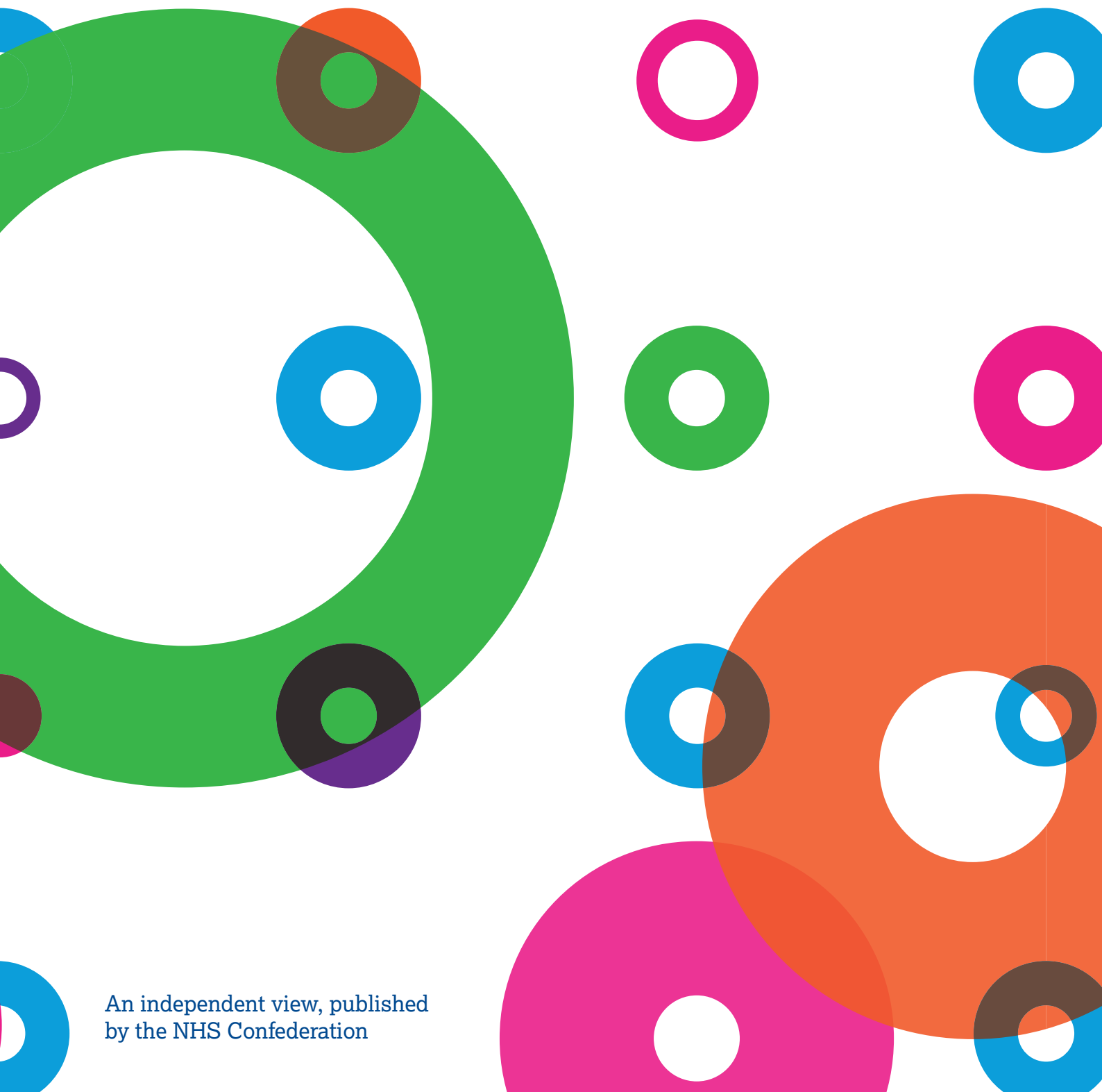




Reconfigure it out

Good practice principles for communicating service change in the NHS



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Introduction

Over the last five to ten years, a number of local NHS reconfiguration programmes have attempted to address clinical quality and financial sustainability issues by reorganising how and where health services are delivered. Some of the programmes have progressed to public consultation and implementation while others are ongoing.

