TRANSCRIPT

Episode 2 – Health scrutiny

Paul Parsons - This is Not a Consultation. I'm Paul Parsons...

Caroline Latta – and I'm Caroline Latta.

Paul Parsons – Welcome to Not a Consultation. Our podcast on all things patient and public involvement and NHS service change.

Today we're taking a look at the local scrutiny of health services. Each of the nations has arrangements in place for local independent scrutiny of changes to health services. It's an important way of making sure the needs and wishes of local people are fully considered by the NHS when it's planning and delivering services. In England, that scrutiny is provided by local authorities. The heady mix of regulations, statutory powers and local politics can make appearing before your local Health Overview and Scrutiny Committee quite intimidating, especially if you haven't presented to them before.

Caroline Latta - We've invited four experts to give us their take on what makes for good scrutiny of health service changes, and we started by asking them to introduce themselves.

Paul Bartlett - I'm Paul Bartlett. I'm chair of Kent's Health and Overview Scrutiny Committee. Our remit is to provide scrutiny across the health services in Kent, and also we jointly scrutinise health services provided across the Kent and Medway area.

Denise Tyrrell - Hi, I'm Denise Tyrrell. I've worked in the NHS for 17 years doing major reconfiguration.

Richard Jeavons - Richard Jeavons, I'm chief executive of the Independent Reconfiguration Panel. We advise the Secretary of State about disputed and controversial NHS service change.

Jacqui McKinlay - Hi, I'm Jacqui McKinlay, chief executive of the Centre for Public Scrutiny. We're a national independent charity who's spent a long time supporting local government scrutiny, including health scrutiny, but also more recently working across housing, public sector, private sector, and really, we're about oversight and I'm trying to encourage better decision-making.

Paul Parsons - Jacqui, that sounds like the perfect place to start this discussion. Can I ask you to give us a couple of minutes on what makes good local authority scrutiny?

Jacqui McKinlay - I think that's the million dollar question, really, Paul, isn't it? And I'm not sure for an organisation that's existed for nearly 16 years, we probably shouldn't exist should we if we had already cracked that? So we've got loads of experience. And I think what's the most interesting thing is, what makes for good scrutiny in health also makes for good scrutiny across all of the sectors. So there's some really strong basic foundations that are needed. And I think for our conversation today, the first is probably clarity of role and responsibilities and what the purpose is. I think what we find is sometimes a confusion of purpose on both sides from health and local authority, whereas the best committees that we see and the best pieces of work that we see is where people really do understand their role, but also how that applies to the particular question or the particular area that they're looking at. The second is the one that's the hardest to get right, really, and that's around trust and confidence. So having the right kind of culture in place, it doesn't really matter what the structures are and the process if you don't have that mindset, which is open to scrutiny, which is willing to see the value of scrutiny, and then on the side of the scrutiny is a commitment to doing the work that's needed to

understand the issue, overcome any of the barriers around language, around knowledge, to be able to write the right question.

And as the old saying, culture is structure and strategy for breakfast. I think if there was one thing that makes for good scrutiny, it is that right culture and the right kind of trust and confidence. We then get into more of the practical things, and I think a great work plan which is visible, agreed, and designed with both parties or more parties in mind. And from that, you can have a clear idea what access to information you need, who you want to talk to, what you want to talk to them about. And you can make sure that that is as timely as possible, both to comply with the regulation and the legal side of it, but also to make for good scrutiny the worst case scenario really is when a topic just pops up and people feel like they're either surprised or caught on the back foot.

