Effective Service Change
A support and guidance toolkit

NHS England

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Introduction

This toolkit is intended to provide an overview of the support and guidance available to local organisations as they seek to progress service change.

This toolkit is built on best practice and will be updated to reflect national developments. It describes how local processes might be agreed to ensure whole system support for, and the successful delivery of local programmes of change.

It is not a ‘one size fits all’ approach and is intended to be a framework, ensuring a consistent application of principles across England, whilst allowing flexibility to local circumstances in how they are applied. The aim is to mitigate risk and securing the confidence of patients, staff and the public in change proposals.

The principles in this document are intended to be applied proportionately, preserving the principles of autonomy that underpin the Health and Social Care Act 2012.

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1. Service change overview

What is significant service change?

There is no single, accepted definition of major service change. It is generally understood to involve a significant shift in the way front line health services are delivered, usually involving a change in the geographical location where services are delivered

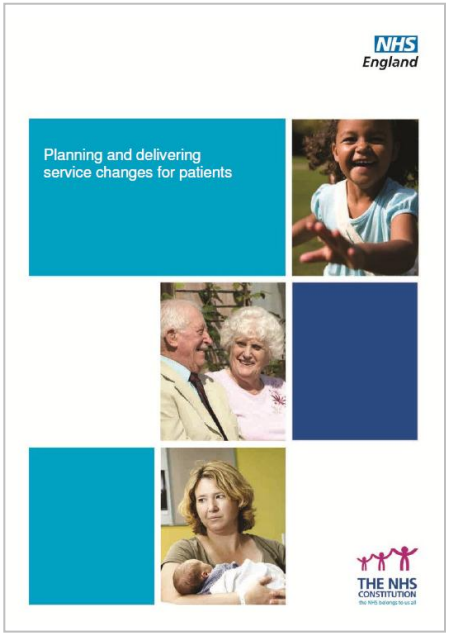
In health scrutiny regulations, NHS commissioners must consult local authorities where there is a ‘substantial development of the health service’, or for ‘a substantial variation in the provision of such a service’. This might mean service users experience a different service model or have to travel to another site for their services.

Given there is no single definition, each case should be examined individually. Local definitions have evolved via custom and practice in health communities.

For these purposes service change is not organisational change (mergers, transfers of responsibility for services), or operational change (e.g. movement of services between wards in same site).

Service change guidance

‘Planning and delivering service changes for patients’ (Dec 2013) sets out a broad framework, roles and responsibilities for commissioners in how they should plan for major service change, work with providers, local authorities, patients and the public. It includes



- The principles underpinning effective service change
- Good practice on developing proposals, business cases, public engagement and consultations
- Guidance on the Government’s ‘four tests’ for reconfiguration
- A summary of relevant legislation including legal duties on public involvement, and consultation with local authority health scrutiny
- A summary of how local commissioner proposals will be supported and assured by NHS England which is expanded on in this assurance toolkit.

The guidance can be found on the NHS England website at
www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

Key principles (1)

- The objective of service change should be to achieve a fundamental improvement in the quality and sustainability of services, in a way that gains the support of patients, staff and the public. Assurance should not therefore be reduced to just satisfying a checklist of legal requirements. Rather, the process set out in the following pages should be seen as best practice, that aims to help organisations take forward complex programmes of service change.

- All service change needs commissioner ownership, support and leadership (even if change is initiated by provider or other organisation). This is so any major service change aligns with commissioning intentions and plans. Where services are commissioned by two or more commissioners, it is essential that proposals align with each organisation's commissioning intentions.

- It is important that, irrespective which organisation proposes a major service change, there is a consistent, robust assurance process so all parts of the NHS are working together to address these issues and that gives confidence to patients, staff and the public.

- The formal assurance of proposals should be undertaken in good time before any formal public consultation exercise.

Key principles (2)

- In assessing proposals against the tests, organisations are advised to ensure they have evidence that demonstrates the changes will bring improvement in quality, safety, effectiveness of care, and that proposals are clinically sustainable within available resources. In addition to the four key tests NHS England have a set of best practice checks for service change (slides 22-23). NHS England will provide advice against these best practice checks, the range of which should be agreed proportionately on a case-by-case basis.

