

Changing for the better



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Foreword

by **David Nicholson CBE, NHS Chief Executive**

Major service change is about modernising treatment and improving facilities to improve patient outcomes, developing accessible services closer to home and saving lives. Sir Ian Carruthers' report on major service change, published in February 2007, was clear that patients' clinical needs must come first in any proposals. This is reiterated in the interim report of the NHS Next Stage Review, which also recognised that the best examples of strong service planning and change had been led by clinicians – with appropriate managerial support – and that no major service change should occur except on the basis of need and sound clinical evidence.

During my visits to local health services, I have seen many excellent examples of local services working in a progressive and open way; with patient representatives, the public and clinical staff each taking leading roles in developing, explaining and implementing service change proposals. Despite this, I also hear from staff and the public that they need to be involved in the development of proposals for major service change from an early stage, rather than simply be asked for their comments during a formal consultation exercise.

This best practice guidance, building on earlier work by Sir Ian Carruthers, has been developed by clinicians and staff working in the NHS as well as patient group representatives. It draws heavily on their experiences of major service change, offers a guide for action to all local health services, and sets out a total of 15 recommendations that will help ensure the process is more open, transparent and fair. I would like to thank everyone who has contributed to its development.

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Introduction

This best practice guidance has been developed in order to provide clear guidance for patients, the public and NHS staff on the processes underpinning changes to NHS services. It will help to ensure that changes to local services are:

- based on sound clinical evidence;
- made in the best interests of patients; and
- made as part of ongoing dialogue with local stakeholders about services in the area.

It is based on earlier guidance¹ and the interim report of the *Our NHS, our future: NHS Next Stage Review*.² Findings and recommendations from the Office of Government Commerce's (OGC) Health Gateway Reviews have also been included as well as expertise and learning from NHS staff and clinicians.

1 www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_072365

2 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079077

3 <http://bre.berr.gov.uk/regulation/documents/consultation/pdf/code.pdf>

Current statutory and Cabinet Office requirements for formal consultation³ and the existing OGC Gateway Review Process itself are not altered by these guidelines.



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NHS Next Stage Review

The interim report of the NHS Next Stage Review, prepared by Professor Lord Ara Darzi and issued in October 2007, emphasised the need to:

“ensure that any major change in the pattern of local NHS hospital services is clinically led and locally accountable, by publishing new guidelines to make clear that:

- *change should only be initiated when there is a clear and strong clinical basis for doing so,*
- *consultation should proceed only where there is effective and early engagement with the public, and,*
- *resources are made available to open new facilities alongside old ones closing.”*

Lord Darzi also said in the report, *“At the same time, I have heard during the first part of the Review that where change does go ahead, it does not always happen as transparently as it should. We need to reassure patients and the public that change is necessary and that it will improve the care they receive. We should be clear from the outset that no major service change should happen except on the basis of need and sound clinical advice.”*

Furthermore, Lord Darzi confirmed the intention to *“raise the standard of evidence we expect before service change takes place”*. The Next Stage Review therefore recommended that a set of guidelines on how local areas should undertake major changes to NHS services should be published, based on the principles and recommendations set out by Sir Ian Carruthers in February 2007. This document fulfils that commitment and makes clear to the NHS and the public that:

1. Change will always be to the benefit of patients and, where appropriate, their carers. This means that they will improve the quality of care that patients receive – whether in terms of clinical outcomes, experiences, or safety.
2. Change will be clinically driven. We will ensure that change is to the benefit of patients by making sure that it is always led by clinicians and based on the best available clinical evidence.
3. All change will be locally-led. Meeting the challenge of being a universal service means the NHS must meet the different needs of everyone. Universal is not the same as uniform. Different places have different and changing needs – and local needs are best met by local solutions.

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4. You will be involved. The local NHS will involve patients, carers the public and partners. Those affected by proposed changes will have the chance to have their say and offer their contribution. NHS organisations will work openly and collaboratively.
5. You will see the difference first. Existing services will not be withdrawn until new and better services are available to patients so they can see the difference.

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Developing proposals for service change

Leadership

Boards, including Chairs, Chief Executives, Medical Directors of NHS Trusts and Chairs of Professional Executive Committees in Primary Care Trusts (PCTs), should exercise collective and personal leadership and accountability when considering the development of proposals for major service change.

They should reach out to their communities to involve them at every stage in the planning and development of existing services and also proposals for change. They should champion, and be strong advocates for, the requirements set out in this guidance.

