Service Improvement:
Quality Assurance of Major Changes to Service Provision

Over the last 60 years the NHS has seen many changes in the way services are delivered and patients are treated. The NHS has always had to adapt to respond to advances in medical technology and to meet patients' and service users and carers' expectations. Change and adaptation is an everyday occurrence for the modern NHS – without it we would be failing patients, professionals and the public. Patients have the right to expect the best possible care, in the safest and most convenient environment. That cannot happen if the NHS stands still, and does not rapidly adopt best practice.

As society, lifestyles and medicine continue to change, so the NHS will continue to change and adapt. The public now demands more say over their care and the latest drugs and treatments used. Advances in technology and treatments allow safer surgery, speedier recovery and shorter stays in hospitals. The public want more choice about where they are treated, and want care closer to their homes. Helped by medical advances the NHS is delivering on this. The public also have a right to expect value for money from the NHS: that too means change.

Local wherever possible, specialist only where necessary
In order to deliver better outcomes for patients, some specialised services like trauma, should be centralised in specialist hospitals, in order that clinicians and frontline staff have access to the best equipment and experience, and patients receive the specialist care they need from specialist staff. In other situations, change might mean shifting care into a community setting, allowing patients to gain access to more services closer to their own home, rather than travelling to hospitals.

Change in the NHS is often perceived as a response to failures in the system, and whilst historically this has sometimes been the case, it is also an essential part of service improvement. This is not to deny that there are other factors at work, such as the need to comply with the European Working Time Directive, which will limit the hours that locum staff or doctors can work as well as the need to achieve financial balance and deliver value for money for the taxpayer. The NHS has seen record levels of investment in recent years, and this has led to major improvement. Numbers of NHS staff have greatly increased, and are paid better than ever, waiting times are the shortest in the history of the NHS, mortality rates from the big killers continue to fall, and facilities and technology are being modernised to create an NHS fit for purpose in the 21st Century. There have always been historical differences in investment patterns at a local level in the NHS to meet the needs of local communities, and this is a significant reason why the proposals for reconfiguration and change will differ between areas. The investment has brought great improvement, but as the growth monies plateau the NHS will need to deliver greater efficiency and productivity.

Saving Lives, not saving money
It is wrong for people always to conclude that finances are the prime driver for change. The overwhelming majority of changes are about safer care and service improvement. Few of the schemes considered as part of this review have significant financial benefit in the short term. Some will deliver financial benefits in the long term, but this is part of longer-term strategies to ensure that the NHS delivers world class services whilst providing value for money for the taxpayer.

The focus of this review was primarily to look at processes rather than individual proposals. Working alongside the Strategic Health Authority (SHA) Chief Executives (CE) the review was undertaken in three distinct stages. The first phase looked at what was currently happening in each SHA and what systems and processes were in place to engage stakeholders at each stage, from developing to implementing proposals, and the processes and procedures used to run consultations locally. The second related to business case assessment, and looked at and tested the strength of Trust and SHA planning, with particular attention focussing on clinical, workforce, governance and financial implications. The third, looked to the future. It considered what aspects of current service development processes could be improved and how best practice might be better shared. The review did not specifically address the development of processes in the future as NHS Foundation Trusts become more widespread. NHS Foundation Trusts have greater freedom in respect of changes to services, this document is not suggesting any changes to NHS Foundation Trust freedoms or obligations. However, many of the best practice principles highlighting the importance of good commissioner and provider relationships should still apply. Where recommendations apply to NHS Foundation Trusts this will be specifically stated.

Managing controversial changes
Whilst quality varied, the consistent message from the review is that where change is well planned and well managed better decisions are made and implementation is more effective. Where proposals are clearly explained to stakeholders and views are sought from beginning to end, levels of understanding of the need for change are far higher. This does not mean that proposals will prove uncontroversial, far from it. It does however mean that a mature, open and productive discussion and consultation can be achieved.