- Service change assurance does not change accountabilities for decision making, which remain with commissioners. Assurance may raise issues and risks that NHS England would expect commissioners to want to consider and address before progressing their proposals.

- If NHS England felt that CCGs were not responding to the advice provided through assurance it may be appropriate, if for example the four tests were not met or delivery of the Mandate was imperilled, to consider escalation through the CCG intervention regime. However this would be a last resort to be used only in exceptional circumstances.

Four tests for service change

NHS England will expect ALL service change proposals to comply with the Department of Health's four tests for service change (referenced in the Mandate Para 3.4 and 'Putting Patients First') throughout the pre-consultation, consultation and post-consultation phases of a service change programme. The four tests are:

i) strong public and patient engagement;

ii) consistency with current and prospective need for patient choice;

iii) a clear clinical evidence base; and

iv) support for proposals from clinical commissioners.

As a proposal is developed and refined commissioners should ensure it undergoes a rigorous self-assessment against the four tests.

Six characteristics of quality & sustainability

Everyone Counts 2014-15 to 2018-19 [1] describes six characteristics of a high quality and sustainable system. Service change proposals should contribute to the creation of a system that has the following characteristics:

1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care
2. Wider primary care, provided at scale
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step-change in the productivity of elective care
6. Specialised services concentrated in centres of excellence (as relevant to the locality)

Evidence of alignment with these characteristics will be sought when assuring service change proposals.

1 http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Timetable

A number of early discussions can help shape the planning of service change proposals, these might include:

- early discussion between commissioner(s) and partner organisations (including Area Team) to flag intentions and discuss potential options and approaches (in advance of the formal assurance process);
- discussion with NHS England's area and regional teams and the national support centre strategic finance team regarding support and assurance (again pre-formal assurance);
- organisations agreeing roles and responsibilities which will then be reflected in programme plan timelines;
- undertaking a full stakeholder mapping exercise (this might include: public, patients, OSC, neighbouring CCGs, providers, HWB, CQC, Monitor, TDA, media and MPs); and
- programmes may need to consider the alignment of service change assurance with procurement and capital approval processes.

2. Assurance

Why have a support and assurance process?

Robustness, openness and transparency

An effective external assurance process should give confidence to patients, staff and the public that proposals are well thought through, have taken on board their views and will deliver real benefits.

Risk mitigation

This support and assurance process mitigates the risk of successful challenge. Schemes can be challenged via a referral to the Secretary of State (who may ask for advice from the Independent Reconfiguration Panel), or a request for judicial review. The risk of successful challenge is greatly reduced by following the appropriate advice and guidance and ensuring best practice is applied.

The high costs of getting it wrong

A recent high profile programme that has been subject to both Judicial Review and referral to the Secretary of State is estimated to have cost >£6m. The proposed changes remain unimplemented.

The potential reputational risks are significant, as is the impact on an organisation's relationships with key stakeholders.

Principles for support & assurance

- NHS England's assurance of service change proposals should be **supportive and confidence building**, adding value by helping mitigate risk. It offers advice and does not change accountabilities for decision making.
- NHS England has both a legal duty and an objective in the Mandate to promote the autonomy of clinical commissioners. Therefore it is **important that assurance is applied proportionately** to the change being proposed, and that the level of assurance required should be tailored to the service change.
- NHS England can support the robustness of local planning, helping commissioners by applying a **single consistent process**, incorporating all relevant national guidance. NHS England also has an important role in working with **other organisations** (e.g. TDA, Monitor, CQC, HEE) so that the service change process reflects policy developments and guidance published by its partners.
- Assurance should be exercised **as locally as possible** to the scheme in question with organisational roles and responsibilities agreed as early as possible
- **Independent advice** may be sought (e.g. Clinical Senates & Gateway Teams)

Decision making tool – level of assurance

This model may assist decisions about the level of assurance required by NHS England for particular service change proposals.

