Rights, risks and responsibilities in service redesign for vulnerable groups

RCN guidance
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Background

In 2012 RCN Congress debated the issue of service redesign. The debate addressed the implications of redesign: the potential loss and fragmentation of specialist knowledge, expertise and staff, and the consequent effect on delivery of high quality services for vulnerable groups such as children, older people and those with learning disabilities or mental health conditions.

This document is designed to support RCN members engaged in service redesign to identify issues and mitigate against risks. While aimed primarily at nurses working with vulnerable groups, the core principles identified in this guidance may be helpful for any member going through any process of service redesign.

Although service redesign may be required to improve patient pathways, move care closer to home, maximise efficiency or centralise specialist services, it needs to be undertaken in the context of planned and managed networks of care which preserve the specialist knowledge, skills and expertise required. The RCN believes that the NHS needs systems in place to spread good practice and encourage real, well-planned service redesign and better collaboration between all organisations involved in delivering health and social care, rather than short-term, financially driven redesign.

The RCN believes that some of the recent legislative and structural changes in the commissioning and planning of services across the UK have lacked sufficient consideration of the implications for vulnerable groups such as children and young people. The resulting loss of well established clinical networks and pathways of care has, in the RCN’s view, created further increased risks to patient care (RCPCH, 2012; RCGP, RCN, RCPCH & CEM, 2011).

RCN members have repeatedly asked that any reform is centred around the patient or service user, and not, for instance, on an enforced, arbitrary distinction between where health and social care start and finish, or made without taking into account how a change in one service can affect another. The RCN believes that it is important that patients, staff, governing authorities and external agencies have a common understanding of integration and integrated care so that they know what to expect in the care journey, and can work towards a common aim. Indeed, the RCN has long considered the importance of the delivery of integrated care. For instance, the principles of integrated care are embedded throughout the RCN’s Principles of Nursing Practice (RCN, 2011a), which identifies the elements everyone can expect from nursing practice, whether they are colleagues, patients or patients’ families or carers.

While the language used across the UK may be different, the same concerns and potential opportunities exist to improve provision for patients and vulnerable groups. Language around these issues is often used interchangeably. Service redesign including reconfiguration and integration can be positive if risks are dealt with, there is full scrutiny, and patients and frontline staff are involved in the redesign.
Introduction

Health care in the UK has always been a dynamic, rapidly evolving service that strives to satisfy competing interests. In this environment the particular needs of some vulnerable patient and client groups can get lost, especially if decisions are made without including clinicians, relevant specialists, and patients or their carers and advocates. This failure to consult may result in poorly planned and under resourced services.

This publication has been designed to support nurses and their representatives in responding to plans for health service redesign which might impact on services for vulnerable groups. Such groups include children, young people, those with a learning disability and/or severe mental health conditions, and some older people.

For the purposes of clarity it is worth establishing from the outset what is meant by the term ‘vulnerable’. A significant component of vulnerability is the susceptibility to injury or harm. This is a characteristic of groups who hold less power, find it difficult to have their voice heard and may have to depend on others to ensure their best interests and to prevent disadvantage and discrimination.

When it comes to the issue of rights, those of some vulnerable groups have been well articulated. In the case of children and young people, for example, the UN Convention on the Rights of the Child (UNICEF, 1990) provides a clear framework. The contrast between a welfare-based approach and a rights-based one can be illustrated by the contrasting phrases 'children need health care services designed specifically for them,' versus: 'children have a right to health care services designed specifically for them'.

The NHS Constitution for England (DH, 2012a) sets out what patients should expect from the NHS – including the right to free NHS services – and what is expected of them as recipients of care. Recently the Francis Inquiry highlighted the right of all patients to receive care which met basic standards around aspects such as a clean environment, clean sheets, food and drink within a caring culture. The RCN Principles of Nursing Practice clearly articulate the elements everyone should expect.

Potential solutions identified by The King’s Fund (2011) include:
- setting minimum evidence-based standards for key conditions
- using the new health and wellbeing boards in England to facilitate discussions about service change between clinicians and the public
- ensuring clinical senates advise on all clinical aspects of reconfiguration
- ensuring that the basis on which reconfiguration plans are referred to the Secretary of State are tightened up
- setting maximum timescales for reconfiguration.

Rights and Responsibilities (Scottish Government, 2012a) sets out what patients should expect from the NHS – including the right to free NHS services – and what is expected of them as recipients of care. Recently the Francis Inquiry highlighted the right of all patients to receive care which met basic standards around aspects such as a clean environment, clean sheets, food and drink within a caring culture. The RCN Principles of Nursing Practice clearly articulate the elements everyone should expect.

Some of the challenges identified concerning service reconfiguration include political and public resistance to major service change which arises from the way the case for change is made. This may result in the process of reconfiguration becoming protracted and expensive, and with quality issues left unresolved or specific elements of patient care threatened. A further inherent challenge is variation and the conflict of interests amongst those redesigning services.
Policy context

The political and policy backdrop for public sector services across all four countries is increasingly marked by uncertainty and complexity, and appears to be characterised by:

- an increased focus on major service change, greater public consultation and involvement of the public in decision-making (Parliament UK, 2012; DHSSPS, 2011; Scottish Government, 2011; WAG, 2011)
- a shift towards care in the community and moves towards integrated health and social care provision (Goodwin et al., 2012; Ham et al., 2012; Hurst and Williams, 2012; Thorlby and Curry, 2012; RCN, 2012g; King's Fund, 2010, 2011; Ham and de Silva, 2009; RCN, 2012h).

Urgent action is no doubt needed to prepare health and social care services for an ageing population and increasing prevalence of long-term conditions. Some of the reforms taking place across the UK will require difficult decisions, particularly those concerning service reconfiguration.

While systems and service provision may need to change, there is a need to look at the best way of providing care and support that is both clinically effective and financially efficient. When a robust and thorough economic evaluation is undertaken, some ways of providing services may prove more costly than others. Such evaluation is critical at a time when health and social care systems across all four countries of the UK are in varying states of transition.

Service redesign must yield value for money and recognise the true cost of care and support. Current service costs for vulnerable groups may be greater than the level of finance available and hard decisions about what to fund, and what not to fund, will be unpopular with politicians, with staff, and with the public across all four countries of the UK. Some commentators have suggested that change will only be effective through reforming the front line, ensuring effective clinical leadership, and developing a flexible workforce (Bosanquet et al., 2010).

In some parts of the UK, independent review panels have been convened to review major service redesign, providing additional scrutiny to decision-making processes. For example, in October 2012 the Secretary of State for Health in England requested an independent review of the Joint Committee of Primary Care Trusts’ decisions regarding children's cardiac surgery service provision. In Scotland, a small number of major service redesigns have been considered by the independent scrutiny panels established by the SNP Government (although none have met since 2009), and in 2010 the Scottish Government published its detailed guidance Informing, engaging and consulting people in developing health and community care services.