Change can all too frequently lead to a loss of public confidence in service providers if the process is not managed carefully, and stakeholders are not fully engaged as early as possible. The goal of any change to services must be to ensure patients get the best care possible, delivered to the highest standards in the most effective, efficient and personalised way. It must not be change for the sake of change. It is in the interests of everyone to ensure that reconfigurations are carefully and robustly planned and managed. It is right that decisions about our hospitals and healthcare are closely examined and questioned, but it is vital that changes are made to ensure safe and effective clinical practice is available to all.

This review has looked at what is good, and what is not so good. It has set out the standards all SHAs and Trusts should aspire to achieve. The bar is already high, but we should set it even higher. The lessons learned and recommendations that follow offer the means as to how this might be best achieved.

It is important to consider carefully the language used in describing the kind of change that this review has considered. Reconfiguration conjures up a whole host of images, not all of them positive, and has become a euphemism for closures and downgrading of hospitals. This is an entirely wrong impression of the schemes looked at over the past few months. Without exception the proposals are not about closure or simple downgrading. They are about the NHS adapting itself to new patterns of care, using leading edge technology and care pathways to treat people more quickly, more safely and in more convenient settings. It is about growing new services and modernising facilities, and it is about saving lives. For the remainder of this report the term reconfiguration should be seen as being synonymous with major service change, service improvement and delivering value for money for the taxpayer.

Conclusion
Delivering change on the scale currently being seen will be fundamental and sometimes difficult, but everyone must be willing to embrace the action necessary to ensure patients access the best possible personal care, and healthcare is improved in every local community. The NHS has always changed and adapted and this must continue, otherwise, services and patient care will suffer. Change will always be controversial but the NHS must not be distracted by often misplaced criticism. It is essential that the NHS remains a dynamic and responsive organisation, and that change continues, often at a rapid rate, if the needs of individuals are to be met. More change will be necessary if the long-lasting improvements in health and social care that we all wish to see are to be achieved.

Lessons Learnt
This paper does not attempt to define ‘reconfiguration’, ‘change’ or ‘service improvement’, as it means many different things to different people. The individual schemes it touches upon all involve major service change programmes, and all aim to improve the local NHS. As you would expect, circumstances, health care needs, and stakeholder positions differ from area to area. Each SHA will therefore need a tailored strategy for consulting upon and managing change. Looking at the national picture, it is clear that best practice exists and can be applied to all service improvements and major service changes in all parts of the country, regardless of their nature, scale or complexity. The lessons learnt and recommendations from this review have been grouped into four key themes;

- Effective Organisational Leadership & Business Processes
- Visible Local Leadership
- Open and Honest Stakeholder Engagement
- Delivery of Results

SHAs must take the strategic lead in ensuring that the lessons learnt and recommendations from this review make a positive difference. SHAs must have, and continue to have, a secure grip on what, when and why service proposals are being discussed in their area. Their role as ‘gatekeeper’ is essential to ensure that PCTs make a clear, coherent and consistent case for change based on sound clinical, patient and financial benefits, which better meet the needs of their local communities.

Each theme is covered in more detail in the remainder of this paper and a summary of the recommendations is provided at **Appendix A**.

Lessons Learnt & Recommendations for Action

Effective Organisational Leadership & Business Processes

Strong leadership is critical. Each region has chosen to manage its service improvement programmes in its own way, and in direct response to unique local circumstances. In some cases this has led to macro level strategies where region wide reviews are being considered. In other cases micro level strategies have been adopted with a variety of smaller and more tactical programmes being delivered. Whatever the approach, local coordination and cohesion is essential. Although individual programmes should be led by Primary Care Trusts (PCTs), or groups of PCTs, the SHA is and must remain accountable for overseeing all proposals for service improvement in their area. In particular, SHAs should consider the robustness of planning arrangements, whether proposals across the patch are individually viable, collectively desirable, and whether the proposed consultations can be carried out in a manageable timeframe. This is, of course, in the context of wider stated policy on patient choice and the greater freedoms of NHS Foundation Trusts.

