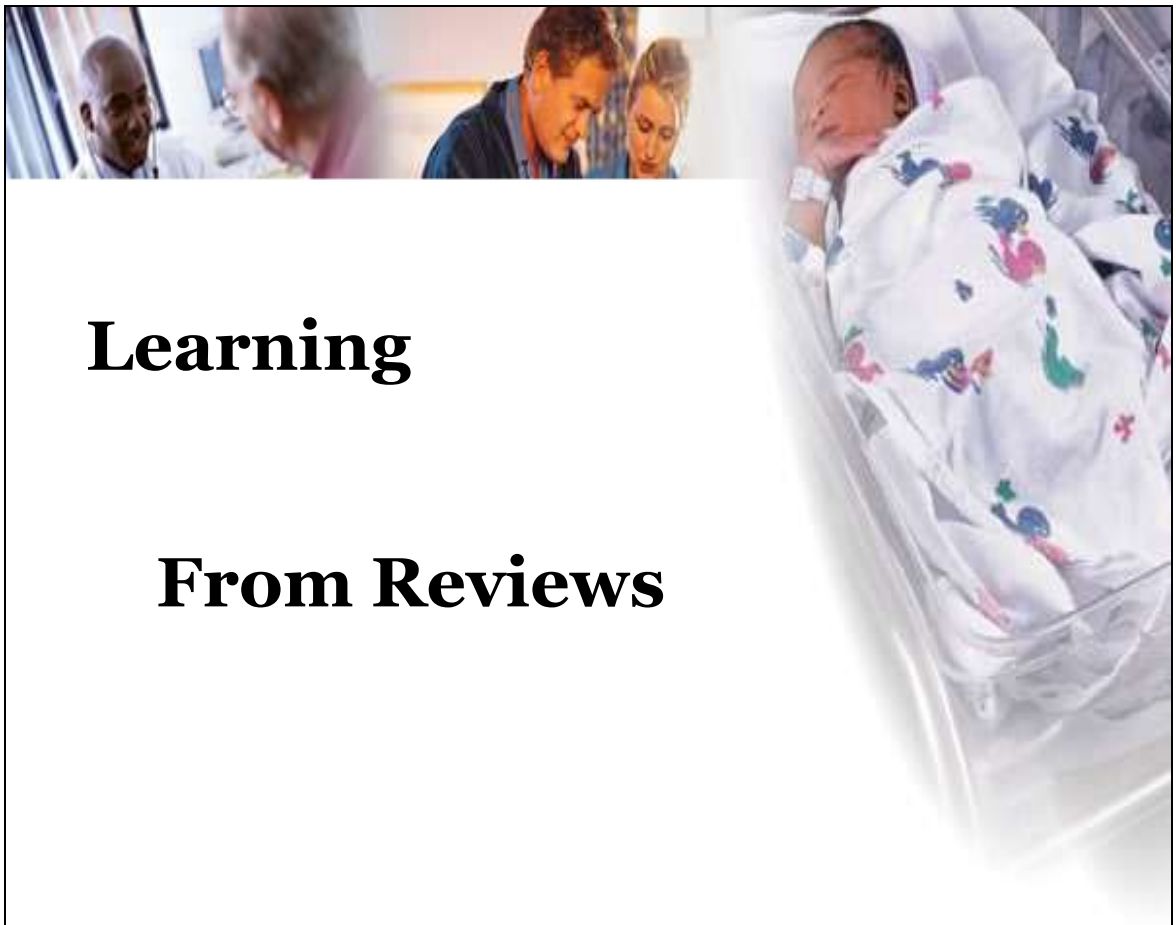
IRP

INDEPENDENT RECONFIGURATION PANEL



Learning From Reviews

AN OVERVIEW

Third Edition – December 2010

Foreword

I have commented, in my previous forewords to *Learning from Reviews*, on the rapidly changing environment within which the NHS operates. Following the publication earlier this year of *Equity and excellence: Liberating the NHS*, those comments have never been more true. The Government's long-term vision for the future of the NHS involves far reaching changes for the way in which the NHS is run. The scope is ambitious, the timetable challenging. As always, placing patients and the highest possible quality of care at the centre of plans remains the key to success.

Commissioning by GP consortia, greater freedoms for providers of services, more patient choice and control, and the new role for local authorities may all have an impact on NHS service change and, therefore, on the work of the Independent Reconfiguration Panel. The IRP stands ready to help the process in whatever way we can.

In updating *Learning from Reviews* this year, we have as previously sought to extract what we have learnt from past reviews but also to place that learning in some context for the future. This edition also includes a new feature - a section on what can be learned from our initial assessments of referrals that have not been deemed suitable for full review. As with our full reviews, a number of common themes emerged and I hope that our observations will be of interest.

