

THE POLITICS OF SCRUTINY

RECONFIGURATION IN NHS ENGLAND

A report to the Nuffield Trust
by Patricia Day and Rudolf Klein

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FOREWORD

Much is being made in the media about the NHS's massive programme of reconfiguration. But there is much confusion as to whether this programme will achieve the Government's twin policy goals: to release resources for the development of community-based services and to improve quality and safety. Amid all this turmoil, it is easy to overlook the fact that there is, in fact, machinery for scrutinising organizational and service changes in the NHS and testing whether proposals match government criteria: machinery whose effectiveness is likely to be severely tested by the impending tidal wave of reconfiguration.

Hence this first "reconnaissance" of the machinery of scrutiny, funded by the Trust. It looks at the work of three different institutional innovations: (1) the Independent Panel which examined the plans for the reconfiguration of PCTs; (2) the local authority Overview and Scrutiny Committees which can and do challenge proposals for service change and, (3) the Independent Reconfiguration Panel, to whom the Secretary of State may refer disputed proposals.

The small scale of this first exploratory study of the new system can only flag up some of the issues involved. First, it suggests that while in theory the introduction of independent panels gives the Secretary of State an opportunity to distance the Department of Health from controversial decisions, in practice this opportunity has so far been largely unused. Second, it prompts questions about the NHS's accountability to local communities : is a system sustainable in which central government pays the piper but local authorities try to call the tune?

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January 2007

INTRODUCTION

Change is becoming the norm for the National Health Service. So, too, is accompanying controversy. The organisational maps have already been re-drawn to the accompaniment of the sound of gnashing teeth. The service maps are in the process of being re-drawn. And if there is one prediction that can be made with confidence, it is that the extensive plans for reconfiguring services now in the pipeline¹ will be strongly contested in many of the localities affected. Hence this essay: a brief survey of the machinery for independent scrutiny of organisational and service change in the NHS.

The first section analyses the role of the Panel set up to advise the Secretary of State on proposals for changing the boundaries of Primary Care Trusts. This was a one-off exercise whose task has now been completed. In a sense, therefore, its activities are water under the bridge. However, it provides an interesting case study of the relationship between an independent advisory body and political decision-making. The second, and main, section deals with the activities of Local Authority Health Overview and Scrutiny Committees. These are relative newcomers in the NHS policy arena, intended to provide a quasi-democratic input into the local decision making process, whose role is likely to grow in line with the pace and scale of reconfiguration. The third section looks at the Independent Reconfiguration Panel, whose expanding role is to scrutinise contested plans for service changes referred to it by the Secretary of State. A final section reflects on some of the issues raised by our reconnaissance.

EXTERNAL PANEL ON PCT RECONFIGURATION

The Government's plans for merging Primary Care Trusts, on the assumption that fewer purchasers would mean more effective commissioning, proved contentious from the moment they were published in July 2005². As the House of Commons Health Committee was subsequently to argue³, "to introduce a large scale reconfiguration of NHS organisations only three years after the last root and branch reform of NHS organisations points to an ill thought-out approach to policy making". Further, the report questioned whether larger PCTs would necessarily mean more effective commissioning or produce the expected financial savings. And it pointed out that "PCTs were established to ensure that decisions about the NHS were made locally. By reverting back to the more remote structures that were abolished only three years ago, this localism will be lost".

It was a powerful critique, all the more so since the Health Committee was only giving voice to the widespread misgivings that had been prompted by the Government's announcement. So it was against a background of simmering discontent that in October 2005 the Government announced the appointment of an independent external panel⁴ to advise Ministers on the proposals for reconfiguring PCTs put forward by the Strategic Health Authorities (about to reconfigure themselves into what looked very much like the regions abolished not so long previously). To an extent, therefore, the appointment of this panel can be seen as an attempt by Ministers to give greater legitimacy to the process of change. The panel's remit did not include ambulance trusts, presumably because their reconfiguration was not thought to be as contentious or politically visible.

The panel was chaired by Michael O'Higgins, then a managing partner of the PA Consulting Group and now chairman of the Audit Commission. Its nine members included a clutch of NHS chairs, two Department of Health officials, a clinician and a nurse, as well as the Chief Executive of Liverpool City Council. Its remit was to examine whether the SHA recommendations met the criteria set for them by the then NHS's Chief Executive, Sir Nigel

Crisp, when he launched the exercise earlier in the year. Changes were to be assessed according to whether they promised to enhance the capacity of PCTs to:

- secure high quality, safe services for patients
- improve health and reduce inequalities
- improve the engagement of GPs
- improve public involvement
- improve co-ordination with social services through greater coterminosity of PCT and local government boundaries
- make effective use of resources.

Two criteria included in the original instructions to SHAs were missing from this list. These were that changes should enhance the ability of PCTs to manage financial balance and risk and that they should deliver at least 15% reduction in management and administrative costs. There is no evidence, however, that this culling of criteria – which may have reflected the Government's anxiety to dispel suspicion that policy was being driven by short-term money scrimping – affected the decisions made by the Panel.