Under the principles of the Compact on Relations between Government and the Voluntary and Community Sector (VCS)⁴ NHS organisations should also ensure they involve the VCS and wider third sector, including social enterprises, when drawing together proposals to change local services.

⁴ www.thecompact.org.uk

The role of PCTs

Strong co-ordination of local proposals is essential. PCTs are ideally placed at the centre of major service change and should drive service improvement where appropriate. This is a key role for PCTs as described within the vision and competencies for World Class Commissioning.⁵

In addition to involving patients and the public, clinicians must also be involved in developing ideas, options and proposals, and this should be an integral part of an ongoing engagement process for the duration of the exercise.

⁵ www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Commissioning/Worldclasscommissioning/index.htm

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The role of the Strategic Health Authorities

It is imperative that each Strategic Health Authority (SHA) makes sure that there is appropriate capability and capacity in the NHS – at both SHA and PCT level – to develop robust, evidence-based proposals, undertake effective consultation processes and successfully implement the resultant changes.

Each SHA and local health community should have a clear and coherent strategy in place that identifies all current and future service change proposals. These should be clearly linked to the outputs of local commissioning strategies.

It is the responsibility of SHAs to ensure that all PCT-led consultations on substantive service change are robust in terms of content, timing and process. SHAs should also ensure that each scheme complies with relevant legislation and other regulatory requirements (such as Equality Impact Assessments), follows good consultation practice and is open, transparent and fair.

Each SHA should also identify the wider impact of major service change, including the implications for neighbouring SHAs and the impact on providers and people who use services as well as the sustainability of the whole system.



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Involvement and consultation

Under Section 242 of the NHS Act 2006⁶ NHS organisations must make arrangements that secure the involvement of people who use services in:

- planning the provision of services;
- the development and consideration of proposals for changes in the way those services are provided; and
- decisions to be made by the NHS organisation affecting the operation of services.

PCTs need to make sure that patients, the public and other relevant stakeholders – such as Local Involvement Networks (LINKs) – are involved at all stages in the development and consideration of proposals, not just at an advanced stage of the development of the options that will be consulted on, or during the actual consultation itself.

The Department of Health is publishing further policy and practice guidance for Section 242 in Summer 2008.

⁶ www.opsi.gov.uk/Acts/acts2006/ukpga_20060041_en_18#pt12-ch2-l1g242

Involving the right people

PCTs should hold early and ongoing discussions with local authority Overview and Scrutiny Committees (OSCs) – comprising elected councillors with roles to consider issues affecting the health of local people – in order to ensure they are involved in, and briefed about, emerging service models.

Consultation should follow the principles of the Cabinet Office code of practice⁷ and will usually run for 12 weeks but additional time should be allowed should, for example, consultation overlap the Christmas and new year holiday periods, or elections.

The outcome of the consultation is also subject to scrutiny by the OSCs or, where a proposal impacts a number of local authority areas, a Joint OSC (JOSC). Where the committee is not satisfied with the content of the consultation, or that the proposal is in the interests of the health service in its area, it has powers to refer these issues to the Secretary of State for Health. The Department of Health will explore options for the introduction of local mediation where individual OSCs in a JOSC cannot agree a shared position.

Local resolution of issues is always preferable. To resolve this issue, early engagement of stakeholders, and also an independent analysis of consultation responses, has been found to be extremely helpful.

⁷ <http://bre.berr.gov.uk/regulation/documents/consultation/pdf/code.pdf>

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The clinical case for change

Service change is about improving patient care; modernising treatment and improving facilities to improve patient outcomes; developing accessible services closer to home; and saving lives.

Sir Ian Carruthers' report on service reconfiguration (February 2007) clearly stated that patients' clinical needs must come first in any service reconfiguration proposal.



Clinicians have also told us that specialist care needs to be “centralised where necessary, localised where possible”, so that clinicians with the right expertise, experience and equipment can treat the sickest patients safely and conveniently. This is reiterated in the relevant clinical cases for change issued by the Department's National Clinical Directors.⁸

Every consultation document and/or business case underpinning service change should therefore set out the case for and against a range of options, in line with best clinical evidence, as well as clearly setting out the implications for no change. Clinical Directors in PCTs should be responsible for generating, leading and managing major service change and for making sure that front-line and other staff are engaged throughout the process.