Dr Peter Barrett CBE DL
Chair
Independent Reconfiguration Panel

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 seventeen 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[1] 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 four covered general care for older people, services for older people with mental health problems, the provision of microbiology services and oesophago-gastric cancer surgery services. A list of our full reviews is 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 people who contributed to reviews as NHS leaders, local councillors or community representatives.

In addition to our seventeen full reviews, the IRP has also offered initial assessment advice to the Secretary of State on a number of referrals that were not suitable for full review. Some of our learning from these referrals has been included in this edition.

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.

[1] 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[2].

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. 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 the time that has been allowed
- that the reasons given for not carrying out consultation are adequate
- that the proposals are in the interests of the health service in its area.

The Secretary of State may then ask us for advice. 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.

[2] As well as 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 are being planned or debated. The IRP has provided advice on proposals or the development of proposals in numerous locations throughout England.

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

Since the IRP was established in 2003, the progress of service change in the NHS has been marked by a number of factors, including:

- 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
- 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
- The implementation of the European Working Time Directive
- The development of clinical and service standards by Royal Colleges and others
- The strategic framework set out in ***High Quality Healthcare for All*** and associated guidance on service change (June 2008)
- The economic downturn and need for the NHS to generate £20bn of savings over the next four years

In May 2010, the advent of a new government brought the Secretary of State for Health's four tests that, in addition to the extant framework of statutory duties and DH guidance, require existing and future reconfiguration proposals to demonstrate:

- support from GP commissioners
- strengthened public and patient engagement
- clarity on the clinical evidence base
- consistency with current and prospective patient choice

The White Paper ***Equity and Excellence: Liberating the NHS*** – proposes reforming the NHS. An NHS Commissioning Board will hold local GP consortia to account for commissioning from a wide range of providers within a competitive market subject to economic regulation. Local authorities will have statutory responsibility for health and wellbeing, including the local public health function. It is also proposed that they will

continue to have powers of health scrutiny, the scope of which will be redefined to reflect the wider reform package.

At the time of updating this edition of *Learning from Reviews*, the legislation to amend local authority oversight of the NHS is yet to be introduced. Rather than speculate at this point on what the future holds, and given that the transition will involve two years or more of NHS reorganisation, greater focus on understanding the existing requirements may be more useful.

The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002[3] require NHS bodies to consult health overview and scrutiny committees (HOSC) on any proposals under consideration *"for a substantial development of the health service in the area of a local authority or for a substantial variation in the provision of such service…"*. Sections 4 (5a) and (5b) of the Regulations allow HOSCs to refer proposals to the Secretary of State for Health where a committee is not satisfied that adequate consultation (with the HOSC) took place or where the reasons for not consulting with the HOSC are deemed in adequate. Section 4 (7) of the Regulations allow HOSCs to refer proposals where a committee considers *"that the proposal would not be in the interests of the health service in the area of the committee's local authority"*.

Disagreements about what constitutes a substantial development or variation aside, this part of the regulatory framework seems to be well understood. However, what is often misunderstood is the duty to involve service users, as set out in Section 242 (1B) of the NHS Act 2006. There is a common misconception that if the HOSC is not consulted, because a proposal is not deemed to be a substantial development or variation to a health service, users do not have to be involved. This is not the case. NHS organisations must involve users where Section 242 (1B) requires arrangements to be made for involvement activity (whether by being consulted, or provided with information, or in other ways), irrespective of whether the HOSC is consulted or not. Therefore, even if an issue is not initially regarded as a substantial development or variation, it does not mean that an NHS organisation need not involve users in planning the service[4].

[3] as enabled by Section 244 of the NHS Act 2006 (which supersedes the NHS Health and Social Care Act 2001)

[4] this issue is considered further in the section *Learning from Initial Assessments*

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 – and insufficient thought was given to how services could be retained locally
- **the clinical case was not sufficient** to outweigh other factors and/or **not all clinicians 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 is not, however, an exhaustive list. 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

Referrals to the Secretary of State for Health have most commonly been made on the grounds that proposals would not be in the interests of the health service rather than because the HOSC itself had not been properly consulted. However, referrals frequently 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 on substantial service changes 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, as previously stated 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.

Those likely to be charged with developing plans for NHS service change in the future should already have noted, of course, that *strengthened public and patient engagement* is one of the four key areas identified by the Secretary of State in which reconfiguration processes need to improve.

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 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

Extraordinary developments have occurred in all branches of clinical care over the last decade (and will in the next) and the NHS must run with evidence-based developments because the public reasonably expect to be able to access them. 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. Again, *greater clarity about the clinical evidence base underpinning proposals for change* is one of the four key areas for improvement identified by the Secretary of State.

