Safety, Sustainability, Accessibility – striking the right balance

Reflections of a retiring Chair

1 July 2012 marks my final day as Chairman of the Independent Reconfiguration Panel (IRP). Over the last ten years, the IRP has established itself as the independent expert on NHS service reconfiguration. In that time, we have undertaken 19[[1]](#footnote-1) in-depth reviews of controversial and highly complex proposals for change covering the length and breadth of England, offering consistent, independent advice to six different Secretaries of State. In addition, we have offered numerous initial assessments of contested reconfigurations, designed to bring quick local resolution to disputes, while the Panel’s informal advisory role has, I know, helped to steer countless other reconfiguration projects clear of referral to the Secretary of State. In short, I believe the IRP has been an outstanding success.

During the lifetime of the IRP, we have seen much change in the NHS. Subtle alterations to our terms of reference over the period offer some clue as to the wider transformation that has taken place. National service frameworks and waiting times were core components of our original terms of reference. Today, the political emphasis is on the Secretary of State’s four tests for assessing reconfiguration proposals.

The period has, of course, not just seen changes in politics and policy. It has also seen significant developments in treatments and in the needs of the population. Many people can and should now be cared for outside of a hospital setting while average lengths of stay in hospital continue to fall. Improvements in anaesthesia and the growth of minimally invasive surgery are just two of numerous examples of developments that are allowing more people to be treated for a wider range and severity of conditions. Combined with an ageing population and the worrying rise in obesity and alcohol related diseases, the demands on the NHS have never been greater. It is regrettable, but unavoidable, that such demand should be occurring at a time when financial and economic constraints on the NHS have also never been greater.

In this climate, it is not only inevitable but essential that the NHS looks to reconfigure its services. As actual or potential patients, we all want the best health service possible. As taxpayers, we all want value for money.

The four tests encapsulate a common-sense approach to service change that, I believe, reflects much of the way in which the Panel has gone about its work since its establishment. Throughout all of our reviews, initial assessments and informal advice, our focus has always been on the patient and quality of care, and on the three aspects of healthcare that, to us, have always seemed to define this – *safety, sustainability and access.*

“Our focus is on the patient and quality of care in the context of

safe, sustainable and accessible services for local people”

But, in offering our advice, we have also had to accept that there is a balance to be struck between these three factors in determining the optimum configuration of services for a locality. My aim here is to explore some of the issues around achieving the right balance between the three that have led us to our advice and recommendations over the last ten years.

The factors that are driving NHS bodies to consider service change all fall, to a greater or lesser extent, within the compass of safety, sustainability and accessibility. Safety, of course, must always be the number one priority and, in many ways, it is difficult to conceive how there can ever be a balance to be drawn between it and sustainability or accessibility. *First, do no harm* is a principle taught to medical students the world over and provides as good a starting point as any for developing proposals about reconfiguring health services. But doing no harm is not the same as doing nothing. The IRP has encountered many examples where the desire of the population to retain services locally, and in some cases the desire of clinicians to maintain the status-quo, has obscured clear indications that a better quality - safer - service could be provided by reconfiguring services.

Further, one of the hardest subjects for the NHS to broach with the public is the possibility that their existing services may not be as safe or providing the best quality that they could be. This does not necessarily mean that the service has deteriorated, just that it hasn’t kept up with modern standards that are constantly evolving and developing as our knowledge increases. What was once considered good practice may no longer be so. After all, just because it wasn’t compulsory to wear seat belts 30 years ago, this doesn’t mean we think it is safe to drive without wearing one today.

Adult emergency care offers a good example of how clinical developments are driving up standards of care. Interventional radiology and its applications mean that it is now the treatment of choice for a variety of conditions, including heart attack, acute vascular conditions and stroke. These modern treatments have undoubtedly saved lives but require the presence of a 24-hour radiological service - something that cannot realistically be provided from every district general hospital (DGH).

It is self-evident that providing such specialised care in a centralised location requires improved ambulance capability. We are all guilty of complaining about congested inner-city roads or treacherous country lanes - whatever our own local situation may be - the concern being that the ambulance will not be able to get us to a more-distant, centralised unit in time. In doing so, we tend to forget that ambulance crews of today have very different skills to their predecessors. Not only are they highly skilled drivers, they are now also highly trained paramedics with skills to diagnose, stabilise and treat patients. Indeed, for many patients, paramedics’ skills are such that a hospital visit is not necessary (a driver for reconfiguration in itself). For those requiring hospital treatment, the DGH setting will continue to be the most appropriate for the majority. Where more specialised care is needed, the combination of effective first treatment by paramedics at the point of pick-up and clear protocols that direct ambulances to units with the necessary skills and equipment, represents a compelling opportunity to save lives and improve outcomes for patients that cannot simply be ignored.