The RCN is using every opportunity to call for a mature and transparent debate which will ensure wise decisions are made. In Scotland, for example, the RCN has developed a set of Principles for the delivery of integrated care to influence the redesign of health and social care services across the country (RCN, 2012g). Meanwhile, in Northern Ireland the RCN has delivered a robust response to the government’s service review, Transforming your care (DHSSPS, 2012).

In England, the RCN has repeatedly voiced concerns about the implications of the Health and Social Care Act (2012), but has remained committed to supporting implementation of changes for the benefit of patients. Overall, the RCN has seen limited evidence of efficiency savings being directly reinvested in frontline services across the UK and has repeatedly expressed concerns about the lack of immediate reinvestment in care provision, particularly in community services.

The financial constraints placed on the health service in Wales have been viewed as an opportunity to address some long-standing and deep-seated problems in the service. There are developments aimed at the integration of public services, achieving regionalisation across high-intensity but low-volume specialist services, and revisiting skill mix and professional demarcations (Longley et al., 2012). There is also a strong focus on the protection of the rights of the most vulnerable groups, such as the legal right of young people in prison to public health provision.
The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) (known as the Francis Inquiry) further highlights issues related to repeated multi-level re-organisations and a lack of focus on the effects of these changes on patients, particularly the most vulnerable. Francis calls for numerous changes to the culture of the NHS, greater openness and transparency, as well as proper accountability at all levels of the service. The Inquiry highlights the need for staffing levels to be appropriate and for all staff to be properly educated, trained and regulated to meet the needs of patients and clients. The RCN has repeatedly called for improved staffing levels across all service areas, as well as the training and regulation of health care assistants, and welcomes the Francis Inquiry recommendations.

Nurses and nursing in service redesign

Nurses are at the heart of health care delivery across all four UK countries in health care, social care and education settings. Nurses are fundamental to service provision and therefore to the processes of service redesign, including ensuring that patients are involved throughout the process. At a time of unprecedented change and stringent financial constraint, the pressure on nurses to deliver both high quality and cost effective care is profound. The increasing complexity in the clinical environment in which nurses work has meant their expertise, knowledge and skills have had to develop and evolve to meet rapidly changing patient needs.

However, at this time of change it is critical that the nursing profession does not lose sight of the fundamental principles that underpin nursing care delivery. In the last year, both the RCN (2011a, 2011b) and the Department of Health (DH, 2012d) have reinforced the foundations that should underpin the whole nursing profession. When considering service redesign proposals, the RCN refers to its Principles of Nursing Practice (RCN, 2011a) which demonstrate our core values. They are based on themes of quality, accountability, equality and partnership. The RCN believes that these principles must form the basis for the design and delivery of health and social care services (RCN, 2011a, 2011b).

With budgets squeezed across the whole of the UK, nurses are increasingly required to promote the value of nursing and to influence and evaluate safe and effective service delivery, while acting as robust role models for other professional colleagues. There is also a growing requirement for nurses to deliver care in any setting or environment, and through a range of NHS and independent health care providers. It is essential that in these challenging times nurses continue to practice within the NMC’s Code (NMC, 2008) and do not place either their patients or themselves at risk.

As a profession which works closely with patients and their families, nurses have a unique insight into how services can best meet the needs of these individuals. However, the role of the nurse is not always recognised. Commissioners and service planners need to understand the workforce and the
professional accountability of the nurse. Nurses have embraced, and frequently led, service change when it is in the best interests of their patients, and have the skills and abilities to safeguard and guide the process of service redesign to ensure that patient safety is preserved, patient outcomes are achieved, and patient experience enhanced.

The RCN therefore fully supports the Francis Inquiry’s recommendation that boards must in future seek the views and advice of nurse directors about the potential impact of any proposed major change, including changes to nurse staffing or facilities, which could affect the fundamental standards and quality of patient care (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

The nurse’s role in ensuring that patients’ voices are heard and their views taken into account during service redesign is important. The Francis Inquiry found that an unhealthy culture, poor leadership and an acceptance of poor standards were widespread in the Mid Staffordshire NHS Foundation Trust. Patients’ and relatives’ voices were not sought or were ignored by those making decisions about service provision. The RCN believes that patients must be enabled to fully participate in decisions affecting service delivery.

There are significant workforce planning and training issues linked to any major service redesign. Often the particular workforce planning and training implications for those working with vulnerable groups is overlooked, and in many cases forward planning does not occur.

For example, the improvement in pre-term neonatal survival rates means there is a growing population of children, young people and adults living with a range of complex mental and physical needs (Tyler et al., 2007). Yet in most instances the workforce working with adult clients has not been prepared with the right knowledge, skills and competences to meet the needs of these young adults.

NHS planning is often contentious as it exists within a highly political environment driven by demographic changes, financial constraints and changes in the regulatory and legislative framework. Workforce planning needs to take account of these issues, but must also incorporate policy driver changes – such as moving care closer to the patient and changes in professional education – as well as the introduction of new roles and new ways of working (Willis Commission, 2012).

The workforce planning function has three key elements:
1. assessing how many and what type of staff are required
2. identifying how these staff will be supplied
3. determining how a balance between demand and supply can be achieved (in effect it provides for some management of the workforce market) and can meet the needs of service provision and patient choice.

Effective workforce planning requires integration with service and business planning processes, as well as the commissioning of education and training. It should also take account of professional guidance where this is available (for example, the RCN’s staffing levels documents).

Workforce planning needs to be an integral aspect of overall
Service redesign: core principles and questions to be considered

All organisations providing health and social care services should have mechanisms for engagement and consultation when service redesign is considered or proposed. It is critical that nurses and their representatives are fully engaged with those mechanisms and processes.

New ideas, listening and learning from each other and implementing what works best are at the heart of many of the changes across health and social care aimed at improving outcomes for all patients and clients. Service redesign may be driven by both cost efficiency and quality improvement programmes, but can be adversely affected by a focus on short-term cost savings targets. A whole systems approach should be used when reviewing service redesign rather than focusing on short-term solutions to particular problems that are often financial in nature.

The RCN has identified some overall core principles and a range of questions for nurses and their organisations to consider when redesigning services, in whatever specialism a service might be. These are set out below, and are followed by specific discussion and questions for services delivering provision for children and young people, older people, those with learning disabilities or mental health conditions. These principles and questions are designed to support engagement in, or challenges to, service redesign. In addition, Appendix 2 provides a further range of suggested tools and resources to assess service redesign proposals.