So having that great plan is a really key part of it. And then the final things are just about running the operations well. And I'm sure Paul is going to talk about his committee, but what works really well is when you have that smooth running of a meeting that it's there and people know what they're there for, but also they're trained well, they've got that right confidence. People who are coming to speak at a committee or provide an information know why they're there and feel like that meeting is open and transparent and challenging, but a positive environment. And then the final thing is just about measuring the impact. I think we can all experience great scrutiny, but then being able to prove that it's made an impact, hopefully positive, but maybe shine in a light is a great test for it. And I think if those things happen, what you're able to do is move on from legislative requirements and a tick box approach. And I think the areas where it works best is where scrutiny has seen to add value. It's there to kind of shape ideas, test assumptions, and maybe hopefully bring about some new thinking. But I think to get there, it needs to be a conscious act. None of that happens by magic. And I think just by setting up a health scrutiny committee or a joint committee that doesn't automatically then lead to great scrutiny. It needs that work and investment to really make that happen.

Caroline Latta - Thank you for that, Jacqui. We'll come onto Councillor Paul Bartlett. Paul, you lead a scrutiny committee responsible for overseeing health services provided

to more than 1.5 million people. And, of course, that's a lot of work. How does your committee decide what issues and services to focus on going back to that great work plan that Jacqui's been telling us about.

Paul Bartlett - Well, thank you, Caroline. Our process and our interest is driven by, first of all, what's changing in the NHS. Now, I first of all wanted to make a few outline comments about how we see our role of scrutiny fitting into the wider scrutiny process of the NHS. Of course, the NHS has its own internal scrutiny system, the CQC, but our view is that that judgment can often be very heavy handed and maybe not lead to the ideal outcomes for patients. The other issue that the NHS clearly suffers from is the issue of it being a political football. Sometimes the Secretary of State wants to send a message to the NHS and can be slightly heavy handed in the approach of change management. Now, we think that our approach is much more nuanced. First of all, we've got our statutory function to look at to determine whether changes to the way in which services are provided are actually need to be referred to the Secretary of State. So we have a legal obligation to refer something to the Secretary of State if, in our opinion, the change has not been done effectively, and that can be through public engagement or just service delivery.

And one of the biggest issues that we face is the risk, or maybe the view that many members of the public have is that the NHS simply doesn't engage with the wider public they're seen as remote and a difficult organisation for the public to provide input into. So we think that we've got a role of being able to provide an interface between what the public want to hear about the NHS and what they can get from conventional means of just routes through the governorships of the various foundation trusts. And those routes aren't open to everybody. A lot of members of the public just feel that they simply don't have a voice in how the NHS is run and how it changes. And this issue of lack of willingness to engage from the NHS is something that we really want to work with them so that we can offer an independent view of how their management and how their change management is being structured. So I think we have a unique role in the scrutiny, the overall scrutiny of the NHS offering something different from the CQC and what the centre NHS England do.

Caroline Latta - Thank you for that, Paul. So in particular, we're here to talk about, aren't we, major transformation programmes in particular in relation to the phase substantial variation, of course. So I was wondering, how do you expect, as the chair of your scrutiny committee, NHS colleagues to bring potential proposals for substantial variation of services to the committee's attention?

Paul Bartlett - Well, first of all, I think we have to work openly with them. So what we absolutely do not have is just one meeting every two months, which spends a day or half a day just looking at issues in depth. What is absolutely vital is to fully engage with senior management of the local trust, to understand their business and what they're about, what we don't want to hear is news about a substantial variation right at the end of the process. So certainly my approach in running the scrutiny committee is to fully embed what we're doing within the day to day business of the various trusts who operate throughout the county. Now that can be time consuming. And one of the issues that we need to be very aware of, particularly at the moment we're still in the midst of the pandemic, is that the scrutiny function does not take away from the really important day job that people are doing in the NHS. They are really genuinely on the front line and they need to be allowed to get on and do what they have to do, which is a very tough job. So what we don't want to do is to appear too intrusive, but it's creating that working relationship with senior figures so that they feel that they can come to the scrutiny committee as quickly as possible and have an open conversation about how things are going wrong.

And it's not unreasonable to think that things do go wrong from time to time. We've had a number of issues within the healthcare in Kent in just the last year or so which need to be addressed. We need the willingness from the NHS management to talk to us about it.