Clinical developments are inevitably, therefore, a considerable driver for reconfiguring services. But as I have hinted, while centralisation must be a serious consideration for a number of clinical services, it does not come without downsides - notably to the range of services that can then be provided from the local DGH. Nor is it the solution for every service, care of the elderly being an obvious example. In general, I think it is true to say that that the public has yet to be convinced of the benefits in healthcare that can be gained from greater centralisation of certain services. Yet, the Bolton footballer, Fabrice Muamba, who suffered a mid-match heart attack provides an excellent example. The decision to pass closer, local hospitals in favour of taking him to a specialist unit several miles further away was a major factor in his remarkable recovery. If any good can come from such a dreadful event, let it be that we see a more reasoned debate about the pros and cons of centralisation - for those services for which it is relevant - in future.

As it is, centralisation - or more widely the rationalisation of services across fewer sites - is seen by the public as being about only one thing. Money (even though such changes do not necessarily result in financial savings). Clearly finance, particularly in the current economic climate, is a major factor driving reconfiguration. Successive government policies for the NHS, such as reinforcement of the purchaser/provider split, introduction of the NHS tariff for services and the move to foundation trust status, have all served to underline the importance of driving out inefficiency and getting the best value from the money that we invest in the NHS.

The trend can be seen from the evidence put to the Panel during reviews over the course of the last ten years. Option appraisals, setting out the financial consequences of a variety of possible options, are now greatly more visible, detailed and clearer in their methodology (though it must be said, this does not always make them any easier to comprehend).

In the IRP’s parlance, such matters come within the realm of sustainability. Looking back on our early reviews, the word *sustainable* did not feature in our terms of reference. It formally entered the IRP lexicon in 2007 with the two Panel reviews in Manchester: *Making it Better* and *Healthy Futures*. Interestingly though, the word “*unsustainable”* – often accompanied by the phrase *“maintenance of the status-quo is not an option” –* has consistentlyfigured large in the evidence we have reviewed.

In practice, sustainability has always been part of our considerations though perhaps not always in the form now so prevalent. If economic sustainability is now the primary arena in which the term is used, it was not always so. That proposals were *“…not about saving money”* is a phrase that may now be consigned to the past but in early reviews, clinical sustainability of staffing and in training and accreditation for those staff was frequently cited as a primary driver for reconfiguration.

In the Panel’s early days, the potential consequences of the European Working Time Directive (EWTD) figured large in considerations. The concerns were that, when implemented, the EWTD would restrict junior doctors working hours and, as a consequence, limit their workload and casemix ultimately hindering training. Reconfiguration of services was seen as the solution to a problem that, perhaps, the public and its representatives could not fully grasp. The Panel has, I believe, been a useful means of bridging that knowledge gap where necessary.

With the benefit of hindsight, I think it is fair to say that the EWTD did not turn out to be the insurmountable obstacle it was originally perceived to be. Instead, in many cases it forced the NHS to think more imaginatively about how best to utilise its staff. Solutions have been found to problems that at one time seemed insoluble – thanks to the boundless invention and ingenuity of the people that make up the NHS.

This is just as well since many workforce issues remain with us today. Issues of sub-specialisation, clinical competence after training, supervision, quality governance and the (in)ability to recruit staff to particular locations and specialities continue to exercise our thoughts. Strange when, at the same time, we hear that there are now more qualified doctors in this country than ever before.

In an ideal world, we would all enjoy access to the very best health services on our own doorstep and I think it is a credit to the NHS that the public assumes that services close to home will be safe. To the public at large, where safety and sustainability are to them a given, access to services is the single biggest cause of concern over proposals for service change. And rightly so.

The reality is that easy access to all services in all locations is neither logistically nor financially possible. Whether or not there are enough doctors – or nurses and support staff - to run such a service, there are simply not enough patients within a category of care to make providing all services at all DGHs feasible. Accessibility has to be a trade-off that offers sufficient coverage and the right level of specialist expertise for a population within the logistical and financial boundaries of what the NHS can realistically provide.