Large	Scale of proposed change	Small
Significant	Financial implications	Minor
High	Profile of services	Low
Weak	Consensus on case for change & proposals	Strong
Many	Organisations involved	Few
Broad	Geographical focus	Narrow
Significant	Impact on directly commissioned services	Minor

More detailed level of assurance and advice

Increasing Area Team support

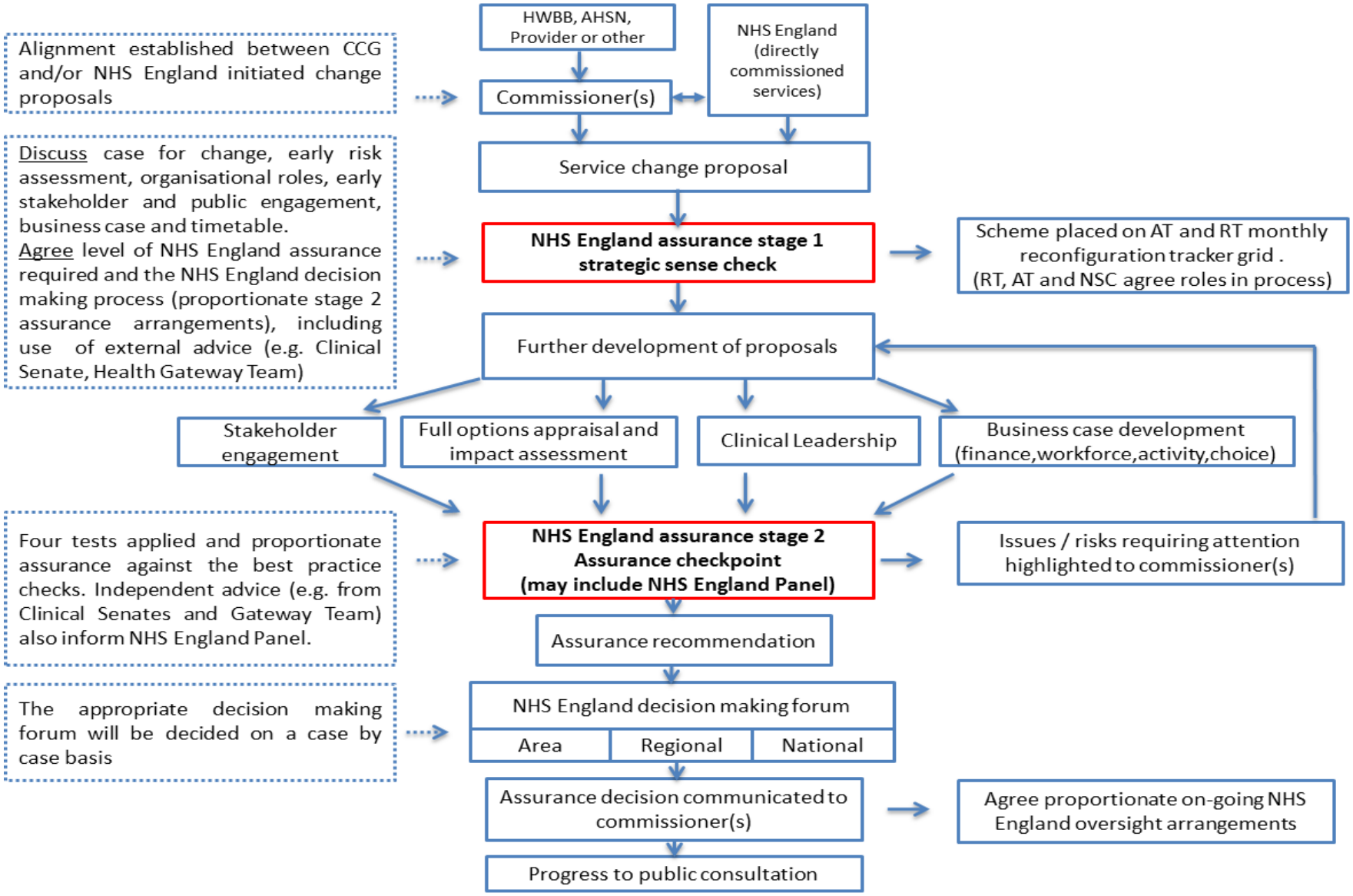
Increasing Regional Team involvement

Increasing National Support Centre involvement

Increasing use of Clinical Senate and Gateway Team support

Assurance against 4 tests required

The assurance process



Stage 1: The strategic sense check

A formal discussion between commissioners leading the change and NHS England at the most appropriate level (usually the Area Team). NHS England will want to explore the case for change and the level of consensus for change; ensure a full range of options are being considered and that potential risks are identified and mitigated. The alignment between the proposed change and the strategic intent of NHS England, other key partners and neighbouring organisations will also be discussed. Commissioners will need to demonstrate proposals align with their statutory functions.