Opposition to service redesign that is based on serious risk identification is entirely legitimate; indeed as a registered nurse there is a professional obligation on you to raise all reasonable concerns. These concerns should be noted as a matter of public record. See the RCN’s guidance Raising concerns: a guide for RCN members, for step-by-step guidance on this. Available at www.rcn.org.uk/publications or to order from RCN Direct on 0345 772 6100 (publication code 004 391). Or you can call the RCN’s whistleblowing hotline on 0345 772 6300.
### RCN core principles

#### Principle 1:
**A clear rationale for any proposed redesign must be articulated which encompasses and considers the needs of vulnerable groups from the outset.**

- The rationale must include the quality indicators and patient outcomes for service improvement.
- The reasons for service redesign must be made explicit and focus on improved outcomes for the most vulnerable client groups; in addition, financial drivers, clinical considerations and workforce issues should also be set out.
- Accessibility, enabling patient choice wherever possible, and a needs-based assessment should be evaluated by the commissioners and/or providers of the service.

(NHS Specialised Services, 2012; Royal College of Midwives, 2010a, 2010b, 2010c, 2010d; Wolfe, 2011; RCPCH, 2011.)

#### Principle 2:
**The rights of all patients to fair and equal treatment must be recognised in any proposed service change.**

- Proposals for redesign must address the specific needs of the patient group(s) and carers affected by any change.
- The redesign of services for vulnerable groups must ensure that no patient is disadvantaged by changes in access or services provided, and ensure that their voice is heard in any change being considered.

(DH 2012a; 2012b, 2012c; Kennedy, 2010.)

#### Principle 3:
**There should be a clear commitment to integration and working in partnership to ensure the full scope of the needs of the most vulnerable can be met.**

- All service redesign should promote the integration of care where this can clearly be shown to support improved outcomes for patient groups.
- All service redesign should be carried out in partnership with patients/clients and their carers; it may require the appointment of patient advocates to represent vulnerable patients.
- This partnership also involves care providers, staff and their representatives, service planners and commissioners of services.

(RCN, 2012g); DH, 2012c; Kennedy, 2010.)

#### Principle 4:
**A robust risk assessment of the service area must be carried out as an integral part of the redesign proposal to ensure the right care can be delivered to vulnerable client groups.**

- The risk assessment should identify all risks existing in the current service.
- The safety and sustainability of current services must be balanced with the risks associated with a new model of service; the impact on other parts of the service also needs to be assessed.
- A robust equality impact assessment must form part of this risk assessment process to establish if any vulnerable groups will be unfairly disadvantaged by changes to services.
- Risk assessment should explicitly address arrangements for the safeguarding of children and vulnerable adults in line with respective legislation across the UK and good practice standards.
- The accountability framework for the service redesign process itself, and any resulting changes in accountability and responsibility, should be clear and transparent.
- Where serious risk is identified, concerns must be raised and recorded (RCN, 2009a, 2009b; NMC, 2010; GMC, 2012; GovUK, 2012).

(Health Development Agency, 2002; Audit Scotland, 2012)

#### Principle 5:
**A robust and evidence-based workforce plan must accompany all service redesign to ensure the most vulnerable groups are able to access appropriate expertise.**

- Consideration of demand and capacity to support vulnerable groups in the service area affected must be made.
- The redesign of specialist services should ensure that workforce plans address the need to preserve knowledge, skills and expertise required to provide specialist care.
- All workforce plans must include the identification of training and development needs of staff affected by the proposed change to meet the needs of vulnerable groups now and in the future.

## RCN key questions to consider

### Principle 1: A clear rationale for any proposed redesign must be articulated which encompasses and considers the needs of vulnerable groups from the outset.

- What is the nature of the proposed redesign? If it is to address safety or quality issues, and if so, what are those issues?
- What are the anticipated benefits to patient outcomes and how will these be measured?
- What are the potential risks to patient outcomes and how will these be monitored?
- Have vulnerable client groups, their carers and staff, all been supported to help develop the plans for service redesign?
- How robust is the equality impact assessment of the choices available?
- How has any preferred option been decided upon?
- Does the proposal fit with the wider strategic direction for services locally and nationally?
- What are the financial drivers? What savings (if any) are anticipated? How will these savings be used?
- What is the financial cost of implementation?
- Can the change be achieved through a different approach?

### Principle 2: The rights of all patients to fair and equal treatment must be recognised in any proposed service change.

- What needs’ assessment process has been undertaken of patients affected by the proposed service redesign, particularly vulnerable groups?
- How was the voice of the most vulnerable and hard-to-reach groups heard within the redesign process? How will these voices continue to be heard throughout the implementation and delivery of the re-designed service?
- Will the proposed change affect access to services for any patient groups, particularly the most vulnerable? Where access or capacity may be reduced, what alternative arrangements are being developed?
- Will any patients or their carers be disadvantaged by the proposed service redesign? What mitigating actions have been put in place?

### Principle 3: There should be a clear commitment to integration and working in partnership to ensure the full scope of the needs of the most vulnerable can be met.

- Do the proposals bring together all the services and agencies required to ensure holistic care packages for the most vulnerable can be delivered seamlessly? If not, how will this be addressed?
- Have service users and the public been engaged or consulted in the development of the proposals? Has this process followed best practice guidance (Health Development Agency, 2003; NLIHA, 2007)?
- Have all stakeholders affected by the redesign proposals been engaged in or consulted on their development?
- Is there evidence to show that the ideas or concerns raised have been acted upon?
- Have the employment implications for staff been identified?

### Principle 4: A robust risk assessment of the service area must be carried out as an integral part of the redesign proposal to ensure the right care can be delivered to vulnerable client groups.

- Has a robust, evidence-based risk assessment been carried out?
- What safety or quality concerns have been identified, particularly for vulnerable groups?
- How have concerns been recorded?
- Is there a means for logging on-going concerns throughout the transition process?
- Have steps been agreed to mitigate those risks, and how are they recorded?
- What specific transitional arrangement will be put in place to ensure smooth transition, particularly for vulnerable groups?
- What assessment has been made for the impact and knock-on effect for other ‘co-dependent’ services?
- Who is responsible and accountable for managing and delivering the change?
- Who is responsible and accountable for the safeguarding of children and vulnerable adults through the process of change and in the final service configuration?
RCN key questions to consider

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<tr>
<th>Principle 5: A robust and evidence-based workforce plan must accompany all service redesign to ensure the most vulnerable groups are able to access appropriate expertise.</th>
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<tr>
<td>• Will the redesign result in a change in the nursing workforce? Is it clear how these proposed changes will support the rationale for the service and meet the identified needs of vulnerable groups?</td>
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<td>• Is the proposed skill mix sufficient to provide safe, high quality services to the most vulnerable client groups and their carers?</td>
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<td>• Have all staff training and education needs been considered and addressed?</td>
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<td>• How will requirements for specialist knowledge and skills be met, particularly for those working with vulnerable groups?</td>
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<td>• Is there funding to support any training or education requirements as identified in the workforce plan?</td>
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<td>• Is the workforce plan fit for purpose, for example, will capacity meet the demand?</td>
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<td>• What impact does this have on the current workforce and what is the available labour market for recruiting to new posts to meet the needs of vulnerable groups? Are there possible risks regarding skill gaps that must be addressed?</td>
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<td>• Are there clear routes for the workforce changes required to meet the identified needs of vulnerable groups to influence regional or national workforce planning?</td>
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Redesigning services for children and young people

In 2010, Professor Sir Ian Kennedy produced a report, *Getting it right for children and young people* (DH, 2010), in which he highlighted poor health outcomes and the lack of priority given to children and young people in the health system. In January 2012, the Secretary of State for Health announced the development of a Children and Young People’s Health Outcomes Strategy for England. The report of this forum (DH, 2012c) builds on the Kennedy report, and shows that in the UK, more children and young people under the age of 14 are dying than in other countries in northern and western Europe. The report highlighted enormous and unexplained variation in many aspects of children’s health care, with the UK having worse outcomes than other countries in Europe. The report saw the lack of focus on preventive interventions and joined-up care as a root cause, and set out the need to redesign health services for children and young people, as well as the key principles and considerations to be taken into account to ensure children, young people and their families are ‘at the heart of what happens’ (DH, 2012c).