Caroline Latta - That's really helpful. And I noticed that Kent has set out its expectations around the process for substantial variation in the protocol giving the top tips that Jacqui was giving us before around the clarity of purpose. So not all overview and security committees set out their expectations, but Kent does with that published protocol. What do you think the benefits of that are?

Paul Bartlett - Well, it's all about working with people and providing you're very clear in your expectations of what you want to see from the CCGs and the various providers of healthcare, then I think it works much more effectively. In short, nothing should become as a surprise to the NHS. I would think that we have failed as our scrutineers of their activity if they feel they can't come to us at an early stage. And by being clear on our structure and our approach, we think that does offer benefits in the long term.

Paul Parsons - Thank you very much for that, Paul. I'm going to turn to Denise. You were involved in one of the most complex change programmes in the country. In fact, it was a specialised service which covered the whole of England, certainly, and the UK as well. So if you could tell us a little bit about that and also how you approached setting up the scrutiny function, because that must have been some job.

Denise Tyrrell - It was a very big job and it took a lot of innovation, and I think you need to be very innovative. I want to pick up with very much what Paul and Jacqui were saying about working early on with the local authorities and all of your other partners and talk to them at the beginning. Go and meet and talk to the chair of the JOSC. Start getting some soundings, get to understand the officers as well, who can be also very helpful, because obviously the chairs of the JOSC are very busy people with other day jobs as well. So you understand the population, the residents. So you know what community you're talking about. Remember, major reconfiguration is commissioner led. It's also a partnership with the provider that may be a provider that's proposing the change, but it's got to be in partnership within the whole system with the provider and the commissioner. And the partnership isn't just with them, it's with the residents and the patients and service users that are going to be most impacted. So I don't see how you can do any change without the service user at the table from the beginning shaping the thinking.

The other thing from the engaging with the local authorities and the JOSC is quantify where your patients are coming from. So do the numbers. That helps in two ways. First of all, it helps which local authorities you need to consult with, and it also helps the local

authorities know how big that major reconfiguration will be for their population, because it may not be big if it's only two or three patients from a specialised service for that population. However, it may still be important for other reasons, and then the local authority can actually make the decision as to whether that's major reconfiguration from their population perspective. The relationship still needs to go through the local CCGs, so we covered the whole of England, but we wrote initially to every CCG and said, how do you want us to engage with your local authorities? The response was mixed. In some local authorities we work directly with and others we went through the CCGs, but we must always remember that CCG knows the issues in the population and the area. And then if you've quantified your numbers and you know where the population is, you can then prioritise because obviously where you've got the bigger populations, the local authorities, where you've got the bigger populations impacted, that's where the major focus is. And then go see go and talk to your local authorities and get to understand how they want to work things as well.

Paul Parsons - So, Denise, you put a lot of effort at the beginning of the programme into understanding the size and shape of the playing field that you were working on and investing in those early relationships. So can I ask what the benefit was to your programme as you moved through the different stages of it.

Denise Tyrrell - The benefit was we had an open door to a number of the local authorities and they talked to us very early on about their residents' needs. The other benefit was there are a few local authorities that said, that's fine the changes that you're proposing aren't a major issue for us, we will have another local authority look on our behalf, and so they didn't need to worry about it. We still communicated. The biggest benefit is actually we made huge changes to the programme of work that we were doing as a result of the conversation we had with local authorities that really, really benefited the service users of the future.

Caroline Latta - Thank you, Denise. I'm going to come to Richard Jeavons now. It isn't always the case that health scrutiny committees and local NHS bodies can agree on service change proposals, and when they can't, local authorities can refer proposals to

the Secretary of State for review. That's when they arrive at the independent reconfiguration panel. Richard, can you tell us a little bit about the panel and its role?