Areas of focus include:

- organisational roles (particularly relevant for complex multi-organisation schemes)
- the level of key stakeholder involvement and sign up.
- likely resource requirements, including support requirements;
- inter-relationship or potential overlap between CCG and or NHS England initiated change proposals and to seek to align these elements (including establishing a lead commissioner for assurance);
- the role networks and clinical senates might offer in providing advice in the development of proposals.
- choice and competition implications of the proposals
- capital and estates implications (in conjunction with the NHS England Project Appraisal Unit)
- parameters for defining and appraising options (in conjunction with the NHS England strategic finance team)

The strategic sense check will agree NHS England's expectations in terms of assurance and the use of a best practice approach. The use of external independent advice, for example the Gateway Team and Clinical Senates, should be discussed and agreed at this stage. Any particular issues to be included in terms of reference for these reviews should be specified.

For some small scale schemes it may be agreed that CCG self-assurance against the key tests and appropriate best practice checks (to include four tests as a minimum) is appropriate and a more limited second stage process is required.

Strategic sense check - questions

Suggested questions to be considered at the strategic sense check (this is not an exhaustive list):

- What is the case for change and how can it be evidenced? How will the proposals benefit patients and the public?
- How can commissioners ensure that the proposals will deliver care that is high quality, safe, effective and sustainable?
- How does the proposal measure against the DH's four tests for service change?
- What options have been considered (and do they include a do nothing option)?
- What is the proposed timetable for change?
- Have the local authority been appropriately engaged via both the Overview and Scrutiny Committee and the Health and Wellbeing Boards?
- What is the level of stakeholder (e.g. HWB, OSC, LA and MP) support, what public and patient engagement work has been undertaken and what is planned?
- What are the implications for other NHS organisations (commissioners and providers) including neighbouring organisations?
- How do the proposals measure up against the factors identified in the 'decision making tool for levels of assurance' and consequently what level of assurance and advice do NHS England feel is appropriate?
- What analysis has been undertaken of the proposals compliance with equalities duties and do plans exist to reduce inequality impact on those unduly affected?
- How robust is the economic and financial case, including assessment of the financial impact during the transition phase and testing of how financially sustainable is the outcome is port-transition?

Strategic sense check - outputs

There are a number of key decisions to be made at the strategic sense check. They should be recorded in a letter to the lead commissioner(s) following the meeting and include:

- the expectation that NHS England assurance will be undertaken and advice will be received before any proposal progresses to public consultation;
- the judgement made against the main factors used to influence the appropriate level of assurance; and
- the range and depth of assurance required by NHS England (as a minimum this will be against the four tests for service change which should be stated).

The assurance process, including specifying use of any independent external advice (e.g. Clinical Senates, Health Gateway Team) should be defined. Any requirements to be included in the terms of reference for either a Clinical Senate or Gateway team review should be specified and recorded in the letter.

The AT letter should state if they anticipate a single stage process where the scale of the proposals doesn't require a second stage of assurance. For complex schemes it should also clarify the organisational roles including the commissioner leading the service change assurance and the NHS England team leading on assurance.

Stage 2 assurance -NHS England checkpoint

A formal assurance of the proposals undertaken by NHS England the scope of which will reflect the agreements made at the strategic sense check. The AT or RT may decide to establish an assurance panel to discharge its responsibilities in terms of assurance against the tests and best practice checks. The panel would be formed by a range of NHS England staff who are suitably qualified to consider evidence submitted against the four key tests and to advise on the additional checks.

