Consultation and public involvement in service change

Draft interim guidance for consultation
About the Scottish Consumer Council

The Scottish Consumer Council (SCC) was set up by government in 1975. Our purpose is to promote the interests of consumers in Scotland, with particular regard to those people who experience disadvantage in society. While producers of goods and services are usually well-organised and articulate when protecting their own interests, individual consumers very often are not. The people whose interests we represent are consumers of all kinds: they may be patients, tenants, parents, solicitors' clients, public transport users, or simply shoppers in a supermarket.

Consumers benefit from efficient and effective services in the public and private sectors. Service-providers benefit from discriminating consumers. A balanced partnership between the two is essential and the SCC seeks to develop this partnership by:

- carrying out research into consumer issues and concerns;
- informing key policy and decision-makers about consumer concerns and issues;
- influencing key policy and decision-making processes;
- informing and raising awareness among consumers.

The SCC is part of the National Consumer Council (NCC) and is sponsored by the Department of Trade and Industry. The SCC’s Chairman and Council members are appointed by the Secretary of State for Trade and Industry in consultation with the Secretary of State for Scotland. Future appointments will be in consultation with the First Minister. Martyn Evans, the SCC’s Director, leads the staff team.

Please check our web site at www.scotconsumer.org.uk for news about our publications.

Scottish Consumer Council
Royal Exchange House
100 Queen Street
Glasgow G1 3DN
Telephone 0141 226 5261
Facsimile 0141 221 0731
www.scotconsumer.org.uk

The views expressed in this report are not necessarily those of the Scottish Consumer Council unless specifically stated.

Edited by Liz Macdonald, Policy Manager
Published by the Scottish Consumer Council
September 2002

© Scottish Consumer Council

The SCC assesses the consumer perspective in any situation by analysing the position of consumers against a set of consumer principles. These are:

ACCESS
Can consumers actually get the goods or services they need or want?

CHOICE
Can consumers affect the way the goods and services are provided through their own choice?

INFORMATION
Do consumers have the information they need, presented in the way they want, to make informed choices?

REDRESS
If something goes wrong, can it be put right?

SAFETY
Are standards as high as they can reasonably be?

FAIRNESS
Are consumers subject to arbitrary discrimination for reasons unconnected with their characteristics as consumers?

REPRESENTATION
If consumers cannot affect what is provided through their own choices, are there other effective means for their views to be represented?

We can often make our publications available in braille or large print, on audio tape or computer disk. Please contact us for details.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>2</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>1 Background</td>
<td>11</td>
</tr>
<tr>
<td>2 The consultation process</td>
<td>14</td>
</tr>
<tr>
<td>3 Past experience of consultation on service change</td>
<td>16</td>
</tr>
<tr>
<td>4 Definition of when there should be a structured consultation</td>
<td>19</td>
</tr>
<tr>
<td>5 Public involvement in the development stages of service change</td>
<td>23</td>
</tr>
<tr>
<td>6 Formal consultation stage</td>
<td>30</td>
</tr>
<tr>
<td>7 What should happen when disagreement remains</td>
<td>35</td>
</tr>
<tr>
<td>8 Methods for involvement</td>
<td>37</td>
</tr>
<tr>
<td>9 Pros and cons of public involvement</td>
<td>41</td>
</tr>
<tr>
<td>10 Anticipated impact of revised guidance</td>
<td>43</td>
</tr>
<tr>
<td>11 Ways in which the guidance could be improved</td>
<td>47</td>
</tr>
<tr>
<td>12 Conclusions and recommendations</td>
<td>50</td>
</tr>
<tr>
<td>Appendix 1: The topic guide</td>
<td>56</td>
</tr>
<tr>
<td>Appendix 2: Organisations taking part</td>
<td>61</td>
</tr>
</tbody>
</table>
Acknowledgements

The Scottish Consumer Council and Scottish Health Feedback are very grateful to all those who helped to identify participants to take part in discussion groups, and to all those who took part in the discussions.

THE CONSULTATION TEAM
The discussion groups reported here were organised by Irene Miller and Anna Sansom of Scottish Health Feedback (SHF).

Alan Ross, Carole Millar and Lyn Jones facilitated the focus groups, and were supported by Irene Miller of SHF, and by Andrew Pulford, Fiona Barnes and Susan Browne of the SCC.

Anna Sansom and Lyn Jones of Scottish Health Feedback prepared four working papers reporting on the four different types of participant.

Liz Macdonald of the Scottish Consumer Council prepared the final report.