All of the programmes have faced significant and similar challenges in communicating and engaging with the public and stakeholders. Not surprisingly, there has been a striking similarity in the arguments and materials used across the country to support acute reconfigurations. More surprisingly, there has to date been little networking and sharing of information between such programmes and limited attempts to develop best practice for those responsible for delivering change to learn from and follow. This is despite the level of public engagement in recent programmes 'raising the bar' in terms of public expectations. It is important that different NHS programmes are aware that a 'do-minimum' approach is likely to be challenged.

This paper draws on the experience and insight of professional communicators who have been involved in reconfiguration programmes (see page 13) and considers the lessons learned to date from communicating service change programmes. It also sets out good practice principles and advice for those leading current and future NHS reconfigurations.

The NHS Confederation is keen to share good practice in the NHS as part of how it supports its members. This paper has been written by external authors who are NHS communications professionals and have particular expertise and experience of large-scale reconfigurations. As such, it does not necessarily represent the views of the NHS Confederation or its members.

“This paper sets out best practice principles and advice for those leading current and future NHS reconfigurations.”

The 'eight L's': tips for change programmes to use

<p>Leadership</p> <p>Excellent leadership is needed to drive the programme (see page 9)</p>	<ul style="list-style-type: none"> • Leadership needs to be flexible, courageous and resilient. • Leaders must build strong relationships with clinicians, MPs and councillors.
<p>Language</p> <p>Describe services clearly and consistently (see page 9)</p>	<ul style="list-style-type: none"> • Programmes should establish what terms mean and use them consistently.
<p>Let clinicians speak and support them</p> <p>A strong and honest narrative is needed, for clinicians to deliver in their own voice (see page 9)</p>	<ul style="list-style-type: none"> • Clinicians should put arguments into their own words. • The case for change should not rely on 'spin'.
<p>Long-term improvements</p> <p>Be clear about timescales and the risks of doing nothing (see page 9)</p>	<ul style="list-style-type: none"> • Solutions will be implemented over several years, not immediately. • Be clear about the consequences of not solving the problem.
<p>Learning</p> <p>Local history, best practice and evidence should inform reconfigurations (see page 10)</p>	<ul style="list-style-type: none"> • Programmes should learn from local history. • The evidence to support service change should be comprehensive and be made freely available.
<p>Leverage</p> <p>Choose the right spokespeople and don't assume the loudest stakeholders speak for all (see page 10)</p>	<ul style="list-style-type: none"> • Choose spokespeople who will have the most impact. • Clinical arguments should be made by clinicians.
<p>Local versus regional</p> <p>Stakeholders don't necessarily live in NHS configurations (see page 10)</p>	<ul style="list-style-type: none"> • People responding to a consultation may not take a regional view of the best interests of patients.
<p>Levels of engagement</p> <p>Reach as many people as possible, before and during public consultation (see page 10)</p>	<ul style="list-style-type: none"> • Engage with local residents, authorities and MPs; involve patient representatives in the decision-making process. • Engage staff early and frequently. • Seek external assurance from national expert bodies.

Why the NHS needs to change

The NHS is facing a period of substantial change. It is treating more people than ever before and medicine is growing increasingly complex. The population is ageing and more people are living with long-term conditions and unhealthy lifestyles. At the same time, the NHS faces rising costs and a static budget.

Care is becoming increasingly specialised, with specialists focusing on a particular area within their discipline. Although this has huge benefits for patients, it means not all places can be providers of every specialism.

With the service becoming increasingly specialised, it is more difficult to find staff in a number of key disciplines, making 24-hour, 365-days-a-year consultant-delivered care across all hospitals impossible. This in turn leads to variations in clinical quality and safety and quality of outcomes at different times of the day and week. Clinicians have expressed concern that patients face both a 'postcode lottery' and a 'calendar lottery'.

Many clinicians agree that the NHS model of care created in the 1950s, based on large district general hospitals covering all secondary care in a borough or area, is out of date. This has been argued in a number of recent reports.¹

There is consensus that more care needs to be delivered in community-based settings (including community hospitals) and GP surgeries rather than in high-tech specialised hospitals, which should be larger, more centralised sites. This would better suit the needs of our changing population, delivering care closer to home. In an environment of static funding, this requires an adjustment in the funding of services, with more money for community and primary care services coming at the expense of hospitals.