The NHS England panel might also consider the reports or findings received from external or independent advisory bodies. Typically these would have examined either the clinical case for change and clinical model, or the programme management arrangements with advice sought from the Clinical Senate and the Health Gateway Team respectively. Other organisations (e.g. LETB, TDA, Monitor, Healthwatch, CQC) might also be invited to share their views of the proposals to help inform the NHS England Panel. They would not however be members of the NHS England Panel.

The key tests and best practice checks are listed on slides 22 and 23. The 'four key tests' are mandatory for all schemes, the best practice checks should be applied proportionally as agreed at stage 1 the strategic sense check. NHS England would also want to assure alignment between proposals and the six characteristics of a high quality and sustainable system described in the 2013-14 planning guidance and on slide 10.

NHS England also expects schemes to be underpinned by robust economic and financial evidence.

The Chair of the NHS England Panel needs to be of sufficient seniority and experience to draw together the Panel's views and make a recommendation on its behalf to the appropriate decision making forum within NHS England.

Stage 2 assurance: NHS England checkpoint

The NHS England Panel would need to consider whether it was assured, partially assured or not assured against each of the key tests and provide comment against the appropriate best practice checks and the six characteristics of a high quality and sustainable system. This would then form the basis of the panel's report, along with any risks, issues or other recommendations they identified. The Panel's report should conclude with a recommendation to NHS England on the next steps, this could be in one of three categories:

- Assurance received and NHS England advises commissioners to proceed;
- Partial assurance received and NHS England advises commissioners to proceed alongside advice on further work for commissioners to consider undertaking (this advice may or may not recommend work be undertaken before public consultation begins); or
- Assurance not received and NHS England advise against proceeding with the proposals at this point.

For proposals that are advised not to proceed at this point NHS England would then initiate further discussions with the lead commissioners on how best to address the case for change.

Each recommendation would be made to the appropriate forum within NHS England. This might be a decision made at Area Team Director, Regional Team Director or national Board level on behalf of NHS England. The appropriate decision making forum will be decided by NHS England on a case by case basis.

The four tests and best practice checks

Criteria	Key Tests	Example Evidence
4 key tests	• Support from GP commissioners will be essential • Arrangements for public and patient engagement, including local authorities should be further strengthened • Clarity about the clinical evidence base underpinning proposals • Proposals take into account the need to develop and support patient choice	• Documented evidence of GP support • See communications and clinical quality and activity sections below
	Best Practice Checks	
QIPP / Finance	• How does the proposal support commissioner and provider financial sustainability? • Does the proposed change improve quality and reduce cost? How (e.g. reduced duplication, increased efficiency)? • What are the savings in financial terms? • What capacity is being taken out of the system and where? • How, when and where is a saving made? Is it a cash releasing saving? • Are the transitional costs (including non-recurrent revenue and capital) identified and properly accounted for? How will they be funded? • Capital investment implications have been considered in terms of the viability, deliverability and sustainability of the proposal and the economic (value for money) impact • Finance links consistently to workforce and activity models	• Business case (if available) or strategic outline case including worked through financial models • Evidence of aligned financial, workforce and activity models • Capital investment implications identified to NHS England Project Appraisal Unit for review
Clinical quality and strategic fit	• Clear articulation of patient, quality and financial benefits • Clinical case fits with national best practice • Fit with local H&WB strategy and aligned with the objectives and commissioning intentions contained in local commissioners strategic plans • Options appraisal (inc. consideration of a network approach, cooperation and collaboration with other sites and/or organisations) • Alignment with 6 characteristics of a high quality, sustainable system • Macro-impact is properly considered • Alignment with QIPP workstreams • Full impact analysis across CCG / NHS England commissioned services and shared sign up of all parties to analysis	• Clinical case for change including risk analysis • Reference to national evidence base which could include NCD reports, NICE, Royal College or NHS Evidence. • Narrative demonstrating alignment with strategic objectives • Options appraisal for network /collaborative / cooperative approach • Narrative against the 6 characteristics (see slide 8) • Analysis of macro-impact • Identify links to local strategic plan and QIPP workstreams • Analysis of impact on CCG / NHS England commissioned services endorsed by relevant parties.
Activity	• All relevant patient flows and capacity are properly modelled, assumptions are clear and reasonable • What are the changes in bed numbers? • Activity and capacity modelling clearly linked to service change objectives • Activity links consistently to workforce and finance models • Modelling of significant activity, workforce and finance impacts on other locations / organisations	• Outputs of accurate modelling with assumptions clearly stated and sensitivity analysis • Clear explanation of reduction in bed numbers • Narrative explaining link between modelling and service change objectives • Aligned financial, workforce and activity models • Analysis of key risks and any mitigating actions