Richard Jeavons - Yes, certainly. The panel was set up off the back of the powers of scrutiny way back in 2003. It is a panel. It's made up of a chair and 15 panel members. They're all public appointees. The 15 are made up of equal numbers of clinicians, lay people and people with management backgrounds. And that is a deliberate design to create the sort of both knowledge, experience and, frankly, sometimes tension and difference of opinions that there are around the purpose and execution of service changes in the NHS. The panel only exists because the Secretary of State wants advice about difficult referrals that land on its desk. It has no statutory role, and it could be abolished at the stroke of a pen if it was found not to be useful. So it's quite easy to be focused about what the panels about. When the Secretary of State asks for advice, we try to provide expert advice that will help him or her to reach a good decision about whatever the service change controversy is. Outside of our role with the Secretary of State, we also provide informal advice to stakeholders. So apart from the nearly 100 cases that were done for the Secretary of State, we get a steady stream of telephone, email and other types of contact with the NHS scrutiny committees, campaign bodies, public bodies about what's going on and wherever we can we try and help with informal advice.

Caroline Latta - There must be a lot of learning from those cases in the independent reconfiguration reviews that would help service change programmes that are being planned at the moment. What are the key points that you would want to draw our listeners' attention to?

Richard Jeavons - Yeah, indeed. The question how to achieve a successful reconfiguration in the NHS is one the IRP has addressed most explicitly in its publication, Learning from Reviews, which we first distilled in way back in 2008. But we actually recently updated it so called LFR 2020 earlier this year. In our experience, there are seven critical factors that make successful service change more likely. I'm not going to go through all seven now, but the first and most important factor is open community and

stakeholder involvement. From the first stage of considering change, the NHS has a duty to involve entirely separate from any duty to consult with scrutiny committees. And the duty to involve for the NHS is continuous. It is unaffected by reorganisation, sustainability and transformation partnerships, integrated care systems and good NHS organisations have active and continuous involvement processes, which they can simply build out from when they need to approach stakeholders about the future of services and the sustainability of those services, and possibly the need to change them in order to improve them. So that's the headline on learning about successful service changes. It's about being open and engaging and involving with those who use the service and have an interest in the service on a continuous basis.

So as Paul said earlier, when it comes to some difficult discussions about how services are structured, there are no surprises. There is only a good constructive discussion.

Caroline Latta - So is there anything else that you'd like to contribute, Richard, in terms of any...

Richard Jeavons - Maybe just to turn a little bit more explicitly to scrutiny. And my comments are based on the 30 cases we've done since the 2013 regulations came into force, and nothing I say can't be read in our advice, which is, of course, all published and in the public domain. In fact, you don't need to read all 30 cases because there are recurring themes and you just look at the cases for the last ten cases over the last couple of years, you can get the themes. And there are really three themes that come out of our reviews of the processes of scrutiny between the NHS and colleagues in local government. The first is that people regrettably still don't fully understand the regulations and don't comply with them. So a classic example is people refer on the grounds of inadequate consultation. And what they're referring about is the public consultation, not the consultation with the scrutiny committee. To take a simple example, so the first message is for both parties is understand the regulations and understand the processes and procedures needed to fully comply with them. The guidance is crystal clear. Referral to the Secretary of State is a last resort, and the regulations set out steps that must be

followed in order to make sure that referrals to the Secretary of State is indeed a last resort.

And it is surprising how many cases, still, the IRP can frankly very quickly see holes and gaps in the processes. So that's the first point. The second is that sometimes these NHS processes go on so long that the personnel involved on the scrutiny side of the house have changed. Indeed, the person on the NHS side of the house have changed. So there's a whole practical question about fitness for purpose of these processes and the stamina to get through them. And one of the risks there, which we've seen in a recent case, is that people lose sight of the purpose of the process and so they're going through the motions and they're having the meetings and everybody's working very closely and working very hard. And at the end of it, they simply can't kick the ball in the net, they can't reach a conclusion, they can't make any recommendations. And people look back and say, what on Earth were those five years of meetings about when we couldn't actually reach the end of the game? So keep in mind the purpose of scrutiny. I'm talking about both parties here. And keep in mind how a scrutiny process around service change must end and therefore how to prepare for that.