Some centralisation of hospital services, concentrating more specialists in fewer units, is likely to improve patient outcomes, as demonstrated by the changes to stroke, major trauma and cardiac services in London.²

While reconfiguration is not a panacea, it is attractive to clinicians and managers because it has the potential to address both the quality and safety concerns of clinicians and the financial challenges faced by the NHS.

“Many clinicians agree that the NHS model of care created in the 1950s is out of date.”

Why communications and engagement matter

The success or failure of NHS reconfiguration programmes largely depends on good communications and engagement.

The **Independent Reconfiguration Panel** – the independent expert on NHS service change, responsible for reviewing contested reconfigurations – gives the following reasons for reconfiguration programmes being referred to the Secretary of State for Health:³

- inadequate community and stakeholder engagement in the early stages of planning
- the clinical case not being convincingly described or promoted
- weak clinical integration across sites and vision of integration into the whole health community
- proposals that emphasise what cannot be done and underplay the benefits of change and plans for additional services
- important content missing from reconfiguration plans and limited methods of conveying information
- health agencies “caught on the back foot” about the three issues most likely to excite local opinion – money, transport and emergency care
- inadequate attention given to the responses during and after the consultation.

Given that many of the most serious risks to service change programmes – and the likely legal challenges – relate to communications and engagement, the role played by communications and engagement leaders is crucial.

Communications and engagement for a large-scale service change programme typically covers:

- leadership of stakeholder and public engagement, public affairs, media and social and online media
- delivery of materials, such as documents stating the benefits of change, consultation documents, websites and presentations
- internal communications with the leaders and staff of impacted providers and commissioners
- development of an overarching, multi-channel communications and engagement strategy that meets best practice considerations
- provision of communications and engagement advice on the day-to-day management of the programme.

See the Appendix on page 12 for a list of High Court judgements and Independent Reconfiguration Panel reports.

“Many of the most serious risks to service change programmes – and the likely legal challenges – relate to communications and engagement.”

What are the challenges?

Some common challenges were recognised by everyone the authors spoke to, and were present in all the change programmes which the authors have been involved in:

- opposition from politicians and campaigners
- challenges to process
- public concerns and confusion
- finding robust clinical champions
- system changes
- engaging effectively.

These are examined in more detail below

Opposition from politicians and campaigners

Proposals to change services at a local hospital tend to meet fierce opposition from the public, MPs, councillors and media in the communities where the change is going to be most felt.

Whatever the strength of the case for change and the evidence that it would improve services, a degree of political opposition to change is inevitable, something that is likely to be more common in the run-up to the General Election. Politicians fear that being seen to support a downgrade of local services will lose them votes or even their seats.

Campaigners in Kidderminster formed a political party to challenge the closure of their local A&E department. Their candidate, Dr Richard Taylor, was elected to Parliament by a landslide in 2001.

Newspaper editors know that campaigns to save local hospitals sell papers, as many people have an emotional attachment to their local hospital, often based on having been born or treated there.

It is important that change programmes do not view the most vocal anti-change campaigners as representative of the public as a whole. For example, while there was vociferous opposition to the recent Shaping a Healthier Future programme in London, most consultation responses supported

the proposals.⁴ The point of consultation is to establish a broad range and balanced picture of views from the population affected, and invite specific proposals for alternative solutions. Consultations should not be biased towards those who simply make the most noise.

Challenges to process

Because non-clinical commentators are not always comfortable debating the clinical case for change with doctors and nurses, and because a judicial review is one of the few legal processes that opponents can use to halt proposed changes, most challenges to reconfiguration programmes will focus on the processes of the programme and its compliance with the law. This typically includes:

- the extent and manner of public engagement
- the timing of consultation or public meetings
- the availability of materials in different languages
- the level of consideration given to the impact on equalities or protected groups
- the way options were evaluated
- the accuracy of materials presented by the programme.

It is, therefore, essential that programmes take legal advice and adopt a best-practice communications and engagement approach. A 'do the minimum' approach to engagement is likely to be open to challenge, especially as the bar has been raised by recent reconfiguration programmes.

“Whatever the strength of the case for change, a degree of political opposition to change is inevitable.”

Public concerns and confusion

Understandably, public concerns about reconfiguration programmes often focus on what people see as the risks of having a longer and more expensive journey to hospital or a suspicion that the aim is to save money. Reconfiguration programmes are also being confused with elements of the Health and Social Care Act 2012 and being wrongly portrayed as a move towards the privatisation of services.

Programmes need to address these issues through effective communications techniques and processes.