Working swiftly, the panel completed its work by May 2006. It relied mainly on the information provided by SHAs, supplemented by feedback from local actors such as local authorities. The papers summing up the evidence for each locality – the basis for the panel's final recommendation – are in the public domain and were made available to us. So, too, were the briefing papers used by Ministers when announcing their final decisions. What follows is based on these documents.

The panel overwhelmingly endorsed the SHA proposals for reconfiguring and merging PCTs. Leaving aside minor reservations about the drawing of PCT boundaries, the panel disagreed with only two out of 23 SHA recommendations (which excluded London, where a ministerial decision had been taken to maintain the status quo). In these cases, the panel increased the number of proposed PCTs: from three to four in Norfolk, Suffolk and Cambridgeshire and from two to three in the case of Bedfordshire and Hertfordshire.

However, the panel's role was only to advise the Secretary of State. And, as it turned out, the Secretary of State, Patricia Hewitt, did not feel bound by the advice given her. In the two cases where the panel recommended an increase in the number of proposed PCTs, the Secretary of State decided to add one more. In eight out of the 21 cases where the Panel endorsed the SHA recommendations, she came to a different decision. In every instance the number of proposed PCTs was increased, dramatically so in the case of Avon, Gloucestershire and Wiltshire (seven PCTs instead of the proposed three), Northumberland, Tyne and Wear (six instead two), County Durham and Tees Valley (six instead of two) and Essex (five instead of two).

One conclusion to draw from this story might be that, in this instance at any rate, there was little point in introducing an element of independent scrutiny into the decision-making process. Further, it might be argued that in all cases where decisions are likely to stir up strong local feelings (and to put parliamentary seats at risk), politics will invariably trump

neutral advice. So why, it might be asked, go through the charade of setting up an independent panel in the first place? Cynicism might be further fuelled by the fact, much noted at the time, that, in the case of County Durham, lobbying for the six PCT solution/option was led by Alan Milburn, a former Secretary of State for Health and a powerful figure in the Labour Party.

The evidence of the Panel papers, however, suggests a rather more nuanced and somewhat less cynical conclusion. They underline the difficulty of coming to a judgment when different policy goals are inconsistent with each other or, indeed, pull in opposite directions. Consider, first, the results of the consultation exercises as reported in the Panel papers. All SHAs were expected to consult the public on the options for change before deciding on their recommendations; similarly, they were expected to consult all relevant stakeholders, ranging from local authorities to relevant voluntary organisations. Much indeed was made of the importance of consultation; one of the Health Committee's criticism was that not enough time had been allowed for adequate consultation. But (and this, of course, is the ambiguity of all consultation exercises) what weight should be given to the views elicited? Were SHAs expected to follow majority opinion? The SHAs (and the panel agreed) did not think so.

Consider two examples. In the case of Essex, the SHA consulted on four options - ranging from a two PCT to a five PCT solution. In the outcome, the five PCT option was favoured by a majority of consultation responses and a majority of stakeholders, including local MPs of all parties. The SHA, however, recommended the two PCT solution, invoking the criteria set by the NHS's Chief Executive. The five PCT option, the SHA conceded, would score better on some of the criteria, notably effective engagement with GPs. But the two PCT option would score better on strengthening commissioning, financial risk management and the public health function.

A similar picture emerges in the case of reconfiguration in Avon, Gloucestershire and Wiltshire. Here the SHA consulted on a two options: three or seven PCTs. Local opinion – again including local MPs of all parties - strongly favoured the seven PCT model. So the SHA commissioned an independent assessment of the two options against the national criteria. The seven PCT option scored highest on improving the engagement of GPs and promoting practice-based commissioning, managing financial balance and improving co-ordination with social services. The two PCT option scored highest on securing high quality, safe services, improving commissioning, the effective use of resources and delivering a reduction in management costs. The SHA plumped for the two PCT model so implicitly giving greater weight (as the panel papers commented) to the latter criteria.

In both these examples, the panel endorsed the SHA proposals, but the Secretary of State did not: instead she decided in favour of the five and seven PCT options respectively, as already noted. The terms in which she rationalised the two decisions (and others reversing SHA and Panel recommendations) were remarkably similar. In these and other cases, she noted that local opposition to the SHA model could result in the public and local stakeholders “opting out “of engaging with the new PCTs and that her preferred model would mean less disruption of existing NHS structures.

It might of course be said that if the Secretary of State was anxious to avoid disruption of existing NHS structures, she should not have embarked on the exercise of reconfiguring PCTs in the first place. But, as so often with Department of Health policy making, the full political and organisational costs of the exercise only seem to have become apparent to Ministers in the process of implementation: while the organisational and political costs were immediate, salient and visible, any benefits were likely to be long-term, speculative and diffuse.