Nursing services for children and young people are currently provided in a variety of settings and encompass a wide range of specialties. Care is delivered within universal services as well as in more specialised health services in primary, secondary and tertiary care. Care is also provided by social care, education and voluntary and third sector organisations.

In England, reforms to the commissioning system, following the NHS Health and Social Care Act 2012, will change the responsibility for commissioning children and young people’s services, with different aspects being commissioned by the NHS Commissioning Board, clinical commissioning groups and local authorities (see [www.rcn.org.uk/nhsreform](http://www.rcn.org.uk/nhsreform) for more details). There is growing concern that services may become fragmented, or ‘fall between the gaps’.

Service redesign can take a range of forms, including large scale change across whole health economies, departmental reorganisation, or the provision of new services.

In secondary and tertiary care settings, service redesign may include the amalgamation of specialist services into ‘multi-specialty’ units. Such changes can dilute specialist nursing care and challenge the maintenance of specialist knowledge, skills and training. The presumption that children’s nurses can work across all specialties needs to be challenged, since children and young people with specialist care-needs require expert skills and knowledge to ensure care is safe and effective.

Changes in the dependency and acuity of patients within current services may require changes in practice and a review of provision long before consideration or acknowledgement is given to service redesign or development. These ‘silent’ changes can put both patients and the nursing workforce at risk. Service managers and commissioners must review and respond to the impact of changes in dependency on the available workforce, the capacity of services, and manage the expectations and demands put upon nursing. This is paramount when considering any future workforce planning.

It is essential that service planners, commissioners, service providers and nursing staff are supported in ensuring the safe and effective delivery of nursing and care services for children and young people across all settings. The following core principles and key questions are intended to support decision making when services are being reviewed and possibly redesigned (DH, 2010; DH, 2012c).
Key questions to consider include:

| 1. Children, young people and their families or carers must be at the heart of any service redesign. | • How have children, young people and families been consulted on proposals?  
• How have hard-to-reach groups, including black and minority ethnic (BME) families, been consulted?  
• How have responses to the consultation process been recorded and taken into account?  
• How do proposals reflect the views of children, young people and families?  
• What mechanisms will be put in place within the service to ensure continuing engagement with children, young people and families? |
|---|---|
| 2. Services for children and young people should provide age-appropriate care, with robust arrangements for transition to adult services. | • What work has been undertaken in the proposed redesign to assess both demand for services and capacity to meet that demand?  
• Will services for children and young people be provided in dedicated facilities, accessible to families?  
• Will all facilities (including out-patient services) provide a child and family friendly environment, staff trained in the care of children and young people, and separation from adult patients?  
• Are services for young people to be provided in line with the You’re welcome principles (DH, 2011a), or similar principles in existence in Northern Ireland, Scotland and Wales which reflect young people’s needs?  
• What arrangements will be in place for timely transition to adult services, planned in partnership with young people and their families? |
| 3. Services for children and young people should prioritise integrated care and partnership working. | • Is the proposed redesign in line with local, regional and national strategies and plans for services for children and young people?  
• Have commissioning organisations been involved in proposed changes?  
• Do proposals for service redesign affect current care pathways?  
• Have all partners involved across care pathways (for example, acute and community care, health social care and education) been involved in service redesign proposals?  
• What arrangements are in place to facilitate information sharing between partners (including children, young people and their families)? |
| 4. Services for children and young people should have clearly identified leadership and robust arrangements for accountability in place. | • Who will be responsible for providing clinical leadership to the service?  
• If there are changes in leadership and accountability, are robust transition arrangements being put in place?  
• What arrangements will be made to ensure information sharing?  
• Do proposals make explicit reference to measuring the impact on improving outcomes for children and young people? |
| 5. Services must be subject to robust monitoring to ensure the safeguarding of vulnerable children and young people. | • What arrangements will be put in place to safeguard children and young people within the service, and do staff have the expertise to recognise potential abuse or neglect?  
• Who will be accountable for safeguarding children and young people within the service? |
| 6. Services for children and young people should have a strategy for workforce, education and training which recognises the need for an appropriately trained workforce | • What arrangements are being made to preserve or develop appropriate knowledge and skills in working with children and young people and their families within the workforce?  
• What arrangements are being made to identify current and future gaps in knowledge and skills within the workforce? How are these being used to influence future training of nursing and other staff?  
• Where specialist services are being redesigned, what arrangements will be made to preserve specialist knowledge, skills and expertise required to meet patient needs?  
• Will the proposals reduce or enhance training opportunities for students? |
Redesigning mental health services

The redesign of mental health services has been a constant in the provision of mental health care for many years. The National Service Framework (DH, 1999) led to a radical growth of new services that refined the vision of community care following the closure of the large mental health hospitals in the 1980s. The services which proliferated after 1999, and in particular specific teams for the new services, are now being dismantled in the pursuit of reconfiguration. Despite assurances that these functions will be retained in other teams, service users and their carers remain anxious about accessing services in a crisis. This was illustrated by the findings of an inquiry undertaken by MIND (2011) which revealed the real anxieties such changes provoke.

While the majority of mental health care is provided outside specialist services, people who do receive specialist care are often the most vulnerable of our citizens. They require not only access to services in times of crisis, but also ongoing support to prevent avoidable admissions to hospital. Such hospital admissions can be made under compulsion, and it is therefore particularly important to provide continual access to avoid crisis admissions if possible.