Doctors, nurses and other healthcare professionals also have an important role to play and should work with stakeholders – including local people – from the outset to develop proposals for major service change.

Where appropriate, the realisation of the benefits should be clearly quantified using techniques such as Quality Adjusted Life Years (QALYs) – a way of measuring both the quality and the quantity of life lived as a result of an intervention. Ideally, these proposals should also outline the projected numbers of lives saved and state the improved quality of service and reduced risks to patients as well as the wider benefits, such as numbers treated in their own homes or community settings, that will follow.

⁸ <http://www.networks.nhs.uk/356.php>

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Taking the lead

Given the emphasis on the clinical case for change and for patient, public and clinical engagement in their development, it is unlikely that proposals for major service change that do not have support (across the relevant sectors) would be allowed to progress to formal consultation.

A senior clinical lead (or leads, and if appropriate from both primary and secondary care) should be identified at the outset for each consultation on a major service change. They should be supported to help them ensure that their fellow clinicians and other stakeholders, including local people, are actively involved in the development of proposals.



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Business cases

All options to be consulted on must clearly demonstrate clinical viability, affordability, and how they will be staffed.

A business case setting out the clinical and patient benefits should be produced for all options. The size and complexity of the business case will vary according to the change(s) being considered. As a minimum, it should:

- be explicit about the number of people – patients, doctors and other clinical staff – affected and the resultant benefits for each group;
- outline how patients, the public and other community stakeholders have been involved and how their views have informed and influenced the development of the options that will be consulted on;
- show that options are affordable and clinically viable (including projections on income and expenditure and capital costs/receipts for the affected bodies);
- show that any planned savings that may arise are realistic and achievable within the specified timetable;
- outline how the proposed service changes will tackle health inequalities;
- demonstrate linkage to relevant Joint Strategic Needs Assessments, Local Area Agreements and broader PCT commissioning plans;

- be explicit about how the proposed changes impact on local government services and the response of local government where appropriate; and
- be explicit about how the proposed changes impact on other public services, informed where appropriate by Compact principles and undertakings.

Options should also include a detailed analysis of the impact on travelling times and distances, identifying the impact on pedestrians and public and private transport users as well as the ambulance service.

Implementation

Implementation plans (even in outline) should be part of the pre-consultation business plan and will also need to be published for all options at the same time as consultation on major service changes.

As a minimum, they need to include the following information:

- the specific changes being proposed and when the new facilities and services will be available;
- how the proposed changes will impact on quality, access to services and patient safety;
- the timescale for implementation;
- the impact on the workforce and any recruitment and other staffing implications; and
- how financial resources will be made available to support implementation of the new services.

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Communicating proposals for major service change

It is essential that the local NHS has an effective plan for communication that will promote enthusiasm for and understanding of the case for change. As a minimum this should cover engagement with staff, patients, the public and representative organisations, MPs, OSCs and the local media. These should be established alongside the development of the options and articulate a consistent message stating:

- the purpose of the proposed options for service change;
- the clinical need for change; and
- key stakeholders and how proposals will benefit each stakeholder group.

Every proposal should also have an individual consultation plan, which is linked to, but separate from, the broader communication plan. This should cover the range of activities planned to involve and consult with local people and representative organisations, staff and other stakeholders. It will indicate who will be involved and how, the dates for each element of the plan and who is responsible for each activity. This plan will act as a record of the consultation process to ensure that all stakeholders – in particular staff and the public – have been

fully involved at all stages. It should be updated on a regular basis throughout the consultation period.

It is also important to respond to, and where necessary correct, any misleading or inaccurate information about particular proposals as soon as this type of information emerges – in many cases this can be negated by ensuring regular updates and information bulletins are made available to all stakeholders.

Getting the message across

Consultation documents should contain specific, relevant and clear information presented in plain English.

Every effort must be made to encourage all local people to contribute to the consultation. Careful consideration should be given as to the most appropriate way of providing access to information for people who, for example, do not speak English as a first language and for people who may require documentation in other formats, such as audio or large print. This will ensure that all stakeholders can comment on local proposals in an informed way.

The most successful staff engagement programmes have recognised that staff can be powerful advocates for change in their local communities, as they are also local residents, patients and stakeholders. Employers must therefore ensure that staff are continuously engaged in the development of proposals and implementation of service changes.