There can be a trade-off between quality of care and distance of travel, but it is now widely accepted that in terms of saving lives, getting to the right clinical team is usually more important than how far you have to travel. However, it is important to recognise that some people feel safer the nearer they are to a service, so travel and transport will be a major area of public concern. Clinicians advising the reconfiguration programme must be content that any expected increase in journey times is of little consequence in comparison to the potential improvements in the quality of care. Programmes should take advice from experts in the field and local transport operators, and aim to follow industry best practice. Many people, understandably but inaccurately, regard their last difficult journey somewhere as evidence of difficulty more generally.

When one of the primary purposes of a reconfiguration is financial, or if it has a significant financial element, programmes should be clear about this, stressing that services which are not financially sustainable will become clinically unsafe. The clinical case for change must be clearly made, but programmes should not shy away from financial challenges. The climate for understanding this and the pressures public finances are under has changed in recent years because of the wider economic situation.⁵

There is much evidence that the need for change in the way NHS services are delivered predates the Health and Social Care Act 2012. Some reconfigurations were already underway when the Coalition Government came to power and, indeed, some programmes were halted by the Coalition. Some clinicians and managers believe the Act has in fact made reconfigurations more difficult to achieve (see 'system changes' below). These issues are likely to be recurring themes in most NHS service change programmes, so it is important that they are addressed from the outset.

Finding robust clinical champions

Many clinicians are aware of the challenges facing the NHS and that change is needed, but many doctors and nurses are not used to being politically and publicly challenged. Those who support change in principle may often find it more difficult to advocate specific changes, for example, to a local hospital.

There seems to be growing public mistrust of information and data from official sources and this has been a challenge for NHS reconfigurations. Even where there is a coherent and evidence-based case for change, this is likely to be dismissed or disputed by those who see any reduction of services at their nearest hospital as a loss, even if it would lead to better clinical outcomes. Factual information about outcomes and clinical standards, or responses to questions about the case for change, will often be dismissed by some as 'spin', even when put forward by respected clinicians.

Indeed, one of the common features of recent reconfiguration programmes has been the way in which the personal integrity of the clinicians proposing change has been called into question, with campaigners suggesting they have either a financial interest in the proposed changes or are acting as a cover for cuts to services.

For clinicians used to giving their professional opinion without fear or favour, such developments can be challenging and it is understandable that some choose not to take part in what can become a very polarised and aggressive debate.

Clinicians, however, have identified the need for change and so it is vital that as many of them as possible publicly support much-needed NHS reconfigurations. Opposition from clinicians and managers who do not want changes in their own workplace – and sometimes from NHS organisations themselves – makes the need for real clinical champions all the greater. The experience of previous programmes shows that it is not possible to drive change without visible clinical support.

System changes

The Health and Social Care Act has resulted in a period of upheaval for local health economies. The transfer of commissioning powers to clinical commissioning groups (CCGs) may have caused disruption and delay to some service changes. Reconfigurations rely on collaboration between commissioning bodies, so changes in these, particularly in leadership and working relationships on the ground, will have an impact. New bodies have been created with a role in reconfiguration, such as health and wellbeing boards and Local Healthwatch. It will take time for these organisations to become established but there is, as yet unrealised, hope that they will strengthen the process.

A recent Legislative Reform Order, expected to be implemented from October 2014, should remove legislative barriers to joint decision-making on reconfigurations. It will then be up to CCGs to work together with their neighbours, and with NHS England, to drive service changes that will benefit the wider population.

With a General Election looming, a change in government might lead to further system changes and disruption.

Engaging effectively

While the NHS has got better at engaging the public in relation to health services, campaigners often express dissatisfaction with the level and depth of engagement. Reconfigurations sometimes cover large areas and more than one borough, and it is vital that they aim to reach as many people as possible, including in the period prior to formal public consultation. This can be a huge challenge and requires investment of time, resources and money that is not always easy for busy clinical leaders and the NHS in general to find.

Programmes need to accept from the start that they will need to use more resources than they want to and plan accordingly. Otherwise, there will often be a knee-jerk reaction if things start to go wrong and even more money is spent trying to correct things.

Programmes need to use a 'multi-channel approach', including public meetings, deliberative events, drop-in roadshows, social media, a good website, media coverage and short films explaining the case for change and proposals. It is often advisable to seek best practice advice and formal assessment of your engagement approach and consultation plan from an external body, such as the **Consultation Institute**.