Unlike the panel, therefore, Ministers appear to have introduced a further criterion when making the final decision about the reconfiguration of PCTs: minimising organisational and political turbulence. They could do so by exploiting the ambiguities in their original list of criteria for assessing change. The various criteria did not – as we have seen – all point in the same direction and were even at cross purposes. Maximising public involvement might suggest keeping PCTs small; maximising the effective use of resources in commissioning might favour large, managerially powerful PCTs; coterminosity with local authorities might inhibit other desirable changes. In such circumstances political judgments – about how to strike a balance between desirable but not necessarily congruent goals – would seem to be inevitable, though the balance finally struck may also have reflected anxieties about votes at risk in marginal constituencies.

So while the panel on PCT reconfiguration gave Ministers an opportunity to shelter behind independent advice – to insulate themselves from politics, as it were, should they choose to do so – they did not take it. Given multiple and sometimes conflicting policy goals, given the ambiguity of many of those goals and given also disagreement about the weight to be attached to any single policy goal, politics may well creep in by the back-door even if expelled by the front-door.

LOCAL AUTHORITY SCRUTINY

Unveiling the new model

The notion of local authority scrutiny of the NHS was first unveiled in July 2000. “The power to refer major planned changes in local NHS services to the Secretary of State will transfer from unelected community health councils”, the NHS Plan⁵ announced, “to the all-party scrutiny committees of elected local authorities”. Scrutiny committees, the Plan further stated, would be able to refer contested service reconfigurations to a new Independent Reconfiguration Panel (IRP), whose so far limited role is discussed in the next section.

The notion of local authority scrutiny marked the confluence of two very different policy streams. External to the NHS, and independent of any developments within it, there was a major change in the structure of local governance. The Local Government Act (2000) introduced an executive model of decision-making in local government, balanced by scrutiny committees which would give councillors an opportunity to call the executive to account⁶. Internal to the NHS, there was dissatisfaction among DH policy makers with the existing machinery of public involvement and consultation. In particular, Community Health Councils were seen as unrepresentative bodies dominated by white middle class people and the over 65s. In a rare example of cross-departmental, joined-up thinking, a DH ministerial adviser came up with the idea of replacing CHCs with the new local authority scrutiny committees⁷. In the new model of public involvement in the NHS, the patient voice would be articulated through Patients’ Forums and the Patient Advocate and Liaison Service: their role would be to change the NHS. The public voice would, however, be represented by local authority scrutiny committees, whose role would be to challenge the NHS.

Policy intentions were swiftly translated into legislation. Section 7 of the Health and Social Care Act 2002 amended the Local Government Act 2000 to give local authorities with social service responsibilities the power to establish overview and scrutiny committees (OSCs) of health services. OSCs have the power to review and scrutinise any matter

relating to the planning, provision and operation of health services in their area and to require NHS officers to provide relevant information and to attend meetings, while conversely a duty is placed on NHS bodies to respond to such requests. If health care issues cross boundaries, local authorities may form joint OSCs.

The potential scope of OSC activities thus goes well beyond the focus of our study, which is on their role in the reconfiguration of services. For example, to cite the DH guidance⁸, they may review “the arrangements made by local NHS bodies for public health, health promotion and health improvement (including health inequalities)”. Their role was to be “to monitor health services as they affect local people, making use of local intelligence”. And most of OSC activity does indeed take the form of such general reviews⁹. In the case of reconfigurations, however, there is a more specific requirement. Each local NHS body has a duty to consult its local OSC on any proposals for substantial developments or variations in the provision of services, as well as carrying out a wider public consultation. In turn, the OSC may refer the proposals to the Secretary of State of health if –

1. The committee is not satisfied that the NHS body has consulted it adequately, or
2. The committee considers that the proposal is not in the interests of the health service in its area

In turn, the Secretary of State may refer the issue on to the IRP for advice before taking his decision: a step, however, which he has so far rarely taken as we shall see. However, in the case of Foundation Trusts, any OSC referral must be addressed not to the Secretary of State but to Monitor.

In using their power to call the local NHS to account OSCs were to be mindful, the DH guidance emphasised, of the need for “a constructive approach based on mutual understanding”. If the process of scrutiny was “aggressive or relies on opinion rather than evidence “it was unlikely to lead to positive improvements. And, the guidance stressed, in the case of reconfiguration issues “the power of referral to the Secretary of State should not be used lightly”. In short, the DH appears to have had a co-operative rather than confrontational model of engagement between OSCs and the NHS in mind: the language of challenge did not feature in official pronouncements, even if the designers of the new model may have used it. In the report produced by Manchester University for the CfPS in September 2005 on various aspects of health scrutiny so far noted, the relationship between NHS organisations and local government was reported as good or very good by 85% of respondents.¹⁰

In what follows we explore further the role of OSCs in dealing with service reconfigurations and some of the issues that have arisen since the model was launched. The study draws on reports and proceedings of OSCs available on the web, material produced by NHS bodies and the reports of the Centre for Public Scrutiny, a Government-funded body whose function is to provide support for local government scrutiny activities. It is also informed by interviews and discussions with OSC members and NHS managers.

While we sought to collect a range of information – in terms of both the geographical spread and different types of reconfiguration situations – this was a small-scale, brief study

designed only to explore issues and raise questions, using material illustratively. It was not designed, we emphasise, to give anything like a complete or definitive picture of OSC activities: for that we shall have to wait for the final results of the three-year study commissioned by the Centre for Public Scrutiny from Manchester University. In what follows, we discuss different aspects of scrutiny.

