Independent Reconfiguration Panel
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Sent via email to:
The Rt Hon the Lord Darzi of Denham OM KBE

28 August 2024

Dear Lord Darzi,

I am writing as Chair of the Independent Reconfiguration Panel (IRP) to offer support to your work in leading an independent investigation of NHS performance following the commission you received from the Secretary of State for Health and Social Care. The IRP is accountable to the Secretary of State and our principal role is to advise ministers about reconfigurations and changes to NHS services in England. We also offer informal advice to any party involved in NHS service change to help improve policy and practice in this area.

As you highlighted in your 2008 report *Leading Local Change*, part of your wider report entitled the *NHS Next Stage Review*, NHS reconfigurations should be clinically driven, locally led and always to the benefit of patients. The NHS has undoubtedly got better at doing this over the years, particularly in its approach to involving the public and patients and for example by using the regional Clinical Senates to support and assure local work.

In recent times however, due to the significant performance challenges faced by the NHS, the IRP has observed that rather than service change being driven by an ambition to improve clinical outcomes, the trend has often been for reconfigurations to emerge from operational necessity such as a lack of NHS staffing to sustain services, as well as the poor condition of NHS estates, an issue particularly seen with community hospitals.

This situation speaks to some learning about successful NHS service change – that it needs to be clearly positioned within a wider strategy for meeting patients' needs; does not shy away from discussing the effective use of scarce resources; and makes explicit the workforce plans for recruitment and retention, alongside capital investment for implementation.

The most common type of NHS reconfiguration referred to the IRP over the last 20 years has been the major reorganisation of acute hospital care, such as the centralisation of emergency and elective care on separate 'hot' and 'cold' hospital sites. These proposals usually result in the 'downgrade' of one hospital site via the replacement of their emergency department with an urgent treatment centre and this is understandably an emotive and contentious issue for the local population. The IRP has also seen a shift to centralisation within the NHS justified as a clinical necessity and a means of resolving staffing issues, even when it presents a risk to access for patients and may negatively impact the patient experience, often with regards to travel, transport and ambulance conveyance times.

The IRP's experience of these cases aligns with the Royal College of Emergency Medicine's (RCEM) position in their 2022 guidance on *Reconfiguring Emergency Medicine Services* that there is a strong argument for centralising emergency care for cases of major trauma, heart attack, stroke or vascular surgery via a networked approach. However, as RCEM point out, this must be balanced by maintaining 'core' emergency departments in other hospitals to serve the needs of their local populations by treating time critical or common conditions closer to home.

The IRP is also concerned about the number of overnight or full closures of services that were originally implemented as a short term solution due to staffing issues during the Covid-19 pandemic but still remain ongoing years later. These type of 'temporary reconfigurations' are

prevalent among urgent treatment centres and freestanding midwifery-led birth units, restricting access to care and calling into question their long term sustainability. The continuing uncertainty around the future of these services is unfair to patients and the NHS staff who work in them. It is important that NHS integrated care boards regularly review these ongoing temporary changes to address any concerns raised and to develop effective long term plans in collaboration with their local system partners and the public.

With the introduction of integrated care boards, it is right that there is greater locally led decision making on NHS service change. The government also expects that where possible, disagreements about NHS reconfigurations should aim to be resolved locally. However, there will always be some NHS reconfiguration proposals with wider regional or national significance or where the level of disagreement among stakeholders is so profound that it inhibits progress. These types of proposals may benefit from a ministerial intervention to scrutinise the proposal in more detail with support from the IRP's independent expert advice.

We therefore welcomed the introduction of new powers earlier this year via the Health and Care Act 2022 to allow the Secretary of State to intervene in an NHS reconfiguration by 'calling in' any proposal for decision and for the Secretary of State to act as the final arbiter. The new legislation presents an opportunity for ministers to take decisions on NHS reconfigurations in a timely manner and ensure progress is made when options for local resolution have been exhausted. Any decision by the Secretary of State to 'call in' an NHS reconfiguration proposal should be viewed as a neutral act to enable ministers to examine concerns raised by stakeholders in more detail with an open mind, using a fair process.

I believe that there is also greater scope to streamline approvals and create a single end to end decision making process for major capital schemes that involve the reconfiguration of NHS services. Currently this involves the need to create multiple business cases, some of which duplicate information and must pass through both NHS England's reconfiguration assurance processes, as well as a separate government capital approvals process, including the Joint Investment Committee for NHS England and the Department of Health and Social Care. This creates an inefficient 'double handling' in the decision making process, adding another layer of complexity for the NHS to be able to deliver timely and effective service change.

I note that your investigation's terms of reference also include a focus on highlighting health inequalities, an issue that is also an important part of the IRP's work. A meaningful integrated impact assessment should be included in any NHS reconfiguration proposal, however in the IRP's experience these often only set out to address health inequalities, when it is vital to also consider the impact on healthcare inequalities, meaning timely access to healthcare, the patient experience and health outcomes. Wider factors such as socio-economic deprivation, healthy life expectancy and changes in population demographics can also often by overlooked in NHS reconfiguration planning and need to be considered using a system wide approach.

I understand that your findings from your independent investigation will provide the basis for the government's 10 year plan to reform the NHS. I hope you have found this information helpful as we both continue to support the transformation of the health service.

Yours sincerely,

Norman Williams

Professor Sir Norman Williams
Chair of the Independent Reconfiguration Panel