Best practice checks

Criteria	Best Practice Checks	Example Evidence
Workforce	• Do you have a workforce plan -integrated with finance and activity plans? • Are you making most effective use of your workforce for service delivery and is it compliant with all appropriate guidance? • Consider the implications for future workforce • Have staff been properly engaged in developing the proposed change?	• Supply high level workforce risks and mitigating actions • Statement of assurance including reference to all appropriate standards • Changes to provider Learning Development Agreements • Evidence of appropriate staff engagement
Travel	• Has the travel impact of proposed change been modelled for all key populations including analysis of available transport options, public transport schedules and availability / affordability of car parking?	• Travel impact assessment
Resilience	• How will the proposed change impact on the ability of the local health economy to plan for, and respond to, a major incident? • Has a business impact analysis been conducted for all impacted organisations and appropriate changes made to Business Continuity Plans? • Local Health Resilience Partnership impact assessment on resilience?	• Statement of assurance • Evidence the proposed service change and the impact on resilience has been assessed at the Local Health Resilience Partnership (LHRP)Business impact analysis
Ambulance services	• Have the implications for ambulance services (emergency and PTS) been identified and impact assessed and appropriate discussions been held with ambulance service providers?	• Statement of ambulance service engagement and impact assessment
Comms and Engagement	• Are there plans to appropriately and effectively engage and involve all stakeholders (to include: staff, patients, carers, the public, Healthwatch, GPs, media, local authority overview and scrutiny functions, Health and Wellbeing Boards, local authorities, MPs, other partners and organizations) and fulfil commitments under s.14Z2 and s.13Q of the Health and Social Care Act?	• Consultation plan and draft consultation document • Public / stakeholder involvement strategy • Communications plan including full stakeholder map with timelines, key messages, named clinical spokespersons, sample materials and plans to reach seldom heard groups
Equality Impact	• There has been an appropriate assessment of the impact of the proposed service change on relevant diverse groups? • Has engagement taken place with any groups that may be affected? • What action will be taken to eliminate any adverse impacts identified?	• Completed EqIA and Action Plan • Evidence that decision-making arrangements will pay due regard to equalities issues
TDA/Monitor	• Is proposal aligned with the TDA's / Monitor's approach	• Business case (if available) or strategic outline case
IT	• Does proposal make best use of technology? • Assessment of the impact on local informatics strategy & IT deployments • Are there likely to be any data migration costs? • Are there any implications for specialist or network technology/equipment contracts associated with the service?	• Evidence of a review of how technology may support the service change been undertaken • Detail of any changes to local informatics strategy and deployment plan, inc. information flows and governance. Key risks are highlighted and mitigating actions identified
Others	• Consistent with rules for cooperation and competition (Monitor/OFT/CC) • Consideration given to the most effective use of estates • Robust programme and risk management arrangements	• Assurance from commissioners • Estates impact assessment • Gateway Team report and response to recommendations

3. Directly Commissioned Services

Directly commissioned services - issues

Changes to directly commissioned services raise potential issues for commissioners, these issues include:

1. Potential **impact of service changes on other commissioners** (e.g. CCG led change impacts on directly commissioned services or NHS England led change impacts on CCG commissioned services). There may also be an overlap in patient pathways that have both CCG and NHS England commissioned elements.*

2. Commissioners need an **awareness of one another's plans** for service change so they can align their intentions and timescales.

3. NHS England's **potential conflict in leading and assuring service change**

* impact on directly commissioned services will predominantly affect specialised however there may be some cases where there is an impact on health and justice or military health services directly commissioned by NHS England.

Directly commissioned services - approach

1. **A best practice check is introduced for proposals** as follows:

   'A full impact analysis (of the proposal) across CCG / NHS England commissioned services and shared sign up of all parties to analysis.'