In addition, the life cycle of proposals can be lengthy, time consuming and may need specialist capability and capacity. The most successful programmes are those where the Trust or SHA have the capacity and capability necessary to lead and deliver service change. It is clear from existing best practice that access to expertise which enables those involved to build a rigorous and robust case for change, based on clinical, patient and financial benefits is critical to the success of proposals, and in helping make the case for change with stakeholders and the public.

The review found many examples of excellent practice, but there is still room for improvement, in all areas and regions, to ensure that preparation is thorough and proposals are robust. The NHS should ensure that clear, detailed and well-formulated business cases, setting out the clinical case for change, the impact on workforce, benefits for patients, the costs and savings are all addressed. **Appendix B** sets out in more detail the minimum requirements for business cases. A framework to test the readiness of service improvement proposals was established (see **Appendix C**) as part of this review and should be adopted permanently as part of the SHA and Trust process for reviewing preparedness for consultation, and subsequent implementation.

As the local commissioning body, PCTs are responsible for assessing the needs of their local population and identifying suitable services to meet those needs. This will involve changes to service delivery models so that the best, safest care is available for patients. PCTs should take the overall lead on service design and change, but must work in partnership with Practice Based Commissioners, local hospital trusts, primary care, third sector providers and social care partners, as well as other stakeholder groups.

NHS Foundation Trusts have greater freedoms in respect of service change. However, NHS Foundation Trusts will consult when considering reconfiguring services. This will normally include engaging on major service changes with their Board of Governors where patients, staff, and other stakeholders are represented. As part of this process it is also important to ensure any change to services is considered in light of their local PCTs' commissioning strategies. NHS Foundation

Trusts are expected to work closely with PCTs and SHAs to ensure that the services on offer deliver the safest, most appropriate services for patients.

Recommendation 1
Each SHA should oversee proposals for major service changes and improvement in their area, in line with the recommendations in this paper.

Recommendation 2
Each SHA should have a clear and coherent strategy and work programme in place covering all (current and future) service improvement proposals.

Recommendation 3
Each SHA should ensure that there is appropriate capability and capacity at both SHA and PCT level to ensure that robust, evidenced based proposals are developed, effective consultation is undertaken and successful implementation is achieved.

Recommendation 4
PCTs should normally lead the preparation and consultation on service improvement proposals.

Recommendation 5
Where NHS Foundation Trusts are planning and taking forward major service change they should take into account the commissioning strategy of the PCT(s), as well as meeting their own regulatory requirements

Recommendation 6
A full business case setting out the clinical and patient benefits of service change (covering the areas outlined in Appendix B) should be produced for all proposals, and should be reviewed by the SHA before consultation begins.

Recommendation 7
The SHA must ensure that the framework for testing proposals is undertaken to ensure that the proposals for service improvement are sufficiently robust and fit for purpose before formal consultation proceeds.

<u>Visible Local Leadership</u>
Good clinical involvement is critical. Service improvement is about providing the best and safest care for patients in the right setting and the right location. Clinicians and frontline staff put forward many proposals for change in order to improve patient safety and clinical outcomes. Clinicians, staff and their representatives should be involved at every stage of the process, from developing proposals, developing the case for change to implementation. Where clinical leaders genuinely develop and support proposals, they play a vital role in building public and patient confidence. In the best examples, medical directors have written forewords to consultation documents, clinicians have supported proposals at public meetings, articles have been written by the heads of the relevant clinical disciplines and letters to correct local media stories have been sent from GPs. This is not a blue print, but it is a good indication of the depth of support necessary before embarking on complex service change. Those areas that do not have such strong clinical and frontline leadership face criticism that proposals are

driven solely for financial or managerial reasons rather than patient safety or service improvement.