“Clinicians have identified the need for change and so it is vital that as many of them as possible publicly support much-needed NHS reconfigurations.”

What we have learned from previous reconfiguration programmes

Below, we provide some tips – the ‘eight L’s’ – for future change programmes to use.

Leadership

Excellent leadership is needed to drive the programme

All aspects of reconfiguration programmes require first-class, hands-on leadership as they will face many obstacles and attempts to derail them. Leadership needs to be supported, flexible, courageous, and above all resilient. Leaders must be able to build strong and effective relationships with key stakeholders such as clinicians, provider trust leaders, MPs and councillors. Reconfiguration is a difficult task and requires real leadership to make it happen.

Part of the role of leadership is to ensure effective engagement, even with opponents. While one frustration of dealing with MPs and councillors is that some may take a different public stance to the views they express in private, it is always worth maintaining dialogue with them, ensuring they are briefed and considering any suggested changes that do not compromise the clinical or financial outcome but which may make them more supportive.

Communication experts have a key role to play in supporting leaders: the most effective leaders are those who are clearly understood, eloquent and can argue effectively in public.

Language

Describe services clearly and consistently

Health services need to be described in a consistent way – the public are confused by terms like ‘emergency department’ or ‘urgent care centre’. We should be clear what we mean when we

“Programmes need to develop a strong and honest narrative about the problems they are trying to solve and how they want to solve them.”

refer to A&E, a major acute hospital or a local hospital. The word ‘reconfiguration’ itself can also be confusing and unclear. It is important that programmes establish early what different terms mean and use them consistently. The programme should also make an early decision about its approach to translating materials into different languages, well in advance of any public consultation, although it may not be cost-effective to print translated materials until you are clear what the demand for them will be.

Let clinicians speak and support them

A strong and honest narrative is needed, for clinicians to deliver in their own voice

Programmes need to develop a strong and honest narrative about the problems they are trying to solve and how they want to solve them. However, it is important that clinicians have the freedom to put the arguments into their own words. Be careful that ‘lines to take’ don’t become over-used catchphrases that lose meaning over time, and that clinicians do not sound like scripted politicians.

The case for change should be strong enough not to have to rely on ‘spin’.

During consultation, it is important to have a well-resourced, well-managed consultation response unit to handle queries from members of the public and Freedom of Information requests. Frequently asked questions should be published and regularly updated on the programme website.

Long-term improvements

Be clear about timescales and the risks of doing nothing

Programmes should be clear that while the process of deciding what should happen is taking place over a time-limited period, the solutions will be delivered in the longer term – for example, any service changes will be implemented over several years. Be clear about the consequences – often loss of life or unmanaged decline of services – of not solving the problems. At the same time, given the likely delays in the process of reaching consultation and possible challenges and other circumstances outside control, programmes should attach caveats to their timescales and describe them as provisional.

Learning

Local history, best practice and evidence should inform reconfigurations

It is vital that programmes learn from and are fully informed by local history, best practice and evidence. Local people will recall previous changes and proposed changes to local services, so programmes need to be fully briefed on previous initiatives and developments. The bar for NHS service change programmes has risen as more and more follow best practice communications and engagement guidance, so a 'do minimum' approach may be open to challenge. The evidence to support service change – clinical, financial and/or workforce – should be comprehensive and made freely and widely available. So should all the information available on equalities and public health.

Leverage

Choose the right spokespeople and don't assume the loudest stakeholders speak for all

It is important to choose spokespeople carefully, in terms of who will have the most impact. Programmes should consider carefully who they put forward and adopt a 'horses for courses' approach. Clinical arguments should be put forward by clinicians, but it is essential to use clinicians who are effective public communicators. It is not necessary for clinicians to be the main spokespeople on financial issues – they should be aware of them, but it is not likely to be their main area of expertise. It is important when listening to public feedback not to consider only the loudest voices, which are likely to be those opposed to change. The views of others who may be less vocal are equally valid. Clinicians need to be encouraged to see 'the public' not just as the people manning the barricades.

Local versus regional

Stakeholders don't necessarily live in NHS configurations

Some recent NHS reconfigurations have covered increasingly large geographical areas. It is important therefore to remember that people responding to the consultation, including local authorities, may not take a panoramic regional view of the best interests of patients. They will not necessarily recognise what the NHS describes as the health economy, understandably focusing instead on

the interests of their own local residents. This can make it harder for 'greater good' arguments – where, for example, one hospital stops providing a service so that everyone in the region can get a better quality service – to be accepted. The advent of CCGs, often closely linked to local authorities, has not made this challenge any easier.