Key questions to consider include:

| 1. Redesign of services must include meaningful consultation with service users. | • How have people with mental health conditions and their families and carers been consulted on the proposals for service redesign?  
• Have carers, in particular, had an opportunity to input to the redesign?  
• How have hard-to-reach groups, such as people from black and minority ethnic families, been engaged in the consultation?  
• Has this service user involvement created a new vision for services which is a genuine co-production by users and care providers?  
• How will the service ensure continuing engagement of service users and their carers as the service develops in future? |
|---|---|
| 2. Services for people with mental health conditions must be designed to meet the specific needs of service users, both at times of crisis and for ongoing care. | • Do the proposals properly address current and future demand for services and capacity to meet that demand?  
• Does the proposed redesign reflect local, regional and national mental health strategies?  
• Does the redesign consider the balance of in-patient beds and community services, given the potential risk of overwhelming community teams and the possible resulting rise in detentions and community orders?  
• Have crisis services, and access to them, been properly considered in the proposals?  
• Will in-patient services be provided in dedicated facilities, with specialist staff, and be accessible to families and carers as well as service users?  
• Does the proposed redesign take into account the need to address the physical health of service users as well as their mental health needs?  
• What mechanism will be used to provide service users with clear information about how to access the newly-designed service on an ongoing basis, in times of crisis, and, in particular, how to re-engage following discharge?  
• Has consideration been given to the risk of individuals disengaging from the service as a result of the changes, with potential negative consequences for them and their carers?  
• Will transition to the newly-designed service be supported with increased provision of peer support workers?  
• What arrangements will there be to ensure that any transition from children's mental health services to adult services is properly planned and implemented, in partnership with the service user and their family or carer?  
• Will this redesign have an impact on improving social inclusion for people with mental health conditions and reducing social stigma?  
• Have equality and diversity impact assessments been undertaken as part of the redesign of mental health services? |
3. Changes to mental health services must show a clear commitment to partnership working, to provide the most appropriate care for people with mental health conditions.

- Does the proposal draw on existing policies, such as *New ways of working for everyone* (DH, 2007), to progress effective, collaborative interdisciplinary team working?
- Do the proposed changes invest in flexible and smart ways of working which would support a diverse and dispersed workforce?

4. Quality, access and appropriateness of services must be subject to robust monitoring to safeguard vulnerable people, and to ensure service users have the right to choice and self determination.

- What arrangements will ensure that people with mental health conditions have fair access to all health care services?
- What arrangements will be in place for safeguarding vulnerable people?
- Do the proposals make explicit the rights of people with mental health conditions to choice and self determination?

5. A strategy for workforce planning, education and training must be in place in any service redesign, with full understanding of the implications for both patients and the workforce.

- What arrangements have been made to preserve or develop specialist knowledge and skills in nurses working with mental health service users? This is especially important where redesign could mean a change of roles for staff, and in particular where movement into teams with specialist functions may present challenges to staff.
- How will the redesigned service ensure that support workers have, or are given the opportunity to develop, the knowledge and skills to support clients safely?
- Has this redesign considered changing roles, re-training and education needs of staff?
- Will redesigned case load reviews consider the level of service user needs in a systematic manner?

Key questions to consider include:
Redesigning learning disability services

According to Mencap around 1.5 million people in the UK have learning disabilities, and this number is projected to increase by one per cent a year over the next 15 years. This will increase the number of children with very complex medical and health care needs who will survive into adulthood and older age, due to advances in medical science, and in health and social care services.

The policy direction guiding services for people with a learning disability is similar in all four countries of the UK: a commitment to enabling people with a learning disability to live as citizens in the community with their non-disabled peers, with choice and control over their lives and the support they need to enable this (DH, 2001; DH, 2009; DHSSPS, 2005; Scottish Executive, 2000; Welsh Assembly, 2009).

A review of health and social care in Northern Ireland (2011) further supports changing the model of care from long term residency in learning disability hospitals and residential care to the development of personalised, community-based services. The report recommends that all agencies work together – housing, transport, education, health, leisure and culture – to reform and modernise policy and provision of services, developing a more diverse range of age-appropriate day support, respite, short breaks, and information resources (for people with a learning disability) to support access to services. There is significant focus on meeting the health and social care needs of people with a learning disability and a drive to support inclusion and to enable them to use mainstream services (RCN, 2007). A robust research evidence base illustrates that people with a learning disability have complex health needs that can go unrecognised and unmet, which impacts on their health care experience, quality of life and mortality.

Despite changes in policy and research evidence regarding the physical and mental health care needs of people with learning disabilities, Nursing and Midwifery Council data shows a decline in learning disability nursing registrants in the UK (NMC, 2011).

The shift away from institutional care to a social model based on independence, inclusion and empowerment (DH, DHSSPS, et al., 2012), has had a negative impact on the recruitment of learning disability nursing. However, learning disability nursing has responded by changing significantly in the past few decades. Learning disability nurses now work in a diverse range of services, including assessment and treatment in-patient services, community teams, social care, education, the voluntary and the third sector, and provide both generalist and specialist nursing care.

The RCN fully supports the development of learning disability nursing, and the RCN’s 2011 report Learning from the past, setting out the future (RCN, 2011c) led the way for a UK-wide review on modernising learning disability nursing. Underpinning the review are four principles: strengthening capacity, strengthening capability, strengthening quality, and strengthening the profession.

The report Strengthening the commitment (DH, DHSSPS, et al., 2012) has captured these areas and set out recommendations that will have the greatest positive impact for people with learning disabilities, their families and carers, nursing, and the services which support them. The actions and developments are underpinned by the principles and values of learning disability nursing, which have served learning disability nursing well over many years. Each of the four UK countries has been charged with implementing the report’s recommendations in 2013 to modernise learning disability nursing throughout the UK.
**Key questions to consider include:**

| 1. People with a learning disability and their families or carers must be supported to ensure meaningful participation in service design and delivery. | • How have people with a learning disability been consulted regarding service design and delivery?  
• How have hard-to-reach groups, including black and minority ethnic (BME) families, been consulted?  
• What arrangements are in place to help people with a learning disability engage in consultation, and how will their voice be heard at all levels during service redesign?  
• How do the proposals for change reflect the views of people with learning disabilities and their families?  
• What mechanisms will be put in place to ensure this engagement continues in future? |
|---|---|
| 2. The transformation of health and social care services must provide appropriate care which leads to better health outcomes and life opportunities for people with a learning disability. | • Has the proposed redesign assessed both demand for services and capacity to meet that demand?  
• What arrangements will be in place to ensure services represent good value for money while demonstrating effectiveness and clear measurable outcomes for people with a learning disability?  
• Will facilities (including out-patient services) provide a supportive environment for people with a learning disability and their families, with staff appropriately trained in the care of these service users?  
• What arrangements will there be to ensure that transition from children's to adult services is planned and implemented in a timely fashion, in partnership with the service user and their family?  
• What arrangements will there be to support people with a learning disability to be part of their local community? |
| 3. Services for people with learning disabilities must demonstrate a clear commitment to inter-agency partnerships. | • Are all agencies, internal and external, involved in the service redesign?  
• Does the proposed redesign reflect local, regional and national strategies for care provision for people with learning disabilities?  
• What arrangements are in place to facilitate information sharing between partners, including people with a learning disability and their families? |
| 4. Quality, access and appropriateness of services must be subject to robust monitoring to safeguard vulnerable adults, and to ensure people with a learning disability have the right to choice and self determination. | • What arrangements will ensure that people with a learning disability have fair access to all services?  
• What arrangements will be in place for safeguarding vulnerable adults?  
• Do the proposals make explicit the rights of people with a learning disability to choice and self determination? |
| 5. Services for people with a learning disability should have a strategy for workforce, education and leadership. | • What arrangements will there be to ensure staff have the specialist knowledge and skills to meet the complex needs of people with a learning disability?  
• What arrangements will be put in place to identify current and future education and training needs within the workforce?  
• Has strategic workforce planning taken account of future needs across the NHS, social care and third sectors, to ensure there are adequate learning disability nurses to meet future need?  
• Has education design been built on the NMC’s pre-registration proficiencies to develop evidence-based curriculum for the future?  
• What mechanisms will support the development of leaders in learning disability nursing? |
Redesigning services for older people