Getting the best outcomes from major service change requires strong, clear leadership at the highest level – from mangers, clinicians and frontline staff alike. Managers leading this should not underestimate the commitment needed to deliver the proposed service improvements. Even then they will find the challenge difficult without strong, early and active support from Chairs and Boards. It is essential that boards oversee;

- the pre-consultation process; including developing a robust case for change and holding an extensive dialogue with a wide range of key stakeholders including; the public and their representatives, patients and carers, clinicians and staff;
- the consultation process; including orchestrating the process, producing documentation, and ensuring that statutory requirements are met;
- local clinical involvement; promoting it at every stage of the process;
- communications and media handling; requiring strong evidence and narrative based on the clinical, patient and financial benefits of service improvement;
- the decision-making process; including sign-off with all appropriate bodies, as well as managing any subsequent challenge; and
- the implementation phase.

Recommendation 8
A senior clinical lead should be identified at the outset, and should have support to help them ensure that clinicians are involved in the development of proposals for change.

Recommendation 9
Chairs, Chief Executives and Boards are accountable for and should take a personal lead in the formulation and delivery of proposals. They should actively champion proposals at every stage; development, consultation and delivery. Their role must be pro-active, not passive.

Open and Honest Stakeholder Engagement

Working with stakeholders – consulting, listening and involving is key to the delivery of successful service improvement. Proposals will inevitably come under scrutiny by patients and carers, the public and their representatives, clinicians, staff and their representatives, local Overview and Scrutiny Committees (OSCs), the local media and other interested stakeholders. Effective engagement and involvement means being open and transparent about proposals, and that local stakeholders can genuinely influence change. The NHS will need to work hard with these stakeholder groups and their representatives to explain and build the case for change based on clinical and patient benefits, and to do so in a language that can be understood by all. It is also important to listen, and to move away from a defensive and reactive position, to one where the case for individual service improvement schemes is proactively and positively made.

The best proposals are often characterised by early stakeholder engagement, driven by in depth stakeholder mapping and analysis, and supported by strong

stakeholder involvement at all stages of the process (pre-, mid-, post-consultation and into implementation). In particular,

- Patients, carers, the public and their representatives; need to understand the case for change, how it will impact on them, what the benefits will be, and it should be done in a way that is easily understood;
- Staff and their representatives; good practice in managing workforce issues needs to be taken into account in any service improvement. It is essential to keep staff informed, and have effective engagement as staff must play a key part in developing commenting upon and implementing the proposals for change;
- MPs and local political representatives; need to understand the impact and benefits of proposals to their constituencies; and
- Media; the media can often be critical of service improvement and run very damaging stories about closures and risk to patient lives. Effective media handling plans, regular engagement of local journalists, care in explaining the case for change and a strong local voice to challenge mis-leading media stories that worry patients unnecessarily can help mitigate this.

Reasons for change need to be clear and well articulated. The recent series of national Tsar reports make it clear that changes to services are first and foremost about saving lives, not money. It is the case, for example that 40-45% of people attending A&E would be better off being treated elsewhere, because they have conditions that other units can deal with more effectively. This is not an isolated statistic. The Tsar reports are peppered with them. The NHS must make better use of this type of information to help make the case for change and explain to patients, the public and stakeholders the benefits that come with service improvement. NHS managers, clinical and frontline leaders will sometimes still have to make tough decisions in order to improve local services that may not always be popular with the public. However, clearly articulating the clinical and patient benefits of change, both nationally and locally is important. In many cases the NHS needs to get better at understanding and explaining the rationale for service improvement in ways that different audiences can understand.

In describing the case for change, it is also important to use clear and consistent language about what is happening and why, specifying whether services are ‘adapting’, ‘developing’, ‘evolving’ or ‘specialising’. If a service is changing to improve the health outcomes for patients and save lives, this isn’t a ‘downgrading’ of the service. Stakeholders should be clear that where options for change do need to be developed they will be done in conjunction with the public, not for them.