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Programme and Project Management Arrangements

A suitably experienced programme manager should lead, and have oversight of, the whole service change exercise. For any proposal there should be a carefully developed plan that sets out:

- how, when, where and by whom decisions will be made;
- the escalation paths for dispute resolution, if required;
- the key dates for meetings linked to the programme for involvement and consultation as well as key board dates and other milestones;
- clear lines of reference to communication and other engagement strategies;
- risk management and contingency arrangements; and
- the leadership and accountability for the overall programme and associated workstreams.

Office of Government Commerce Gateway Review Process

The Interim Report of the NHS Next Stage Review recognised the benefit of clinical involvement when considering major service change proposals. It also set out a recommendation that any proposals to change services should, prior to consultation, be subject to independent clinical and management assessment.

These assessments will be provided for all schemes from April 2008 through the Office of Government Commerce's (OGC) Gateway Review Process.

The Gateway Review Process is a series of short, focused, independent peer reviews carried out at key stages of a programme or project. The reviews are designed to highlight key risks and issues, which if not addressed would threaten the successful delivery of the business outcomes.

The review process usually takes approximately 3–4 days and involves interviewing a wide range of key stakeholders, including clinicians, patients, users, boards, staff and responsible managers for the programme.

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At the end of the review the Gateway Review Team provides a short, focused report outlining key findings and recommendations.

The Gateway Review Team will take account of the findings of the independent clinical review process conducted by the National Clinical Advisory Team (NCAT) or – and in agreement with the Department of Health – be based on any other such clinical advice that may be appropriate that will precede the Gateway Review. The chair or a member of the clinical review team may also become a member of the Gateway Review Team.

Further detail about Health Gateway Reviews and NHS service changes are available via:

www.dh.gov.uk/reconfigurationgatewayreviews

Action plans produced by programme/project teams in response to Gateway Review reports will be made publicly available in future.

Annex A

Changing for the better – summary of recommendations

1. Each SHA should oversee proposals for major service changes and improvement in its area, in line with the recommendations in this guidance.
2. Each SHA should have a clear and coherent strategy and work programme in place covering all (current and future) service improvement proposals.
3. Each SHA should ensure that there is appropriate capability and capacity at both SHA and PCT level to ensure that robust, evidence-based proposals are developed, effective involvement and consultation are undertaken and successful implementation is achieved.
4. Each SHA should also ensure that the appropriate staff, skills, resources and project management arrangements are in place to deliver a successful change programme.
5. PCTs should normally lead the preparation and consultation on service improvement proposals.
6. A business case setting out the clinical and patient benefits of service change should be approved for all proposals, and should be reviewed by the SHA before consultation begins (the business case should also include implementation plans – see next recommendation).
7. Implementation plans should also be drawn up for all options. These should include the clinical model, clinical viability, affordability, implementation timetable and staffing implications. Resources for new facilities or services should be made available to open new facilities alongside old ones closing.
8. Reconfiguration proposals need to be specific about the impact of the proposed change on the quality of patient services, including the number of lives saved, risk reduction, improvements in health inequalities etc.
9. SHAs should ensure that there is a framework in place for testing the options to show that they are sufficiently robust and fit for purpose – before formal consultation proceeds and for testing any new options that may result from the consultation.
10. A senior clinical lead should be identified at the outset, and be supported to help make sure that other clinicians are involved in the development of proposals for change.
11. Chairs, Chief Executives and Boards are accountable for and should take a personal lead in the formulation and delivery of proposals. They should actively champion proposals and act as advocates for these guidelines, ensuring their adoption and application locally. Their role must be proactive, not passive.

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Summary of recommendations (continued)

12. Before embarking on the process, it is important to have a clear, evidence-based communications and stakeholder engagement plan, which is managed and effectively delivered throughout, and makes best use of available clinical evidence such as the relevant clinical cases for change issued by National Clinical Directors.⁹
13. Every service improvement scheme should have a clear stakeholder engagement plan involving the most senior officers and clinicians in the organisation, which includes involving stakeholders routinely and regularly throughout the lifecycle of the scheme.
14. SHAs should ensure that each scheme in its work programme complies with consultation legislation and guidance in an accurate, effective and timely fashion.
15. Each SHA should provide assurance to the Department of Health that effective local gateway mechanisms are in place. All proposals for major service change will be subject to separate OGC Gateway Reviews. These reviews will include an independent clinical assessment of the proposals for service change.

⁹ www.networks.nhs.uk/356.php



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