   Appropriate evidence might be an impact analysis on CCG and NHS England commissioned services, endorsed by the relevant parties. In practice this would mean: for a CCG led change, checking overlaps and impact on directly commissioned services with the appropriate AT(s); for an NHS England led change, checking overlaps and impact with the appropriate CCG(s) or lead CCG(s).

2. **Sharing of the monthly service change tracking grid** with RT and AT direct commissioning leads will provide a conduit by which the appropriate connections between commissioners and their proposals can be made. Issues of mutual interest can be identified early and ATs/RT can ensure early discussions are held to align or influence proposals.

Directly commissioned services - assurance

3. NHS England's potential conflict in leading and assuring service change

NHS England will be mindful of both potential conflict of interest and the perception of such conflicts when assuring service change proposals; this is particularly pertinent in its dealings with proposals that effect services it directly commissions.

A robust assurance process, proportionate to the scale of the proposed changes, will be agreed following discussion between teams within NHS England on a case-by-case basis. The level of assurance required will be determined using the same principles as for locally-commissioned proposals. This provides the flexibility to respond pragmatically to the variation in scope, geographical scale, complexity and other factors that will characterise proposals with an impact on directly commissioned services.

Assurance will need to be undertaken and overseen by an NHS England team with no direct links to the proposals, their development, implementation or consequences. In practice this may mean that a geographically and/or functionally and/or organisationally separate team within NHS England's structures undertakes the assurance process. The NHS England Panel would apply a strict 'chinese wall' around this assurance process to avoid any conflict of interest. These arrangements should be described to major stakeholders before the second stage of the assurance process to ensure all are content that the assurance arrangements are suitably insulated from any organisational conflict of interest.

NHS England may want to take advantage of independent and impartial external advice, potential sources of advice include Clinical Senates and the Health Gateway Team.

Directly commissioned services - assurance

Each proposal will be considered on its own merit with a judgement made on the assurance requirements, the appropriate team within NHS England to lead the consultation and the appropriate team to lead the assurance process. The following principles should inform this judgement:

- The default position should be that consultation is led as locally as possible to the proposed changes, in line with the principle of subsidiarity. In practice this may mean the local Area Team leads the consultation.
- Oversight and appropriate assurance should usually be coordinated by the next level team within NHS England (the regional team), the method used for discharging this assurance may include peer review by an independent Area Team, the establishment of an assurance function within the same area team with chinese walls between the assurance and consultation functions, or regional team review. When considering the range and level of assurance required, NHS England will consider the same factors as a CCG led proposal. The regional team are responsible for agreeing robust assurance arrangements are in place.
- These arrangements should be fully discussed at the strategic sense check stage and confirmed in the letter to commissioners that follows.
- Once these arrangements are confirmed this information will be shared with the national service change oversight group who retain the right to recommend alteration to local arrangements where they feel it is appropriate to do so.

It is recognised that for certain change proposals the process outlined above will not be appropriate, these schemes will be dealt with individually, by exception to ensure that NHS England's assurance remains robust and as impartial as possible.

4. Supporting information

Public consultation

Effective proposals should have on-going engagement with staff, patients and the public. Proposing organisations should avoid presenting a fully worked up set of service change options to the public unless there has been on-going dialogue.

Commissioners may wish to seek views on a set of specific configuration options relating to particular services or units. One way of doing this is through a public consultation exercise though there is no legal requirement for this if alternative forms of engagement would be more suitable and proportionate (see guidance below). Commissioners may find it helpful to discuss with local authorities local Healthwatch and with commissioning support services the full range of methods for engaging with the local population.

Cabinet Office's Consultation Principles

The governing principle is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than following bureaucratic process. Consultation is part of wider engagement and whether and how to consult will in part depend on the wider scheme of engagement.

Timeframes for consultation should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response. The amount of time required will depend on the nature and impact of the proposal (for example, the diversity of interested parties or the complexity of the issue, or even external events), and might typically vary between two and 12 weeks. In some cases there will be no requirement for consultation at all and that may depend on the issue and whether interested groups have already been engaged in the policy making process.