Equally, understanding the process: pre-consultation, consultation and implementation is critical. It is important to recognise that public discussion, and opposition, begins as soon as pre-consultation starts. At this stage, all options are considered, no option is disregarded. As such, levels of opposition are often at their highest. Pre-consultation can also be a protracted process and needs very careful planning and management. Even the best planned, managed and considered schemes can go wrong if the process is poorly handled.

There is a need to get our documentation right. Consultation documents should contain specific, relevant, clear information. They should;

- Explain why service improvement is required, setting out what the results of change will look like in terms of clinical, patient and financial benefits, presenting a balanced view;
- Provide details of all options for change with well balanced pros and cons for each option;
- Inform the public of how they can contribute to the consultation; and
- Be clear, concise and written in plain English.

Recommendation 10
Before embarking on the process, it is important to have a clear evidence based communications and stakeholder engagement strategy, which is managed and effectively delivered throughout, and makes best use of clinical evidence like the Tsar reports.

Recommendation 11
Every service improvement scheme should have a clear stakeholder engagement plan involving the most senior officers and clinicians in the organisation, which includes involving stakeholders routinely and regularly throughout the lifecycle of the service improvement programme.

Recommendation 12
It is essential that the local NHS has effective communication processes in place to respond to, and where necessary correct, any misleading information which enters the public domain, and to promote an effective understanding of the proposals for change.

Recommendation 13
The SHAs, with the Department of Health should develop a national set of templates for consultation documents to promote consistency of quality and content across the country.

Recommendation 14
SHAs should ensure that each scheme in its work programme complies with consultation legislation and guidance in an accurate, effective and timely fashion,

<u>Delivery of Results</u>
Where change works best, the SHA and Trusts have a clear 'gateway' mechanism in place, that quality assures local proposals, and makes sure that proposals are fit for purpose, before they progress to consultation.

As a minimum, all SHAs need to establish their own 'gateway' mechanisms to quality assure local proposals and make sure they are fit for purpose at the earliest possible stage. The Department of Health should hold the SHA to account for the effective introduction and maintenance of these systems. These processes should, where appropriate, use the Office of Government Commerce (OGC) Gateway system[1]. Some SHAs have already used the OGC Gateway process as an assurance tool.

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[1] OGC Gateway Reviews will be centrally funded by the Department of Health.

Having established the need to raise the bar, the NHS needs to guarantee that once improved, performance will be maintained. This will be critical in safeguarding the quality of future reconfigurations. It would also benefit the local NHS in helping to demonstrate openness, and transparency with local stakeholders, including frontline staff, MPs and OSCs. Opposition and criticism wouldn't be entirely eliminated, but it would be hard for critics to suggest that reconfigurations were poorly planned, managed and delivered, if they had been given the green light by an OGC review.

The OGC Gateway process (see **Appendix D** for more detail) provides assurance and support to the organisation proposing service changes and improvements. It ensures that:

- the scope and purpose of the change has been adequately researched;
- there is a shared understanding of what is to be achieved by the main stakeholders;
- it fits within the overall commissioning strategy and is consistent with national policy direction and priorities; and
- there is a realistic possibility of securing the resources needed for delivery.

The review should focus on the overall justification and process for change, and not the proposals themselves. Gateway reviews should be applied on a proportionate basis, with OGC thresholds applied based on the risk and/or size of the schemes. Therefore, a service moved into the community is likely to be subject to a less indepth review than a proposed PFI scheme and its associated consequences.

It is essential more is done to identify and share best practice and encourage networks to grow and flourish in the NHS. The NHS Institute for Innovation and Improvement is working to develop 'Service Change' learning sets' to promulgate best practice and learning. Other networks at both a local and national level will also need to be established to ensure that the capacity and capability in SHAs and PCTs is sufficient to ensure well managed processes.

The Department of Health must also play it's part and continue to provide support, advice and guidance to the NHS on good design and consultation practice. Mechanisms should also be established to ensure an open dialogue and escalation of issues at all levels within the NHS and Department of Health.