And then I guess the last comments I'd make about scrutiny are about practical things. The message to the NHS is embrace scrutiny. Good scrutiny can help the NHS reach the right conclusions about difficult challenges of balancing safety, sustainability and accessibility. Message for scrutiny is that good scrutiny is objective. It's based on objective analysis of evidence, really hard to do in a joint scrutiny committee where there are proposals that might divide communities. So I don't underestimate the difficulties, but retain objectivity. And finally, scrutiny is not about simply criticising or critiquing, it's about helping to find the right answers, about helping to shape outcomes that will be better for patients and citizens.

Paul Parsons - Thank you. According to the regulations, it's there in the first paragraph of Regulation 23, NHS bodies have a duty to consult their local authorities when they have under consideration substantial variations or developments. We heard from Paul

that Kent's got a protocol in place. The question I get asked most often is what is substantial?

Paul Bartlett - This discussion has raised a number of really crucial issues about how the scrutiny committees properly set themselves up to determine and agree what is substantial. Now, part of this problem is the political nature of the local scrutiny committees. We always have the issue that there will be winners and losers when there is a change configuration within the NHS. Quite often that's geographic and we see that regularly in Kent. It's a very large and diverse county and transport is a real issue. Travel times to a reconfigured unit can be materially different for patients. Now, it may well be that the overall treatment time is better, but people quite often don't get that. And what they focus on is the travel time under blue light from the event, from the accident to the point at which they receive treatment. Well, the point they received treatment within the hospital setting. Now, that creates a number of issues for a scrutiny committee because they are political and because members of the scrutiny committee are to some extent playing to the gallery and want to provide representation for their residents. And there is a risk that scrutiny can become highly politicised.

And the easy answer is to refer it to the Secretary of State, when actually that is entirely the wrong thing to do. The much, much better solution is to work locally with the commissioners and with the various providers in order to develop a solution that works for all stakeholders. And the priority is always the residents, because they are the priority as to who needs the treatment in the NHS. And so, regretfully, and almost inevitably, because you've got a political structure you are going to end up with referrals, might possibly be argued to be unnecessary, because the scrutiny committee is taking the easy option to refer it.

Paul Parsons - Thank you, Paul. And I'm going to ask Jacqui now if there's anything in terms of best-practice that you think might help our listeners.

Jacqui McKinlay - Yeah. I mean, I think what's been really helpful is we've had health scrutiny for quite a long time now, so we're actually talking about quite a mature system. And I agree with colleagues. Whilst personnel changes, the kind of sector has learnt and grown and health has learnt and grown with. And I agree with both Paul and Denise. Some of them are very, very obvious the massive change, while some of the smaller service change, whilst, might not fall into a substantial, as the word indicates, both from a political or a particular service user group. So you can think of lots of examples, maybe some aspect of children care, hearing impairments, whatever it might be, you can see that that reputational element and the community interest element may mean that whilst it's not technically a kind of substantial variation, the scrutiny committee may ask to talk about it. So I think that whilst the vagaries of the regulation and that we're not going to tell you what it is, you need to decide it locally is for exactly those reasons. What might be an important issue in one part of the country might not necessarily be in another. And I think what's happened over the years is that experience has grown within the sector and I think organisations like ours mean that we shouldn't be getting the same sort of issues arise and where there is confusion there.

But I think, as Paul said, the difficulty is it is a political system, both of the big P and a small P. Health is a very emotive issue that the community gets engaged in, wants to have its voice heard, wants to kind of have their views heard. So I think some of that needs to be thrown into the mix. There's a process and there's a protocol and there's agreement and then there's that alchemy of what's happening in the local context, what's happened in the history of the place, how does consultation engagement normally work out? And then there's that decision as to how active scrutiny needs to be involved.

Paul Parsons – Richard.

Richard Jeavons - The very fact that the guidance doesn't give you an easy cookbook definition means that the answer to the question what is substantial is a matter of dialogue and discussion locally. If relationships are good and communication is good between the relevant parties and they perhaps have a working protocol that they use as well, it's unlikely that people are going to disagree or fall out about substantial, really. And

you can look around the country and you can spot the places where they do fall out, and you can spot the reasons they fall out. It's usually because the NHS has decided it's not substantial and goes along and says, by the way, we're doing this, but it's not substantial. Well, talk about a red rag to a bull. I mean, what a way to open the conversation.