I said earlier that the drivers for reconfiguration can be categorised as coming within the compass of safety, sustainability or access. But is access really a driver for reconfiguration or actually just something that has to be accommodated within proposals? It is a matter of great regret to me that while analysis of accessibility issues - borne out of requirements to produce health impact assessments - has grown seemingly exponentially, the number of innovative solutions found to tackle problems of accessibility has remained stubbornly low. Greater emphasis needs to be placed on such issues as they are of great importance to the patients, our “customers”. It is undoubtedly true that closer tie-ins are needed between the NHS and local authorities (as true for social care as for transport issues). But, where necessary, the NHS should also look to develop its own transport solutions – the Medilink bus service linking Nottingham’s hospitals and park and ride sites being one such scheme in which I take a particular pride.

Throughout the lifetime of the IRP, maternity services have consistently proved to be a major source of contention. While clinical developments are changing the way in which we plan and provide adult emergency care, the same cannot be said for maternity services. Given that childbirth is primarily a natural event rather than a medical procedure this is hardly surprising.

A combination of drivers provide the motivation for reconfiguring maternity care. The nature of the service is such that capacity and quality of service have to be assessed against the fluid backdrop of changing population numbers and needs. Royal College guidelines are driving up standards for consultant presence in obstetric units. At the same time, the desire of many women to experience a non-medicalised birth is driving the need to provide more midwifery-led care. Both drivers are leading to improvements in quality of care but, combined with population changes, raise issues of capacity.

The proposed solution in several cases has been to consolidate obstetric care on fewer sites, preferably with new midwifery-led services. To those leading reconfigurations, this can be portrayed as an increase in access – access to high quality obstetric care and increased availability of high quality midwifery-led care. But to the public in the place that loses its existing facility, whether it be a rural or urban location, this is only ever seen as a diminution of services.

While the Panel’s advice has tended to support rationalisation of maternity services in urban locations, it is also true that we have been less supportive towards proposals relating to geographically isolated areas. The debate about the maximum acceptable distance that mothers-to-be should have to travel to access an obstetric unit continues. 20 miles is often cited as the maximum acceptable distance but there is still no definitive agreement. In any case, the real question is one of time rather than distance.

The truth is that the appropriate model of care varies from location to location – which is why all IRP advice is offered on a case-by-case basis. But it is perhaps no co-incidence that two IRP reviews encompassing maternity services in isolated locations – in Oxfordshire and East Sussex – concluded that accessibility was a significant factor that led to our advice that the existing obstetric units should be retained. In both cases, the real reduction in accessibility compared with current services were not, in the Panels opinion, outweighed by the compensating improvements in safety and sustainability.

As a brief aside at this point, it is worth remembering that all of the IRP’s reviews have been undertaken as a result of referrals to the Secretary of State for Health by local authority health overview and scrutiny committees. I am firmly of the view that, since its inception, health scrutiny has been a force for good. While accepting that some refinement to the process may be beneficial, my steadfast hope is that health scrutiny will continue and will continue to exert a positive influence over the NHS in its new form.

If my challenge to the NHS is to build greater consideration of accessibility issues into its reconfiguration proposals, the challenge to the public is to think more deeply about what the NHS can offer for the money it’s given. Does the public desire for locally available services extend to paying more for them through increasing taxation? Is the perception of, and attitude to, risk realistic? If not, can people truly weigh up the balance between risk and convenience? What is needed, if we are to progress the agenda on patient choice and public engagement, is open and honest dialogue about these issues. A debate that is firmly couched in a healthy dose of reality.

Even against previous challenges for the NHS, the coming years look especially turbulent. The nature of NHS services is changing to meet patient choice, an example being the increasing numbers of patients electing to use their Emergency Department as a first point of call if they feel they have an urgent problem. Delivering more consistent higher quality services in an immensely difficult economic environment will challenge the NHS to its limits. The risks of financially driven change and fragmentation are evident but there are also opportunities for more fundamental change and improvement and for tackling issues that have so far been avoided.

My time as Chair of the IRP has come to an end. I said at the outset that if, in 10 years time, we could make the Panel redundant, we would have done our job. On reflection, that was overly optimistic and there remains much work to be done as the NHS enters this latest crucial phase of its existence. But I remain fiercely proud, of the NHS in general and of the IRP in particular. It has been a great privilege to Chair the Panel. My heartfelt thanks go to the members and secretariat – past and present – for their support, friendship and sound advice. I wish the IRP continued success, confident that it will continue to strike the right balance.

1. Details of IRP reviews can be found on the IRP website www.irpanel.org.uk [↑](#footnote-ref-1)