How the model works: two cameos

The two cameo studies that follow are very different. The first involved the closure of a small local hospital. The second involved a major reconfiguration of services as between two acute hospitals. The outcomes were also different, as we shall see. They have been chosen not because they are in any sense representative but because they illustrate the wide range of issues that crop up in the scrutiny process and the scale of the activities generated by it.

An example of a successful – in the outcome consensual – NHS service reconfiguration was that of the Keynsham hospital closure plan: in many ways a text book instance of open and transparent planning and intense public consultation. Keynsham Hospital provided services for older people requiring slower stream rehabilitation, palliative or end of life care and high intensity nursing care, as well as intermittent respite care for disabled adults under 65. This apparently modest service change actually covered a wide area and mix of communities, and involved five PCTs and one large healthcare trust. A Joint OSC was set up by Bath and North East Somerset Council, Bristol City Council and South Gloucestershire City Council.

The circumstances of the Keynsham plan appeared to have as much potential for dispute as anywhere. For a start, the communities involved were heterogeneous. So, too, were the members of the custom-built Joint OSC, some of whom took the line that they disagreed with all closures on principle. There was also the fact of closure of a whole – albeit small – working hospital steeped in history, tradition and mythology with its loyal staff and patient supporters. Local people, including local GPs, wanted to keep the beds open.

Yet, after two years of consultation and negotiation (from November 2004 to September 2006) the beds did close. The Joint-OSC held five meetings, consulted with local organisations, patient groups and GPs, as well as visiting the facilities which were to provide the care once Keynsham Hospital closed. It challenged many of the assumptions in the plan put forward by the PCTs, including the cost calculations involved, while accepting that financial pressures could not be ignored. It looked hard at the transitional arrangements proposed to test their viability and acceptability. It invited the Independent Review Panel (see below) to review the consultative processes and advise on the PCT plans. And in line with the IRP advice, it finally accepted the proposals, subject to 21 recommendations – including one for the redevelopment of the Keynsham Hospital site as a health park. In turn, the NHS trusts accepted the great bulk of the Joint-OSC recommendations.

It appears to have been a solution which left both parties feeling satisfied. The Joint-OSC felt that it had done its job by pressing for information and insisting on the conditions required to effect smooth changes, in the process overcoming the cultural reluctance of the NHS to share information about health services. The NHS trusts involved recognised that the local community – and local authorities – had not indulged in knee-jerk reactions but had wanted to understand the details of the change and to have their worries about the future adequacy of services for older people dispelled. In short, there appears to have been a process of mutual engagement and mutual modification.

The Keynsham hospital closure is an example of smooth sailing, following hard work on consultation and communication. But the still unresolved dispute about the reconfiguration of acute services in Teesside and North Yorkshire – our second cameo study – provides a warning that while hard work on consultation and communication may be a necessary condition for securing agreement to change, it is far from being a sufficient condition.

In June 2003 the Tees Review of health services in the area was launched. Its starting point was that reconfiguration was needed in order to concentrate some specialist services, to take account of the European Working Time Directive and staff shortages in some areas. It became clear from NHS and public discussion that this review needed an input of external expertise. Accordingly, a review was commissioned from Professor Sir Ara Darzi, a distinguished surgeon with experience of other hospital service reviews around the country. He recommended extensive changes in the distribution of services, designed to concentrate expertise, as between the three acute hospitals in the area. There followed a large scale public consultation exercise, involving no less than 150 public meetings, 350 meetings with stakeholders and the distribution of a consultation document to 377,000 properties.. Finally, the plans were considered by a Joint OSC, on which the six local authorities affected were represented.

In its 74-page report, the Joint OSC declared itself satisfied with the consultation exercise, though pointing out that the “wider public” was being asked to comment on something which they had not had an adequate opportunity to understand and that only 10% of the population had responded to the invitation to comment (criticisms which probably could be made of most consultation exercises involving complex changes). Most of the report, though, concerned itself with the substance of the Darzi proposals. And in analysing these, the Joint OSC drew on evidence from clinicians and others, including a highly critical economist from the local university who described the Darzi plan as “short-sighted” and lacking any explicit rationale for moving services to different sites. Overall, it appears to have been a very rigorous examination.

In the event, the Joint OSC endorsed five of the proposals in the plan, including those for gynaecology, breast surgery, and the concentration of elective orthopaedics on one site. But it rejected four others: those for the reconfiguration of maternity and paediatric services, and the establishment of a Tees-wide upper gastro intestinal service at one site and that of a Tees-wide endo-luminal vascular service at another. The NHS trusts decided to withdraw the proposals for the latter but to go ahead with the former. Hence the referral of the proposals for the maternity and paediatric services to the Secretary of State who, in turn,

referred them to the IRP, which in turn published its advice to the Secretary of State in January 2007 (see page 21).