Paul Parsons - So if you had one piece of advice that you could give to the programme teams who are planning this, what would that one piece of advice be? Jacqui?

Jacqui McKinlay - I think my one bit of advice would be build relationships. I think as colleagues said if you only rely on the meeting every six weeks to two months, you're going to fail. So this is about the coffee when times are quiet, catching up informally, picking the phone up to the scrutiny officer to say, I'm not sure if this is an issue, but this is what we're thinking about and just building up those relationships. So that's where you'll get the confidence to disagree. That's where you'll get the confidence to have that kind of dialogue and openness. And without that, you'll struggle, I think.

Paul Parsons - Thank you. And Paul.

Paul Bartlett - Thank you, Paul. Yes, I just wanted to reiterate, we're all in this together and we all have exactly the same purpose to ensure that the NHS is providing top quality services to its residents. It needs hard work. It's all about building relationships, investing in the time, understanding why the change is being brought forward. People are generally adverse to change, even if it's change for the very, very best of reasons. So talk to people and remember, we're all in this together to deliver excellent services.

Paul Parsons - Thank you very much, and Denise.

Denise Tyrrell - I'm going to have to reiterate build the relationship well before you do any service change, make it a culture, talk early, listen to what's being said and act on it.

Paul Parsons - Thank you very much, and Richard.

Richard Jeavons - I agree with all the above. Embrace scrutiny as a positive force in reaching the right decisions about the future of healthcare in your area. Do not treat it as an unnecessary tick box overhead that you want to circumvent.

Paul Parsons - That covered a lot of ground. It's hard to pick just a few key points, Caroline, but what are your take-aways from that discussion?

Caroline Latta - I very much like Richard's point about learning from the independent reconfiguration panels, and in particular that the best NHS organisations and NHS partnerships, of course, these days, are doing open and continuous involvement all the time. So they have that strong basis for stakeholder and partner relationships, as well as a very good understanding of what is important to patients to inform service reform. It's my experience that for some NHS leaders, it can be an intimidating prospect. And the excellent advice from all our panelists is around taking the time to build relationships. So the first time that you meet elected members is not on the other side of a committee table that you've already had those conversations and built those relationships. Things get done by developing personal relationships and trust. And this is the same for scrutiny relationships to really develop that mutual interest that Paul talks about, that we're all in it together and ultimately that's all about making things better for patients. Like Richard said, don't make it a tick box exercise, make it part of ongoing business.

Paul Parsons - I couldn't agree more. I really like the way that the points raised by the panelists kept highlighting the framework that Jacqui set out at the beginning. Clarity, that both sides need to be aware of their role and the purpose of both scrutiny generally, and in each specific instance that was reflected in points that Paul, Denise and Jacqui raised that trust and confidence are the key. We heard that in a resounding chorus describing how relationships and communication are critical and how important it is to have an agreed plan and a shared understanding of approaches. And Paul set that out so clearly and Richard describes the benefits of that. And I really liked Richard's closing

point that scrutiny has to be objective and we have to embrace it. Really making sure that scrutiny is a positive force in these programmes and understanding that relationships are critical and service change doesn't happen in a vacuum.

Caroline Latta - I like to think of scrutiny as the way the local NHS is democratically accountable.

Paul Parsons - I think that's a good place to end a great discussion. I'm sure we'll be back to look at scrutiny again. Thank you to our panelists, Jacqui McKinlay, Councillor Paul Bartlett, Denise Tyrrell and Richard Jeavons. We put some links to useful resources with this episode on the website, notaconsultation.com, and that's where you'll find all our other episodes.

Caroline Latta - You can find us as Not a Consultation wherever you get your podcasts and you can send your comments and questions to listen@notaconsultation.com.

Paul Parsons - And remember this is not a consultation...

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