Policy makers should think carefully about who needs to be consulted and ensure the consultation captures the full range of stakeholders affected. Information should be disseminated and presented in a way likely to be accessible and useful to the stakeholders with a substantial interest in the subject matter.

Business Case

Either as part of the assessment of proposals against the four tests, or during the refinement of proposals, the proposing organisation may want to develop a business case setting out the clinical and patient benefits for all options. In many cases, the lead commissioner(s) will prepare the business case, though this is for local determination and the detailed development could be undertaken by a relevant provider – with the commissioner(s) undertaking an oversight and approval role. The size and complexity of the business case may also vary according to the changes being considered.

As a minimum, it should:

- be clear about the impact in terms of outcomes
- be explicit about the number of people – public, patients, and staff affected and the benefits for each group;
- outline how patients, the public and other stakeholders have been involved and how their views have informed the options that will be consulted on;
- show that options are affordable and clinically viable including an evaluation of options against a clear set of criteria;
- demonstrate that proposals are affordable in terms of any necessary enabling capital investment, its deliverability on site, and its transitional and recurrent revenue impact;
- show that any planned savings that may arise are realistic and achievable within the specified timetable;
- outline how the proposed service changes will promote equality and tackle health inequalities;
- demonstrate links to JSNAs, JHWSs and broader commissioning plans;
- be explicit about how the proposed changes impact on local government and other public services where appropriate; and
- 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.

Lessons learned

The Independent Reconfiguration Panel publish analysis on the common themes in contested service change proposals that have been referred to the Secretary of State for review. They are a handy checklist for anyone seeking to establish a service change programme. The common issues are as follows:

- 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 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 the service change plans and limited methods of conveying them
- 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 responses during and after the consultation.

Governance

- It will be mutually beneficial for CCGs and NHS England's teams to agree organisational roles and assurance requirements for individual service change proposals as early as possible.
- The approach to engagement and consultation should be proportionate to the change being proposed and will also need to be discussed with the local authority Overview and Scrutiny Committee (OSC)
- Area Teams will support service change through on-going oversight of schemes (from inception through to implementation) offering advice and guidance. Regional team and national support centre team advice and support is available for larger scale or more complex proposals, and on more technical aspects (for example options definition and appraisal).
- The decision making tools in this document should assist local organisations in deciding when and how to escalate issues.

5. Appendices

Organisations

A brief overview of the roles, responsibilities and powers of key groups involved in service change:

Organisation	Role
Overview and Scrutiny Boards (OSC)	Oversight of the local health economy, scrutiny of proposals for service change and power to refer proposals to Secretary of State.
Independent Reconfiguration Panel (IRP)	Offers expert advice on proposals referred to Panel by SoS.
National Clinical Advisory Team (NCAT) and Clinical Senates	Sources of independent clinical assurance
Health Gateway Team	Source of independent programme assurance
Trust Development Authority (TDA)	Assurance of clinical quality, governance and risk in NHS Trusts
Monitor - includes the Competition and Co-operation Panel (CCP)	Promotes the provision of health care services which is effective, efficient and economic, and maintains or improves the quality of services.
NHS England	Service change policy framework, national evidence base and national partnerships (e.g. Monitor, TDA, Royal Colleges). Oversees delivery of NHS services. Leads service change for directly commissioned services.

Sources

- **Planning and delivering service change for patients, NHS England (December 2013)**

  www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pd

- **NHS England's business case approval process**

  http://www.england.nhs.uk/resources/bus-case/

- **Independent Reconfiguration Panel**

  Learning from reviews: http://www.irpanel.org.uk/view.asp?id=100

- **Consultation**

  Cabinet Office guidance (July 2012): www.gov.uk/government/publications/consultation-principles-guidance

- **Public, patient and carer participation**

  NHS England interactive guide: http://www.england.nhs.uk/2013/09/25/trans-part/

- **Overview and scrutiny**

  DH guidance on legal obligations and good practice is currently being updated, link to the existing DH document: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4066238.pdf

- **NHS Confederation**

  Case studies and helpful resources: http://www.nhsconfed.org/priorities/reconfiguration/Pages/useful-resources.aspx

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