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?

Within the existing organisation of the NHS, reconfiguration has normally been led by PCTs, which have been charged with planning and commissioning a full range of services. The NHS

is set to undergo a period of considerable change over the coming years with the establishment of the NHS Commissioning Board and GP commissioning and continuation of the move towards greater freedoms for NHS provider bodies. The mechanisms by which NHS reconfiguration will take place in this new environment have yet to be finalised though we do know that *support from GP commissioners* will be essential. In developing a process, it is to be hoped that learning from past experience will be of use in informing the development of plans for the future.

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 NHS 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 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? How well has it fared in *developing and supporting patient choice* – the fourth of the Secretary of State's key areas for improvement? 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

The Local Authority (OSCHSF) Regulations 2002 require NHS bodies to consult their local HOSCs on any proposals for substantial changes to 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 NHS 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 NHS 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, the mechanisms by which local authorities will oversee the NHS in the future are still in development. But local authority oversight of the NHS has been, and should continue to be (in whatever form it subsequently takes), a positive influence on the process of reconfiguration. Such oversight helps 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.

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 NHS 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 that 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.

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 17 reviews have supported the proposals, eight 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 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.

LEARNING FROM INITIAL ASSESSMENTS

The IRP is pleased to offer advice on any referral where the Secretary of State for Health requests our views. However, this does not mean that all referrals to the Secretary of State will automatically be reviewed *in full* by the Panel.

In July 2007, Alan Johnson, then Secretary of State for Health, announced in the House of Commons that all referrals to the Secretary of State under the Local Authority (OSCHSF) Regulations 2002 would routinely be passed to the IRP for advice. In the three years since that announcement, the IRP has undertaken eight full reviews. Over the same period, a similar number of referrals have not proceeded to full review. This section describes some of the important themes to have emerged from what has proved to be an equally interesting and varied case mix.

The Initial Assessment process

On receipt of the appropriate documentation, the IRP carries out an initial assessment to assess the referral's suitability for full review[5]. The IRP does not, at this stage, seek information from other interested parties or arrange to take oral evidence from the parties involved – though we may seek clarification on particular issues. Instead, the process relies on documentary evidence, comprising:

- Scrutiny committee referral letter and supporting documentation
- IRP initial assessment template - to be completed by the relevant SHA

Where the IRP considers that a referral is suitable for full review**,** the Secretary of State will then decide whether to commission one[6]. Once a full review has been requested, specific terms of reference and a timetable for reporting will be agreed.

Where a referral is not suitable for full review**,** we will explain why and, where possible, provide advice to the Secretary of State on further action to be taken locally. The Secretary of State will make the final decisions about what happens next.

[5] In general, if the Secretary of State decides to seek initial assessment advice from the IRP, we will assume that the referral is legally valid under the Local Authority (OSCHSF) Regulations 2002.

[6] Since the July 2007 statement, the Secretary of State has to date agreed with all of the IRP's initial assessment advice about the need (or not) for a full review.

How does the IRP decide whether to carry out a full review?

In considering the suitability of a referral for full review, the Panel's first consideration is whether more work can be done locally to achieve a resolution. Service change can be an emotive issue leading, on occasion, to referral letters being dispatched before all avenues for resolution have been fully explored and even while further work is still taking place. Other referrals have largely centred on the need for further information to enable the HOSC to understand a proposal fully. The information has frequently been readily available but – despite the best intentions of those involved - not shared.

Wherever possible, local resolution is preferable to full review. Only where it is clear that all options for local resolution have been exhausted will the IRP consider a full review.

The Panel then needs to consider whether a full review will add value. A full review can help to bring closure to a situation by giving all interested parties the opportunity to express their views to an independent body. It also enables the IRP to look more closely at the issues involved and to offer specific advice to the locality in question - but which may also be relevant to other areas of the country.

The earlier sections of this report focus on the most common objections raised by HOSCs. These can generally be summarised as being *not in the interests of the NHS locally*. However, referral can also be made on the grounds of *inadequate consultation with the HOSC* or that *no consultation with the HOSC* was undertaken and the reasons for not doing so were inadequate. Referrals solely on these grounds are relatively rare – a HOSC is unlikely to refer on the grounds that it was not consulted if it is otherwise content with the proposal – but they do occur. In such cases, the IRP's experience to date has been that they are best dealt with through detailed advice at the initial assessment stage.

Some useful examples of our learning from initial assessments are described below.