Recommendation 15
Each SHA should provide assurance to the Department of Health that effective local gateway mechanisms are in place.

Recommendation 16
Each SHA should engage in the NHS Institute for Innovation and Improvement's 'Service Change' learning set.

Recommendation 17
Each SHA should establish a local mechanism to ensure, where necessary, issues are escalated to an appropriate level.

Appendix A: Recommendations

	Recommendations
1	Each SHA should oversee proposals for major service changes and improvement in their area, in line with the recommendations in this paper.
2	Each SHA should have a clear and coherent strategy and work programme in place covering all (current and future) service improvement proposals.
3	Each SHA should ensure that there is appropriate capability and capacity at both SHA and PCT level to ensure that robust, evidenced based proposals are developed, effective consultation is undertaken and successful implementation is achieved.
4	PCTs should normally lead the preparation and consultation on service improvement proposals.
5	Where NHS Foundation Trusts are planning and taking forward major service change they should take into account the commissioning strategy of the PCT(s), as well as meeting their own regulatory requirements
6	A full business case setting out the clinical and patient benefits of service change (covering the areas outlined in Appendix B) should be produced for all proposals, and should be reviewed by the SHA before consultation begins.
7	The SHA must ensure that the framework for testing proposals is undertaken to ensure that the proposals for service improvement are sufficiently robust and fit for purpose before formal consultation proceeds.
8	A senior clinical lead should be identified at the outset, and should have support to help them ensure that clinicians are involved in the development of proposals for change.
9	Chairs, Chief Executives and Boards are accountable for and should take a personal lead in the formulation and delivery of proposals. They should actively champion proposals at every stage; development, consultation and delivery. Their role must be pro-active, not passive.
10	Before embarking on the process, it is important to have a clear evidence based communications and stakeholder engagement strategy, which is managed and effectively delivered throughout, and makes best use of clinical evidence like the Tsar reports.
11	Every service improvement scheme should have a clear stakeholder engagement plan involving the most senior officers and clinicians in the organisation, which includes involving stakeholders routinely and regularly throughout the lifecycle of the service improvement programme.
12	It is essential that the local NHS has effective communication processes in place to respond to, and where necessary correct, any misleading information which enters the public domain, and to promote an effective understanding of the proposals for change.
13	The SHAs, with the Department of Health should develop a national set of templates for consultation documents to promote consistency of quality and content across the country.
14	SHAs should ensure that each scheme in its work programme complies with consultation legislation and guidance in an accurate, effective and timely fashion.
15	Each SHA should provide assurance to the Department of Health that effective local gateway mechanisms are in place.
16	Each SHA should engage in the NHS Institute for Innovation and Improvement's 'Service Change' learning set.
17	Each SHA should establish a local mechanism to ensure, where necessary, issues are escalated to an appropriate level

Appendix B: Minimum Requirements: Service Improvement Business Cases

Business cases submitted to SHAs for approval prior to consultation should include, as a minimum;

- a detailed outline of proposal(s)
- the objectives to be achieved with clearly defined benefits realisation plans for patients, carers and the wider community
- cost benefit analysis
- clear plans to communicate during all stages (pre-, during and post-consultation) detailing handling arrangements for communication and implementation
- a plan setting out the proposed consultation process
- a financial framework to handle the transition, manage the change and ensure benefits are realised
- a description of the grain and acceleration of reform(s), including Payment By Results, use of the independent sector, productivity metrics
- plans detailing how these changes will be implemented, including establishment of services to support the change, such as transport strategies, and resourcing (including staffing) requirements
- a timetable for pre-consultation, consultation, and implementation/ delivery
- a risk assessment and management strategy and associated contingency arrangements

Appendix C: Service Improvement Readiness Framework

1. Why is the service improvement proposed? For example:
    - Clinical viability of a range of services at small to medium sized general hospitals
    - Addressing patient safety issues
    - Improving the quality of patient care
    - Responding to newly built Private Finance Initiatives
    - Preparing the case for a potential new hospitals
    - Responding to failure
    - Financial recovery
    - Reconfiguration of acute and community services across a large population

2. What are the objectives to be achieved?
    - Is there clarity?
    - Is the proposed way the only way?
    - Is it urgent?
    - Will the change be sustainable both clinically and financially in the longer term?