It is also important to consider the different political make-up of local, regional and national government. Party politics will be important in terms of how politicians relate to the programme and to each other.

Levels of engagement

Reach as many people as possible, before and during public consultation

Service change programmes should take a best practice approach to engagement. This could include:

- carrying out representative surveys
- holding deliberative events with the public and stakeholders to set out the problems before any solutions are developed
- engaging extensively with local resident groups, local authorities and MPs prior to public consultation
- involving patient representatives in the decision-making process and in developing consultation materials
- ensuring people know how the feedback they provide has been used.

Closer work with local authorities through health and wellbeing boards should in theory make this process easier.

NHS staff should be engaged early and frequently, with briefings organised at their place of work and including senior trust staff. Staff are of course also members of the public and use local health services themselves, so briefings should focus on the case for change as a whole, not just their role as employees. Close work between communications teams in provider and commissioning organisations will be critical, including disseminating information via their established internal communications routes.

NHS Confederation viewpoint

The bar has been raised by recent programmes that have acted according to best practice and it is likely that future independent reconfiguration panels and judicial reviews will consider how the programme compares with others when considering whether local people have been sufficiently engaged.

As part of the engagement process, it is worth seeking external assurance from national expert bodies, which tend to be supportive of the principles behind reconfiguration where there is a strong clinical case for change. It is also useful to seek the advice of overview and scrutiny committees, local authority engagement leads and independent bodies such as the Consultation Institute, or other public opinion experts, when planning both pre-consultation engagement and the consultation itself.

For more information on the issues covered in this paper, contact rory.hegarty@gmail.com or lb@londoncommunications.co.uk

“Facilitating information exchange and learning is one of the ways the NHS Confederation can support its members as they lead service change.”

Last year, the NHS Confederation published *Changing care, improving quality*, in partnership with the Academy of Medical Royal Colleges and National Voices. As part of the work, we discussed reconfiguration with over 60 senior leaders, representing the views of patients, clinicians and managers. A theme we heard continually was the importance of communications. This report highlights why NHS organisations need to continue ‘raising the bar’ in terms of public expectations and how they engage with and manage these, and sets out some of the lessons learned from recent large-scale reconfiguration programmes.

Facilitating information exchange and learning is one of the ways the NHS Confederation can support its members as they lead service change at a local level. Experience may be a better guide than the words of others, but sharing lessons can help our members know what to expect before they embark on reconfiguration. Not all lessons will apply across the whole service and communications strategies will need to be tailored to local factors. Yet, many lessons are transferable and useful in starting a discussion across the NHS about the common challenges faced.

Reconfiguration is an important part of helping the NHS adapt to the challenges we set out with partners in our 2015 Challenge. For more information on the 2015 Challenge, visit www.nhsconfed.org/2015

For more information about our work on reconfiguration, visit www.nhsconfed.org/change

Appendix

High Court judgements and Independent Reconfiguration Panel reports

There have been a number of contested NHS reconfiguration programmes which have been referred to the Independent Reconfiguration Panel, acting on behalf of the Secretary of State for Health. For recent Independent Reconfiguration Panel reports, go to www.irpanel.org.uk/view

There have also been some significant judgements where cases have gone to the High Court. These include:

- ‘Shaping a Healthier Future’ programme – the north west London reconfiguration programme, which was challenged in court by the London Borough of Ealing. All grounds were rejected by the High Court. The judgement is available at: www.healthwatchhillingdon.org.uk
- the successful challenge brought by the London Borough of Lewisham and the ‘Save Lewisham Hospital’ campaign against proposals by the trust special administrator to downgrade services at Lewisham Hospital as part of his response to the financial difficulties experienced by the South London Healthcare NHS Trust. Available at: www.judiciary.gov.uk
- the Royal Brompton and Harefield NHS Foundation Trust’s legal challenge to the consultation on a reconfiguration of paediatric cardiac surgery in England, which was upheld by the High Court but then overturned by the Court of Appeal. The original judgement is available at: www.hsj.co.uk

The Court of Appeal judgement which reversed it is available at: www.judiciary.gov.uk

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Acknowledgements

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