The Tees case is interesting for a variety of reasons. First, it shows a Joint OSC which was not hostile to change as such, given that it approved many of the proposed changes, but which was highly selective in its opposition. Second, it suggests that certainly in this instance - and possibly maybe more generally - the critical factor may be less opposition from the population at large than from the clinicians likely to be affected by the changes. The Joint OSC's report raises a number of issues relating to the distribution of access and transport problems, reflecting the concerns of the population. Similarly, the credibility of the NHS plans may have been undermined by the failure – acerbically noted by the Joint OSC – to provide any information about the financial implications of the plans.

In particular, the Joint OSC's selective opposition appears to reflect partly the views of clinicians hostile to the proposed reconfiguration. So, for example, the Clinical Director of Paediatrics at one of the hospitals described the proposals as not being in the interests of paediatric care while other clinicians were similarly critical of various aspects of the plan, questioning the assumption that the proposed changes would lead to higher quality, safer services.

The Tees-side case also underlines the problems associated with the scrutiny of reconfiguration proposals involving complex services for large populations with diverse and sometimes differing interests. The proposals affected a population of about 1,000,000 people. The Joint OSC which decided on the referral to the Secretary of State was composed, as already noted, of the representatives of the six scrutiny committees in the area concerned. It had several sub-committees each with differing opinions about what should be accepted and what rejected, reflecting the views of individual local authority committees: so, for example, one of these was in favour of recommending that all the Darzi proposals should be implemented.

So our two cameos offer very different perspectives on the activities of OSCs. But there are common elements. Both cases show OSCs to be assertive new comers in the NHS policy arena, ready to question and challenge. Equally, though, both show OSCs basing their challenge on evidence, rather than on knee-jerk opposition to change in principle, and being rigorous in their endeavours to seek out information and cross-examine the evidence. Both, too, suggest that local councillors have taken to their new role as scrutineers with enthusiasm and some dedication, in the hope of making a difference to the delivery of local services. We have no way of telling what the balance is among OSCs as between pragmatists and populists – those who see it as their role to understand the problems faced by the NHS even while criticising specific proposals and those whose instinct is simply to voice popular opposition to any change in local services – but we suspect it tilts towards the former.

An inverse passion law

NHS bodies have the duty to consult OSCs, as we have seen, if they are proposing to make substantial changes in services. But what is a “substantial” change? From the start, it was

recognised that this is a contestable and malleable concept, as DH guidance acknowledged. Early on some NHS trusts sought to transmute a “substantial” change into several, piecemeal changes in order to avoid both public consultation and local authority scrutiny, leaning on legal advice. The process was described by one chief executive as “reconfiguration by stealth”. The strategy did little for relations between the NHS and OSCs. Subsequently the Centre for Public Scrutiny, drawing on case law, produced guidance for all parties¹¹, and increasingly NHS bodies and their corresponding OSCs have now drawn up concordats defining when (and what) changes should trigger consultation.

Consultation remains an issue but, on the limited evidence available to us, it appears that it is disagreement about the substance of proposed service changes which prompts most of the OSC referrals to the Secretary of State (see below). Sometimes the two issues are intertwined: perceptions of rushed or inadequate consultations reinforce suspicions of the proposed changes. In any case, it is clear – and has been generally accepted – that “substantial” change is a relative concept. The impact of any change varies with the size of the community, or patient group, affected. If there is any relationship between the *intensity* of objections and the scale of proposed changes, it is if anything an inverse one: the more changes are concentrated in a small community or defined patient group, the more vocal and mobilised is the opposition likely to be and the more intense the opposition. The loss of six beds, for example looms large to a small, possibly isolated population; similarly the loss of a small community hospital may create an emotional upheaval as well as anxieties about access to services.

So, for example, there have been disputes in some places over what appears to be a handful of beds or a single ward (e.g. in Gloucestershire and Hertfordshire), while in others the dispute is more obviously about service reconfiguration on a grand scale involving whole hospitals in wide geographical areas (e.g. Teesside and North Yorkshire and Greater Manchester). Thus in Gloucestershire the issue was not so much about the loss of 15 beds but the proposed location of those beds. The NHS proposal for cutting the number of beds for mental health and older health, from 80 to 65, involved a sharp reduction in the number of sites on which the service was provided. The change of location turned out to be a major issue for the local communities affected and the proposal was rejected by the OSC in September 2006. If the complexity of large-scale proposals affecting large diffuse populations can cause problems (the Tees-side case), so can the high visibility of modest proposals in concentrated small constituencies, whether geographical communities or patient populations. These are likely to be more passionate in their opposition to change than large, diffuse ones, even though there are more obstacles to overcome in the latter case.

To make this point is to raise a further, related question. How is the community, on whose behalf the members of OSCs speak and act, to be defined? Is it the responsibility of councillors sitting on OSCs to speak on behalf of their own constituents, articulating their specific, local interests – which, as we have argued, often means defending the status quo? Or should their duty be to consider the implications from a wider perspective and, if so, just how wide should it be? Should they be testing the overall logic of proposed reconfigurations for the population of, say, a Strategic Health Authority or should they concentrate on the impact on their constituents? Local authorities are already discussing

the place of regional government in local planning. Given possible asymmetries in the costs and benefits falling on specific sub-populations, different answers to these questions may deliver different verdicts on proposals for change.