3. Do the proposals follow the strategic policy direction in term of
    - The white paper “Our Health our care our say - Making it happen” a new direction for community services
    - The strategic framework for local NHS
    - Going with the grain and accelerating reform

4. Do the proposals meet best practice in term of
    - Evidence on service models
    - Safety
    - Clinical appropriateness
    - Accessibility
    - Responsiveness
    - Efficiency
    - Effectiveness
    - Prevention
    - Equity

5. What is the level of support from:
    - The public
    - Service users and carers
    - Patients’ Forums and other patient and carer representative groups
    - Staff
    - Clinicians
    - General Practitioners
    - Trade Union and staff side representatives
    - Boards
    - Commissioners
    - Monitor
    - NHS Foundation Trusts
    - NHS Trusts

- Members of Parliament
- Royal College and national bodies
- Local Authorities
- Overview and Scrutiny Committees
- The Media

6. How controversial are the proposals?
   - who are the main opponents and why?
   - is a stakeholder handling strategy in place?
   - are local concerns being addressed?

7. Is there a robust business plan for the service development which covers the:
   - Objectives to be achieved
   - Cost benefit analysis
   - Need to communicate the narrative
   - Organisation of the consultative process
   - Financial framework to handle the transition, manage the change and secure the benefits
   - Grain and acceleration of reform including Payment By Results, use of the independent sector, productivity metrics
   - Implementation of the changes including the establishment of services to support the change and their resourcing, including workforce and transport strategies
   - Handling arrangements for communication and implementation
   - Timetable for pre-consultation, consultation, and delivery
   - Risk assessment and strategy
   - Contingency arrangements

8. Is there capability, capacity and resources in place to:
   - Undertake the process of consultation
   - Implement the plan within the timeframe
   - Handle communication and media relations
   - Provide strong leadership

9. Has a conclusion been reached on the way forward, based on whether the proposed service improvement:
   - Demonstrates readiness to proceed
   - Requires further work to reach the decision stage
   - Can be achieved through other means
   - Is worth the upheaval given the benefits which will be achieved

10. What has been learned which might improve national practice on service improvements for the future?

Appendix D: OGC Gateway Process - Overview

The OGC Gateway process provides assurance and support to the organisation proposing service changes and improvements. It ensures that the scope and purpose of the change has been adequately researched, that there is a shared understanding of what is to be achieved by the main stakeholders, that it fits within the overall commissioning strategy and is consistent with national policy direction and priorities and that there is a realistic possibility of securing the resources needed for delivery.

An OGC review will also examine how the work will be organised to deliver the overall objectives, and that the management structure, monitoring and resourcing is appropriate. In short, it aims to test whether stakeholders' expectations are realistic, in relation to costs, outcomes, resource needs, timetable and general achievability.

The review focuses on the business justification and process for change, and not the proposals themselves. It also provides assurance that the proposed approach to meeting the business requirement has been adequately researched and can be delivered.

It does this by ensuring that:

- the best available skills and experience are deployed
- all the stakeholders fully understand the proposed service improvement and the issues involved
- there is assurance that the proposal can progress successfully to the next stage of implementation
- more realistic time and cost targets are achieved for proposals
- knowledge and skills among SHA and PCT staff are improved through participation in review teams
- advice and guidance to change teams are provided by fellow practitioners

Different types of change may be delivered by the programme:

- delivering new facilities - led by a clear view of what is required and scope well defined
- changing the way the organisation works - led by a vision of the outcomes and benefits
- policy change focused on changes and improvements in society
- if a project is very large and/or complex

More information can be found at:
http://www.ogc.gov.uk/what_is_ogc_gateway_review.asp