Office support was given by the SHF team of Anna Sansom, Elizabeth Burchell and Ann Rennie, and by the SCC team of Kirsty Aird, Fiona Barnes and Liz Stewart.
The Scottish Consumer Council (SCC), with Scottish Health Feedback, were commissioned by the Scottish Executive Health Department to carry out a consultation exercise on the draft interim guidance on Consultation and Public Involvement in Service Change. This guidance was issued to NHS boards, trusts, local health councils and voluntary sector health organisations in May 2002 for immediate use, but subject to revision following the results of this consultation and any other feedback received by the department.

The main findings of the consultation exercise cover the following areas:

- Past and current experience of consultation on service change, and more generally of public involvement
- Factors which impact on successful consultation and public involvement
- Views on the draft guidance issued to the NHS in May 2002
- Particular comments on the draft guidance
- Anticipated impact of the draft guidance
- Suggestions for improvement of the guidance

PAST AND CURRENT EXPERIENCE OF CONSULTATION

There was general agreement that consultation has not always been done well in the past. Staff within the NHS admitted this as readily as members of the public and people from health councils. This is considered to have been the result of lack of knowledge, skills or resources, and sometimes from poor attitudes towards public involvement and consultation. Consultation would often take place too late, once decisions had already been made. There was often poor information for members of the public about the consultation, and little or no feedback to those who had been consulted about how their views had been taken into account. There is a feeling that this is changing, and that NHS bodies are taking public involvement and consultation more seriously.
FACTORS WHICH IMPACT ON SUCCESSFUL INVOLVEMENT AND CONSULTATION

Much of the discussion about past, present and future practice dealt with the factors which it is considered essential to get right to make consultation and public involvement work. These include:

- the honesty and openness of the process, including honesty about the constraints within which decisions must be made. This creates mutual trust, and a virtuous circle, in which involvement will be seen to have an effect, which will encourage future involvement.
- effective partnership working. This might involve working with local authorities as well as organisations in the voluntary sector, and making use of existing consultation mechanisms.
- involving the right people. This could be done through existing networks, patient and community groups, but it was also important to include members of the public who were not involved in such groups, as well as allowing channels for individuals to become involved. NHS staff must also be involved. It is important to ensure that local politicians are involved at an early stage. Health councils considered that they might have a role in helping to identify who should be involved in particular consultation exercises.
- not excluding people who should be included
- choice of methods appropriate to the task in hand
- realistic timescales
- adequate resources, skills and support
- good information for those being consulted or involved
- providing feedback to those who had been involved in the process, explaining how their input had been taken account of
- carrying out evaluations of public involvement and consultation activity.

Often good practice in the past has depended on the presence of a key individual who is committed to the process.
VIEWS ON THE DRAFT GUIDANCE
There was general agreement that the draft guidance was correct in being based on the importance of developing public involvement at every level of NHS board activity, in appropriate ways. If this is done, it is less likely that particular issues will cause controversy, and it will be easier for NHS bodies to be aware of when they need to adopt particularly rigorous consultation exercises.

Those consulted also broadly supported the approach taken in the guidance, which suggests a range of methods which boards could consider using. Some people commented that this guidance should also make it clear that in some circumstances it is helpful to use more than one method, either because different groups are being targeted, or to provide some triangulation or verification of the findings of any one of the methods.

The main concern about the guidance related to its open-ended, flexible nature, and the consequent need to interpret it and make judgements about what was required in a particular situation. Those consulted welcomed the flexibility but remained sceptical, or even suspicious about how it could be manipulated in practice. Public groups were suspicious that NHS boards and trusts would use the flexibility to do less than the spirit of the document called for. NHS groups were concerned that special interest groups might use it to try to force boards into unnecessarily elaborate exercises for relatively small issues, or to challenge the results of consultations. NHS and health council groups were apprehensive that politicians would be able to exploit the openness of the guidance to challenge the validity of any decision they wanted to oppose, since it would always be possible to find some aspect of the guidance where the high aspirations expressed had not been fully met.
Despite general support for the approach taken, there were many comments on the guidance, suggesting ways in which it could be improved and strengthened. These points reflect the concerns about areas in which judgements will have to be made by those using the guidance. They included the following:

- While "consultation" can be seen to be one aspect of public involvement, the word is used in the document to suggest a more formal process, in distinction to ongoing public involvement. However, many participants felt that there was no clear explanation in the document of the use of these words, and of the distinction between them. Some of the NHS and local authority managers suggested that a three-fold distinction could be made. There should be ongoing public involvement, early involvement on possible substantial service changes, and a formal consultation on such service changes. Health councils were more concerned that in every situation an appropriate approach and method was used. It was misleading to suggest that there was one particular set of circumstances in which one particular formal method should be used.