Another hurdle: judicial scrutiny

There is yet a further form of scrutiny, which deserves to be briefly noted. This is judicial review. Cases of judicial review of service changes and consultation in the NHS are not new and in the past this procedure was used by Community Health Councils to challenge insufficient consultation. For example, in 1988 the local CHC successfully challenged Tunbridge Wells Health Authority's decision to close a cottage hospital without consulting the Council. Since then, individuals and groups of NHS staff have contested a number of NHS plans for service changes in the courts on grounds of inadequate consultation, supported by law firms which provide advice, arrange legal aid and guide staff in taking action.

More recently, there have been examples of judicial review being sought in cases where the relevant OSCs had agreed services changes with the NHS trusts concerned but where there were still outstanding public and individual objections on the grounds of insufficient or inadequate consultation. And in at least one case the complainants (NHS staff) argued that the OSC involved was as responsible as the NHS trust because it had agreed with the proposed services changes. The judge found against the trust but not against the OSC. The ruling was that planning health service change is different from scrutinising it.

This brief summary is a reminder of the extent to which reconfiguration frequently involves legal considerations. Indeed a number of large, national firms of solicitors have moved into this field, giving advice both to NHS trusts and potential objectors. On the basis of this experience one such firm has concluded that any NHS trust contemplating change should carry out a risk assessment of the likelihood of a legal challenge¹². Legal challenges follow mostly plans for closure or service reductions, it warns, in the following areas:

- local A&E services
- maternity units
- popular community hospitals
- long-stay facilities (elderly and mental illness)
- any service changes opposed by local clinicians

The advice is no doubt good. But any NHS trust which sought to avoid these minefields would find its scope for reconfiguring services very restricted. We draw particular attention to the last point, to which we return in our concluding reflections: the role of NHS staff in leading or orchestrating resistance to change.

Enter the Secretary of State

It is the Secretary of State of Health who, as we have seen, is the final court of appeal if NHS bodies attempt to drive through change without adequate consultation or if they

cannot persuade OSCs to accept their proposals for change. If OSCs cannot veto change, they can delay it. To this extent, then, NHS bodies have an incentive to accommodate the views of OSCs. But how often do OSCs use their power of referral and what happens when they do so? To answer this question we asked the Department of Health to update information about referrals provided earlier this year to the House of Commons Health Committee, and the analysis that follows is based on this data.

The first point to note is that OSCs have been sparing in using their power of referral. In the two years between October 2004 and October 2006, there were just 17 referrals. We have no base line figures for the number of proposals for “substantial” changes or variations in service provision that were put forward in the NHS in England during those two years. Our guess (it is no more) is that the number of proposals greatly exceeded that of referrals. Interestingly, however, the rate of referral has accelerated over time. Up to October 2005, there were only seven referrals. In the following 12 months, though, there were 10. Again, lacking any base line figures, we can only speculate whether the increase reflected a rise in the number of proposals for change in recent months or a greater propensity to refer matters to the Secretary of State: the latter view was taken by some of those interviewed, who argued that OSCs were inclined to refer matters too quickly and too early in the process of negotiations with the NHS.

What happens to the referrals, once made? At the time of writing, the Secretary of State had as yet made no decision about what to do in two out of the 17 cases. In eight out of the remaining 15 cases, the Secretary of State decided to support the local NHS proposals. In three recent cases, the matter was referred to the Independent Review Panel (see next section). In two cases, the dispute was referred back to the local NHS, with an exhortation to reach an agreement with the OSC and with the IRP acting as broker in one instance. In one case, the PCT concerned withdrew its proposals, while in another the Secretary of State reversed the local decision about where to site a new hospital (only to reverse this decision in turn).

The Independent Reconfiguration Panel

A small but perhaps significant change in the role of the Independent Reconfiguration Panel took place between conception and birth. According to the NHS Plan, it was Overview and Scrutiny Committees which would be able to refer “contested major service reconfigurations “to the new body. However, in the process of turning policy rhetoric into administrative reality, the open door for OSCs was shut. It is the Secretary of State who does the referring. And, as we have seen, so far Secretaries of State have been slow in turning to the IRP for advice.

Launched in the spring of 2003, the IRP is an advisory non-departmental body. The panel’s chairman, Dr. Peter Barrett, is a general practitioner. Its nine members are chosen to provide “an equal balance of clinical, managerial and patient and citizen representation”. It is parsimoniously staffed with only a part-time Chief Executive (ex-NHS) and a Secretary (ex-DH), conspicuously lacking the long tail of Personal Assistants and others which tends to characterise many other public bodies.

Indeed the formal business of the IRP would hardly justify more generous staffing. Between April 2004 and April 2006, as noted, the Secretary of State did not refer a single case to it, though in one instance the IRP was asked to act as broker in an agreement between the NHS and the local OSC in Surrey. In effect, the IRP was left to create a new role for itself as a consultant and mediator. It offers advice in the early stages of planning change in the hope of preventing confrontations, acts as a mediator and aims to diffuse knowledge about good practice both in England and elsewhere.