Older people are major users of health and social care, and have a right to services designed to meet their needs: ‘If we get it right for them, we can also get it right for everyone including children and young people and other key groups,’ (DH, 2012d, Equality and Human Rights Commission, 2011).

The average age of hospital patients is now over 80, while the majority of people receiving support with daily living activities at home are aged over 75 (Cornwell, 2012). Most care home residents are in advanced age (BGS, 2011).

People in the UK are living longer, but not necessarily healthier, lives. The proportion of people who are very old is growing most quickly; there are currently three million people aged over 80 and this number is expected to almost double by 2030. For many people, advanced age is associated with multiple chronic illnesses, disabilities and frailty (Cornwell, 2012). In the UK currently, about 750,000 people have a dementia and this number is expected to double in the next 30 years (DH, 2009).

Given the complexity of health in later life, it is essential that older people have access to specialist multidisciplinary and multi-agency services including geriatricians, old age psychiatry and consultant or specialist gerontological nurses, as well as general practitioner access for those in nursing homes (BGS, 2011, (RCN, 2012d, 2012e, 2012f)). The needs of people with dementia can be particularly complex – for example, towards the end of life – and specialist services are essential (Alzheimer’s Society, 2012).

Older people are likely to use several services across health and social care, and may rely on carers (DH, 2012d). Service redesign must acknowledge whole systems and the impact of service change (such as schemes to facilitate early hospital discharge) on other services (Abraham, 2011; BGS, 2011; Cornwell, 2012; Oliver, 2008; Tadd, 2012). All service options, including statutory, voluntary and independent services, should be considered. Proactive anticipatory and preventive services can be particularly helpful for older people and highly cost-effective in the long term (BGS, 2011).

Older people living in care homes are disenfranchised from the multi-professional health services they would receive were they living in their own homes (BGS, 2011). Service planners and commissioners should ensure that clear service specifications are agreed with local providers; these should link with quality standards based on patient experience and appropriate clinical outcomes (RCS, 2012).

The choices and priorities of older people and people with dementia must remain central in all services provided, alongside the wishes and needs of carers.

The competence of the workforce is a vital element in delivering quality services. All staff must receive core training in working with older people including communication skills, caring for people with dementia and, for clinical staff, principles of comprehensive assessment (RCN, 2012d, 2012e, 2012f). Staff must have access to training and development pathways in gerontological care and clinical supervision and support (RCN, 2012b).
Key questions to consider include:

| 1. Older people and their families must be consulted as part of planning for any service redesign. | • Are older people being consulted about the services they are offered? Has there been meaningful consultation with people with dementia and their carers?  
• How have hard-to-reach groups, such as families from black and ethnic minorities (BME), been involved in consultation?  
• Are advocacy services available?  
• Are the wishes, choices and priorities of older people respected?  
• What methods will be used to ensure consultation and engagement continues in the future, once redesign is underway or in place? |
|---|---|
| 2. All service changes must be designed to meet the needs of older people with complex needs and/or dementia | • Are the new services clear about their core business and designed around the needs of their major service user groups from among older people, particularly people with complex needs?  
• Has assessment of demand for services and the capacity to meet this demand been undertaken?  
• Will facilities for older people (including out-patient services) provide a safe, friendly environment for this user group and their families, with specifically-trained staff?  
• Will specialist services (such as a geriatrician, specialist gerontological nurse or dementia nurse) be available to the people with the most complex needs? |
| 3. There should be a clear commitment to integration and working in partnership to ensure the full scope of the needs of the most vulnerable are met. | • Does the service redesign promote integration of services in all sectors and smooth transition of older people and people with dementia across service interfaces?  
• Does the proposed redesign reflect local, regional and national strategies for providing older people’s care?  
• Have the full range of available services been considered in any redesign (for example, care homes offering hospital avoidance and early discharge services)?  
• Are all services designed to support the needs of older people with complex co-morbidities and frailty, and the needs of people with a dementia?  
• Will an appropriate range of services be available to support people at the end of life? |
| 4. The rights of all patients to fair and equal treatment, regardless of age, must be recognised in any proposed service redesign | • Will services be offered on the basis of clinical need, clinical appropriateness and clinical effectiveness, or are older people excluded from services on the basis of age alone?  
• Do any proposed service reconfigurations meet the needs of equality legislation?  
• Are older people in care homes to be offered access to the health services they would receive if they were living in their own homes?  
• Will older people and people with dementia be offered appropriate rehabilitation/re-ablement services on the basis of their potential to benefit, or are they excluded on an assumption that they would not benefit? |
| 5. A robust risk assessment of the service area must be carried out as an integral part of the redesign proposal to ensure the right care can be delivered. | • Are the services accessible to older people? Will appropriate transport be available? Are the services geared to support people with sensory deficits (such as sight or hearing loss), physical disability, or disorientation (which can accompany delirium and/or dementia)?  
• Does the service redesign acknowledge the rights and responsibilities of older people to take risk and to be supported in doing so?  
• What mechanisms will be available to safeguard adults at risk, and will staff have the expertise to recognise potential abuse or neglect?  
• Will services be available to support service users through the period of change? |
| 6. A robust and evidence-based workforce plan must accompany all service redesign to ensure older people and people with dementia can access the most appropriate expertise. | • Will all staff who will work in redesigned services have received training in awareness of the needs of older people with multiple, complex long-term conditions and people with dementia?  
• Will specialist multidisciplinary professionals (including consultant and specialist older people/dementia nurses) be available to support staff?  
• Are appropriate staff development pathways in gerontological care and dementia care in place?  
• Will there be appropriate staff/clinical supervision and ongoing support? |
If you have concerns or need help

You will find further information to assist you in responding to a redesign consultation in Appendix 3.

The RCN, working in partnership with stakeholders, fully supports members in responding to and raising concerns about service redesign or regarding the care of vulnerable people, including children and young people, older people, and those with mental health problems or learning disabilities, and about the protection of their rights as individuals.