Keep trying

Things move on, even once a referral has been submitted. Events can sometimes overtake a referral - particularly if the interested parties are keen to take matters forward themselves. A referral to the Secretary of State/IRP need not stand in the way of localities sorting matters out

for themselves where the will is there. In some instances, referral can help to prompt further action and renew the desire to find a solution. Where this is the case, the IRP will try to help the process in whatever way we can (bear in mind that the matter can always be referred again if, ultimately, local resolution proves unsuccessful).

Missing pieces of the jigsaw

Sometimes concerns are not really concerns about what is being proposed but concerns about *not knowing* what is being proposed. Despite the best intentions of those involved, misunderstandings and breakdowns in communication have led to gaps in understanding. Requests from the IRP for missing pieces of information have resulted in HOSC concerns being resolved. In such cases, we have usually advised that procedures be put in place to ensure future information requests are handled appropriately.

Don't jump the gun

The 2002 Regulations relate to consultation with the HOSC. This is different to, and separate from, the need for formal public consultation – though the two may run in tandem, particularly where a HOSC has previously advised an NHS body that it considers a public consultation to be necessary.

A public consultation is an opportunity for all concerned to offer views and to try to influence the final outcome. NHS bodies are required to demonstrate how their proposals have developed in response to feedback. Objecting to a proposal on the grounds that it is not in the interests of the NHS locally before a public consultation has been completed, and decisions made, is premature. Where the IRP considers that a matter has been referred prematurely, we are likely to advise that the process be allowed to proceed to its conclusion.

On the other hand, referring a proposal during a consultation (whether public or with the HOSC) because of deficiencies in the consultation *process* may save time and expense if the NHS body is willing to address legitimate concerns straightaway. With the right timing and tone, the desired outcome may be achieved without any IRP intervention at all (why not contact the NHS first?).

But don't leave it too late

The 2002 Regulations do not provide a deadline by which referrals must be made. But clearly the longer a referral is delayed after a decision has been made, the more progress will have been made towards its implementation. At some stage, there will inevitably be a *point of no return*.

Sometimes, a delay in making a referral may have resulted because the HOSC was not informed of a service change that has since been implemented. In such circumstances, it may be necessary to adopt a pragmatic approach – see *The past is history* below.

Know the rules

The *Background* section of this report outlines the main areas of legislation relevant to NHS service change. The IRP website www.irpanel.org also offers some useful references. Finding all the relevant legislation and guidance and keeping up-to-date with revisions is essential. For example, how many people are aware that paragraph 4(2)(b) of the 2002 Regulations – which covers exemptions for pilot schemes - was revoked in 2006?

Is it substantial?

Some proposals might initially appear to be minor issues. That does not mean that they are not important to someone. What represents a substantial development or variation is not defined. Joint consideration through protocols agreed locally between the NHS and HOSCs can help in this respect. Unilateral determination by an NHS body without discussion with the relevant HOSC is certainly not helpful.

The IRP acknowledges that central guidance on this matter is not as clear as it could be – the DH 2003 document *Overview and Scrutiny of Health - Guidance*[7] remains the most relevant reference available. For the avoidance of any doubt, the IRP takes the view that determining whether a proposal is a substantial development or variation is a matter for *joint discussion and agreement* between NHS bodies and HOSCs.

[7] Para 10.1.2 "The NHS body will need to discuss any proposals for service change with the overview and scrutiny committee at an early stage, in order to agree whether or not the proposal is considered substantial."

The past is history

The NHS is rapidly changing and constantly evolving. The IRP tries to add value by looking to the future and concentrating on how to take things forward. Criticisms of engagement or consultation processes that took place many years ago may or may not be accurate but they are now history. In many instances, if decisions have since been taken and acted upon – contracts signed, buildings constructed, staff recruited or redeployed - it simply is not feasible to return services to how they once were.

In such cases, IRP advice is likely to acknowledge that the clock cannot be turned back and that further action should concentrate on the future – refining planning assumptions and assessing future needs. The Secretary of State's four tests set out the basis for undertaking future service change.

A final thought

The IRP aims to do a balanced and thorough job. Our task is made much easier when *all* relevant information is provided by the relevant parties in timely fashion. Gaps in information – such as a missing letter or absent piece in the chronology – only raise questions and lead to possible delays.

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 8046
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 subject to availability of funding.
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	Proposals fully implemented.
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 – was to be completed spring 2011. Second phase – urgent care, emergency inpatients and planned care – was expected to be implemented in 2013. New review against four tests ongoing.
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
17	South west peninsula	4 June 2010	Oesophageal cancer surgery services	Supported with conditions	Service change implemented with further work on IRP recommendations ongoing.

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[8]

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.

[8] See also section *Learning from Initial Assessments*

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 current or likely impact of patients' choices and the rigour of public involvement and consultation processes

iii. the views and future referral needs of local GPs who commission services, 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.