The Panel has, as of January 2007, only published three formal adjudications, the first of which, in 2003, involved a referral under the old CHC Regulations. No conclusions can yet be drawn, therefore, about its approach or style. But the recent report on maternity services in Calderdale and Huddersfield gives some clues¹³. The reconfiguration of these services aroused local opposition because it involved replacing two consultant led units – one in each city – by one consultant-led unit and one midwife-led unit. The Panel supported the proposed changes, on the grounds that they would offer a safer, more sustainable service.

This was essentially a technical judgment, based on national standards for consultant cover and related clinical factors. And much of the Panel's 59 page report is devoted to explaining, as persuasively as possible, why the proposed arrangements were both necessary and desirable: a midwife-led unit, it argued, should not be seen as second best. Indeed, the report's main concern appears to be to dispel local anxieties, elicited by means of extensive consultations. So while endorsing the local NHS's proposals, it also recommended measures to meet those anxieties, such as ensuring adequate transport between sites.

In the case of the proposals for reconfiguring maternity services in North Tees (see page 17), the Panel's January 2007 report¹⁴ again came out in favour of concentrating consultant-led services on one site, with a midwife-led unit on another. And, as in the previous case, it stressed that such a move was necessary in the interest of safety and viability, and emphasised the need to improve transport services. But in its latest report the Panel ranged more widely. While accepting the arguments for concentration, the Panel recommended a different site of the consultant-led services from that proposed in the NHS plans. Further, it saw this as only a short-term option, while urging the building of a new hospital as a long-term solution. In short, the Panel's recommendations to the Secretary of State for Health were made as part of a wider analysis of the complex and long-standing problems of the area's healthcare services and local anxieties (and rivalries) about the distribution of access.

The Panel's low profile may, however, soon be raised. In the first nine months of 2006, as we have seen, the Secretary of State referred three cases to the IRP. And the DH has suggested that the IRP might consider expanding its staff. This could imply a change of policy. The record so far shows a remarkable similarity with the independent panel on PCT reconfiguration: having invented a device for insulating themselves from politically sensitive issues, Ministers then largely ignored it. It could be that, in the expectation of ever more high voltage reconfiguration disputes in the pipeline, Ministers have decided that they need insulation after all.

SOME TENTATIVE REFLECTIONS

It is not only the small scale of our exploration which inhibits drawing conclusions about the likely role of local authority scrutiny in the impending wave of NHS reconfigurations. So do two other considerations. First, there is the fact of variations between OSCs. They vary in the amount, and quality, of officer support provided for them. They vary in the direction and tone set by their chairmen: in particular, whether the chairmen are (in our terminology) populists playing to the political gallery or pragmatists engaged in seeking acceptable solutions. The calibre of support staff and chairmen is likely to become all the more important if a growing volume of business is not to overwhelm OSCs.

Second, OSCs are still in an evolutionary process of learning their trade in what is for most of their members the new and strange world of the NHS, a process which is at times stuttering since local elections may reshuffle the political cards and the membership (and, as a consequence, dislocate any negotiated relationship between the NHS and the committee). So what follows are a series of tentative reflections, always with the caveat that dealing with reconfigurations is only part of the OSC business agenda.

Our cameo evidence suggests that OSCs are financial realists, insofar as they recognise budgetary constraints even while defending local institutions. At the same time they appear to be suspicious of “financially-driven” changes, a phrase which is used pejoratively in many OSC reports. How to make sense of this apparent contradiction? The acceptability of change depends on confidence that the plans for a new model of service will actually deliver on quality, safety and access. In turn, this requires confidence in the competence and good faith of NHS trusts when it comes to translating paper plans into service provision: everyone knows that the real problems will crop up in the process of implementation.

It may be difficult, however, to have such confidence if the proposals for reconfiguration are a response to deficits that should have been dealt with long since. Sudden, out-of-the-hat proposals invite suspicion both about good faith and competence. Will the promised

benefits ever materialise? Will the new consultants actually be appointed, will the improved transport services materialise, or will the planned changes be driven off course by yet another self-inflicted fiscal crisis?

To the extent that this explanation holds, the implication is that NHS bodies cannot take trust in their good faith and competence for granted but have actively to earn and generate it. Hence the generally recognised importance of consultation seen as a process not just of communication but of active engagement with a willingness to modify proposals: to meet criticisms and to open the books. However, as we have argued, effective consultation is a necessary but not sufficient condition for winning acceptance for reconfiguration proposals.

Perhaps equally important, and less well recognised, is that the proposals should demonstrate competence: that they should include, for example, a risk analysis of what might go awry in the process of implementation. In other words, the quality of information provided is at least as important as the quantity. Failing this, one effect (among others) is likely to be to strengthen the ability of NHS staff - medical and nursing - to use the machinery of scrutiny to oppose change: opposition which may be based on, and help to expose, real weaknesses in the case for change or simply reflect self-interest in maintaining the status quo.