If you feel compromised, that you are not being listened to, or not receiving the help you need, then contact your local RCN representative, or call the RCN’s whistleblowing hotline on 0345 772 6300. The RCN also offers step-by-step guidance called Raising concerns: a guide for RCN members. Available at www.rcn.org.uk/publications or to order from RCN Direct on 0345 772 6100 (publication code 004 391).

Appendix 1
Policy context summaries

England

The Health and Social Care Bill introduced in July 2011 was granted royal assent and became the Health and Social Care Act in April 2012. The RCN has stated publicly that despite the concerns it raised since the publication of the NHS White Paper in 2010, it is committed to help support implementation on the changes for the benefit of patients.

The NHS Commissioning Board (NHS CB) formally took up its role on 1 October 2012. The NHS CB will play a pivotal role in the new NHS and will provide the top level commissioning and managerial guidance for the NHS following the dissolution of primary care trusts (PCTs) and strategic health authorities (SHAs). The NHS CB will also commission some services itself (for example, general practice and specialist services). The NHS CB also has the responsibility for authorising every clinical commissioning group (CCG) as ‘being fit and ready to take on its commissioning role’.

The authorisation process requires that CCGs seek approval from their local authorities via their health and wellbeing boards, and their respective local involvement networks; after April 2013 this authorisation must be sought from their local healthwatch. The CCGs are expected to seek relevant advice from clinicians, patients, the third sector and others for the development of services. To achieve this, CCGs may approach clinical senates and strategic clinical networks which hold sector, service and disease specific expertise. It is expected that clinical senates will inform ‘big decisions’ such as service reconfiguration.

The NHS CB has authorised the first wave of CCGs (there are four waves in total). On 1 October 2012 Health Education England and the NHS Trust Development Authority were established as special health authorities, but in shadow form without full functions.
The Secretary of State has published a ‘mandate’ of services which must be provided by the NHS, and NHS CB will be responsible, via its overseeing of local service commissioning, for delivering this. The first mandate is available at: www.mandate.dh.gov.uk. Public health service commissioning with a ring-fenced budget will transfer from the NHS to local authorities.

Monitor, the current regulator of NHS foundation trusts, will have its role extended to act as the economic regulator of the new system. All providers of NHS services will have to achieve a licence from Monitor in order to bid for and provide services. Monitor and the NHS CB will also set out guidance on how competition should be applied across services. Monitor will set the national tariff or pricing of services, will assess the financial viability of providers, and will step in when a provider triggers the system wide failure regime. It has the power to appoint administrators and temporary management of failing providers. Monitor will also hold CCGs to account in regard to the financial viability of their chosen providers.

The Care Quality Commission (CQC) will maintain its role as the independent regulator of all health and social care settings. However, it has had its responsibility for assessing commissioners taken over by the NHS CB. The CQC will register all providers and assess their viability to provide a high quality NHS services. The CQC role is very separate from that of Monitor, as it focuses upon the quality of service provided. It will maintain its inspectorate role of all care settings.

Overall, the RCN has seen very limited evidence of NHS Quality, Innovation, Productivity and Prevention (QIPP) efficiency savings being reinvested in frontline services in England. An analysis of the Government’s 2012 budget statement by the Nuffield Trust showed that £500 million of the predicted £900 million ‘under spend’ of the NHS for 2011 to 2012 will go to the Treasury for central deficit reduction instead of being used to transform the service (see www.nuffieldtrust.org.uk/media-centre/press-releases/government-claws-back-500-million-nhs-aid-deficit-reduction). On 6 July 2012, HM Treasury confirmed that £1.4 billion of the £1.7 billion not spent by the Department of Health on the NHS in England in 2011 to 2012, had been ‘clawed back’. The Government announced that this would be used to help fund the freeze in council tax, major infrastructure projects, and other key areas of public spending not related to health. The RCN has expressed strong concerns that these efficiency savings are not immediately re-invested in frontline care.

The changes are supposed to encourage integration and service redesign with health and wellbeing boards as a forum for discussion across boundaries, and clinical senates are supposed to be dealing specifically with, and encouraging, service redesign. There is, however, the danger of fragmentation and variation in service provision due to the commissioning changes.

**Northern Ireland**

In December 2011, the Health Minister endorsed the outcomes of a review of the health and social care service in Northern Ireland. The review, *Transforming your care* (DHSSPS, 2012), prioritises the need to shift the focus of care provision away from acute hospitals and traditional institutions, towards a greater emphasis on caring for people in their own homes and communities. It also defines the need for a reconfiguration of hospital services, reducing the number providing the full range of acute care from ten to ‘between five and seven hospital networks’.

The RCN submitted detailed written evidence to the review, stressing that any strategic shift in the focus of care provision must be underpinned by a workforce review that matches service need with the right numbers of the right nurses. The evidence also highlighted the need to ensure that service changes and reconfiguration deliver safe and effective patient care and are conducted in consultation with the nursing workforce.

The outcomes of the review were broadly welcomed by the RCN, particularly the recognition that nurses are fundamental to care delivery in Northern Ireland. The key role of specialist nursing and nurse-led services was also endorsed but it was reiterated that the strategic shift towards the community will only come about if it is properly planned, well-resourced and underpinned by good workforce planning. Concerns were expressed that there appears to be little progress made in addressing the workforce implications of the review, particularly as just nine per cent of nurses in Northern Ireland currently deliver care in community settings.

The RCN met the Health Minister in June 2012 to outline these concerns. It is also working with members to assess
the impact of Transforming your care at a local level across Northern Ireland and to highlight the key issues for nursing. Consultation has now closed on the implementation of the review and the RCN’s response focuses heavily upon workforce implications.

Scotland

In 2007 the Scottish Parliament election debates were dominated by decisions in two Scottish boards to reduce hospital provision and redesign local services. When the SNP formed the new Government, it set up a system of independent scrutiny panels to examine decisions on major service change and both board plans were overturned.

In 2010, building on the early findings of these scrutiny panels, the Scottish Government and the Scottish Health Council set out new guidelines on how NHS boards should involve local people in deciding on major services changes (www.sehd.scot.nhs.uk/mels/CEL2010_04.pdf). However, it is not clear how widely this guidance is being used. For example, when NHS Highland and the Highland Council recently undertook a wholesale integration of health and social care services, the Scottish Government did not formally designate this as a major service change requiring additional scrutiny. No independent scrutiny panels have been convened since 2009.

There are two reasons why it is important that the implications of major service redesigns in Scotland are considered openly and frankly, using the guidance the Scottish Government itself has developed. First, the pressures on money in the public sector during the economic downturn means the long-term sustainability of NHS Scotland is going to require tough choices about what is affordable. As a recent Audit Scotland (2012) report states, ‘Meeting the financial challenges ahead means doing things differently by transforming service delivery’. Hard decisions about what to fund, and what not to fund, may well be unpopular with politicians, with staff and with the public. However, facing these choices is vital if Scotland’s NHS boards are to balance their books in the long term. The alternative is to keep chipping away at the workforce year by year and see the quality of service fall. The RCN in Scotland is using every opportunity to call for, and take part in, a mature and transparent debate to help these choices to be made wisely.

Secondly, the Scottish Government is driving forward with plans to undertake significant change across the whole country by integrating health and social care services. This is one of the largest whole system changes the NHS in Scotland will have faced for many years and, in some areas, change is already underway. The RCN is keen to ensure that information on options for redesign, and the consequences of those options, are debated and then delivered in a spirit of true partnership. For this reason, the RCN in Scotland has been working with members to develop a set of Principles for the delivery of integrated care (RCN 2012g, and see www.rcn.org.uk/aboutus/scotland/professionalissues/scotland_integration). These focus on the importance of openness and strong relationships in delivering change. The principles are guiding all our national and local work in influencing redesign of health and social care services in Scotland.

Wales

With the creation of seven new health boards, the purchaser–provider split was eliminated in Wales. Planning, based on the Welsh Government’s strategy for health Together for health, and the health boards’ health, social care and wellbeing strategies, is advancing (RCN, 2012h). The constraints placed on the health service by the financial climate are being seen as a driver to address some long-standing and deep-seated problems in the service. Moves are afoot to increase the integration of public service, achieve regionalisation of some high intensity but low volume specialist services, and revisit skill mix and professional demarcations. General Welsh health policy in relation to a wide range of vulnerable groups is summarised in the 2012 European Observatory on Health Systems and Policies document which can be accessed at www.euro.who.int. Some examples from children’s services illustrate the fact that there are some specific factors which highlight vulnerability.

• During the reorganisation and reconfiguration there has been a tendency for senior children’s nurses to ‘fall out’ of executive structures and their contribution to policy and strategy formation is being lost. Equally, strong advocates for the rights of children are not necessarily well placed to be heard.

• Service redesign is likely to lead to bed/cot losses with more focus on community-based care. Unfortunately, this comes at a time when community children’s nursing services are in retreat.
Appendix 2
Tools and resources to assess service redesign proposals

Health impact assessment (HIA)

Health impact assessments (HIAs) use a range of methods and approaches to help identify and consider the potential or actual health and equity impacts of proposed service changes.

The primary output of a HIA is a set of evidence-based recommendations to inform and influence decision making at different levels and across different contexts.

The HIA draws on a range of methods, techniques and skills, including project management, research and evaluation, experience and expertise.

There are three types of HIA: prospective, concurrent and retrospective. A HIA has six stages: screening, scoping, assessment, recommendations, further engagement, and, monitoring and evaluation.

More details can be found at: www.nice.org.uk/niceMedia/documents/hia.pdf.

An article describing a rapid HIA of the reconfiguration of maternity services, reports how it may be impeded by its timing and the politically charged environment in which reconfiguration is planned (Fell and Haroon, 2008).
Service change assurance programme (SCAP)

Service change assurance programmes (SCAPs) minimise the risk for NHS organisations in developing, consulting or implementing major service change and reduce the risk of judicial review and Overview Scrutiny Commission (OSC) referrals to the Secretary of State.

Undertaking a SCAP is mandatory for any scheme seeking to progress to formal public consultation in England.

The Yorkshire and North Humber SCAP is described as an approach by which reconfiguration will be reviewed to ensure it is fit-for-purpose. It is designed to assure all stakeholders that major service change programmes are being managed effectively and are on track to realise expected benefits and desired outcomes. Responsibility for major service change is shared between: commissioners, NHS providers, OSC, Gateway Team, National Clinical Advisory Team, Secretary of State, and the Independent Reconfiguration Panel (IRP).

The SCAP has four phases: pre-consultation change, consultation, post-consultation and implementation. The time taken to carry out a SCAP can be anything between six months and one year.

For more details, visit www.yorksandhumber.nhs.uk

Service reconfiguration assurance framework (SRAF)

Service reconfiguration assurance frameworks (SRAFs) include a range of checklists that can be used for assessing major service change: a summary of local commissioner requirements, a briefing checklist, a business case checklist, and an assurance review self-assessment checklist.


Normalisation process theory (NPT)

Full details on normalisation process theory (and a bibliography) can be found at www.normalizationprocess.org. The website offers a set of NPT conceptual tools and explanatory models that can be used to support the evaluation of disruptive change. NPT has been used to evaluate models of transitional care for young people with complex health needs.

Research evidence for the case for change

Systematic reviews exploring the relationship between high volume and improved clinical outcomes show some evidence of association, although there is disagreement as to whether this association is indeed causal or is influenced by other factors, such as case-mix.

For example, selective referral may indicate that only those patients referred to larger centres will have better outcomes. Yet some specialties may use different technologies in higher volume centres, and if similar techniques were used in lower volume centres then better outcomes may result. Some commentators indicate that ‘practice-makes-perfect’, or that improved outcomes in higher volume centres happen as a result of mutual support and surveillance from colleagues. If this is the case then we might expect the suggested association to be robust at an individual clinical level rather than at a hospital level (Spurgeon et al., 2010).

Further analysis of hospital reconfiguration plans suggests that much of the research evidence on the association between volume and outcomes cited as justification for reconfiguration comes from the US, yet organisational differences may limit transferring findings to the NHS (Raine, 2012). Most of the research undertaken in the UK is observational research, which has limited power to demonstrate causality. Given that large experimental research designs to explore major service reconfiguration are not feasible, Raine suggests that the justification for major service change often relies on a mix of observational research evidence and expert clinical consensus.
Appendix 3
Responding to a service redesign consultation

There are mechanisms in place for partnership working and negotiation with recognised trade unions such as the Royal College of Nursing.

The precise details will be based on local agreement on proposed changes. There should be adequate time for you to prepare for and engage with the consultation process. Often you will have been involved from the outset, but this may not always be the case.

Evidence and detailed information is crucial to underpin your response. Using the core principles and key questions in this guidance will help develop a plan for responding. Your response should encompass factual information and include case experiences of similar changes elsewhere, as well as information about similar reviews, the rationale, recommendations and implementation.

Research evaluating care-closer-to-home

This article reports the findings from a study (Heath et al., 2012) exploring stakeholders’ views on providing paediatric ‘care closer to home’ (CCTH) in community-based outpatient clinics and delivered by consultants. The research took place in a specialist children’s hospital in the UK and the stakeholders included health care professionals, managers, commissioners and executive team members. The researchers report that participants acknowledged that outreach clinics would involve a change in traditional ways of working and that the physical setting of the clinic would influence aspects of professional practice. Different models of CCTH were discussed, as were alternatives for improving access to specialist care. Participants supported CCTH as a good principle for paediatric outpatient services. The challenges identified in setting up and maintaining community clinics revealed that the place of service delivery is both an issue of physical location and professional identity. The authors conclude that policy initiatives, which ignore assumptions about place, power and identity, are likely to meet with limited success.
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