The phenomenon of “professional capture of scrutiny” is, as noted, already apparent and reinforces the view that an essential pre-condition for bringing about change in the NHS is bringing staff on board. This certainly is the view of Sir Ian Carruthers who has been asked by the government to carry out “a six month review of all plans around the country to cut services or close units, to see if more can be done to win public support for change”. Sir Ian is expected “to deliver a blunt message to local NHS chiefs that there is no point in announcing closures without first winning the backing of hospital consultants and GPs”.¹⁵

It is, of course, much too early to draw up a balance sheet of the costs and benefits of local authority scrutiny of the NHS. In what follows we therefore simply discuss the elements that should be entered into the equation, without attempting to attach weights to them. The direct financial costs of running the OSC machinery should be easy enough to establish. Much more difficult is recording and costing the time commitments of council officials and elected members.¹⁶

On the NHS side of the ledger the picture is much the same. It is easy enough to establish the direct costs of consultation exercises, such as sending out leaflets, hiring rooms for public meetings and so on. But identifying and costing the time commitments of staff and trust executives is more problematic. We have not been able to identify any such exercises, and can only record the fact that officials with whom we discussed this issues considered the costs to be heavy. On present evidence it is impossible to draw up a balance sheet of the relative cost of carrying out a consultation and keeping the facility in question open.

Further, it might be argued that there is another kind of cost to the NHS that should be included: the cost of delaying change. If local authority scrutiny delays the introduction of changes designed to produce savings (perhaps in services that have never been cost effective), there will be a direct financial loss; further this loss will be compounded if

referral to the Secretary of State and an IRP inquiry add to the delay. However, estimates of the savings flowing from reconfiguration have proved wrong often enough to induce scepticism about including this element in any cost benefit calculation. In any case, the road to service change – particularly when the closure of a hospital is involved – has been strewn with obstacles and booby-traps throughout the history of the NHS¹⁷. Delay has been the norm. It would be difficult, perhaps impossible, to establish with any certitude the extent – if any – to which local authority scrutiny has added to the time required to overcome political, professional and trade-union resistance to change.

If there are problems in reckoning up the costs, they are as nothing compared to totting up the benefits. While the former can – in theory at any rate – be quantified, the latter cannot. Does local authority scrutiny – buttressed by the requirements for preceding consultation – produce better decisions? First, it can be argued that OSC activity makes decisions about the NHS acceptable to the local population: acceptable in the sense that, while some people will still disagree with the proposed changes, there will be a general perception that the process of introducing change has been reasonable, giving an opportunity for debate and for opponents to be heard. To the extent that this is indeed the outcome, so the NHS policy will appear to be less dominated by managerial and professional concerns to the exclusion of public or patient interests: to be more “democratic”, in at least one of the senses of that ambiguous, slippery and many-layered term.

Second, it can be argued that local authority scrutiny will produce better decisions just because it puts NHS proposals on the rack of critical cross-examination. In other words, the prospect of a critical challenge may persuade NHS decision-makers to be rigorous in analysing their own proposals, identifying possible pitfalls and rehearsing the evidence in support of their decisions. Corner cutting becomes more difficult when exposed to the public gaze. It is a plausible line of argument but only becomes convincing if, in fact, OSCs have the willingness, ability and resources to mount a testing challenge rather than acting as an amplifier for local protests. On that point, our evidence is encouraging but very limited.

There is a larger consideration still. This is that the system of local authority scrutiny is a mechanism for holding the NHS to account. Like democracy, accountability is a word with many meanings¹⁸. But the present system appears to satisfy at least some minimum requirements. It makes the policy-making process more transparent and it compels decision makers to justify their action. All this is undoubtedly desirable in its own right, but lacking is the notion of sanctions: that is, if the decision-makers fail to justify their actions convincingly, there is nothing that can be done about it. Inevitably so, given that public accountability follows money. And money in the NHS comes from the centre.

So local authority scrutiny can be a complement to, but not a substitute for, parliamentary scrutiny. To this extent OSCs do not offer a solution to the problem of political overload at the centre of government (and the corresponding problem of over-intervention locally by government). If Secretaries of State were prepared to allow neutral advisory bodies to adjudicate local disputes about service reorganisation or reconfiguration, this might indeed be at least a partial solution to the twin-problems of over-load and over-intervention, but the evidence on this point is not altogether encouraging as we have seen.

In the meantime, the risk facing the NHS may be one of over-scrutiny and multiple accountabilities. What if local and national priorities diverge and with them the lines of accountability? What if local communities place a higher value on having, say, a local hospital or clinic than allowed for within the framework of national policy? What if there is a dispute among local communities on the equity of health service provision?

Maybe at some future date – if growing pressures on the NHS mean that there is a widening gap between what is nationally affordable and a variety of community perceptions of the desirable – local authorities will be given an opportunity to put their money where their mouth is: that is, they will be allowed to top-up central funding to support local priorities. However, that may depend on radical reform of local authority governance and finance, perhaps a utopian and certainly a distant prospect.

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