- The definition of "substantial" is unclear - this is important as the guidance suggests that in the case of substantial change there is a need for a more rigorous process referred to as "consultation" in the guidance. The guidance suggests that a decision about what is substantial will be based on common sense. This definition is not acceptable as it begs many questions about whose common sense is involved, and provides no other guidance about how to decide whether something is substantial. Few suggestions were made about how this could be defined, but one respondent suggested that a substantial change might involve closure, reduction of opening hours, increased charges, or revised strategic goals. Many respondents commented that a series of small changes could have a major impact on services, and what seemed a small change to a service provider
could have a substantial impact on a particular group of service users. There was a view that if public involvement is being carried out on an ongoing basis it may be easier to recognise when a proposal is likely to have a substantial impact on a particular group or locality.

- Some people thought that it was unclear when it was appropriate to start "early" involvement.

- Many comments were made about the need for more guidance in relation to both the earlier stage of public involvement and the more formal consultation stage. This would cover specific elements such as who should be consulted, the timescale, the information which the public requires, the distinction between public involvement and consultation, the relationship with local authorities and agencies in the voluntary sector, feedback and links with local politicians.

- There was a concern that the guidance may not be strong enough to deflect challenge, either political or legal (for example through judicial review). Particular concerns were expressed about how to ensure that politicians do not hijack the results of consultation processes, and how to demonstrate that boards had conducted consultations and reached decisions in a legitimate way.

- People in the health council groups would like to see more reference in the draft guidance to primary care, and to LHCCs.

WAYS IN WHICH GUIDANCE COULD BE IMPROVED
Concerns about the degree of flexibility in the guidance led to three main responses:

- to ask for the guidance to be more specific
- to ask for fuller guidance on a range of issues
- to suggest that the guidance specifies the processes for making judgements about how to involve and consult effectively
Those who asked for the guidance to be more explicit about definitions and procedures recognised the difficulties in and drawbacks of being more prescriptive. There were very few suggestions about how definitions could be tightened up.

Those who asked for fuller guidance did not, for the most part, address the fact that this would not solve the problem of trust: flexibility and judgement would still need to be exercised. Indeed, the fuller the guidance, the more scope there is likely to be for alternative interpretations.

The third avenue suggested was to call for the guidance to specify processes through which these judgements could be made; in many cases asking for these processes to include some input from an independent body. This would appear to be a constructive approach although it was not articulated with much clarity. A few people drew attention to, and approved of, the suggestion in Annex D that consultation plans should be drawn up (both for ongoing involvement and for specific consultation exercises). Others suggested that various aspects of a consultation - such as the methods to be used - should be agreed with (for example) the health council. Others suggested that an independent body should either undertake some key part of the process (such as presenting the relevant information to the public, or analysing the feedback) or scrutinise the process by undertaking retrospective evaluation. What body this might be was not often identified, though the proposed Scottish Health Council was mentioned a few times.

Specific suggestions about how to improve the guidance included the following:

• The guidance should be statutory.
• There should be more about what to do when agreement could not be reached between the board and the public.
• There should be guidance about what to do in situations where more than one health board area was affected by a proposal.
• There should be commitment to reviewing the guidance.
• There should be independent evaluation of the NHS board's public involvement activity as part of the PAF process.

• As discussed above there should be more clarity about stages and levels, about the implied distinction between public involvement and consultation, and about the definition of substantial service change.

• There should be more reference to local authorities and the voluntary sector, and the ways in which joint working could add value to the process of public involvement.

• The guidance should cross-reference to other documents - particularly other toolkits, such as that prepared by the Involving People team, and by Cosla. Some of those consulted felt that it would be better to refer to these documents rather than try to include an incomplete or arbitrary list of methods in this guidance.

ANTICIPATED IMPACT OF THE GUIDANCE

Groups were asked whether they thought that NHS Boards could and would make public involvement happen in the way envisaged in the guidance, and what effect the guidance would have on the way they went about it.

• The groups of managers believed there was willingness and political will to put public involvement into practice.

• Members of the public had mixed views about NHS commitment to public involvement, with some scepticism remaining.

• There were mixed views on the effect of the guidance. Some in the managers group felt that the guidance was not ambitious enough, and that in some board areas practice was already in advance of the guidance. At the same time they felt the guidance might not provide enough help in areas where there was poor practice. On the other hand, there were others who felt the guidance would help.
Presentation and distribution could heighten the impact of the guidance.

There was a feeling that the guidance neglected staff, with very little reference to the importance of including them in consultations.

Many groups commented on the importance of monitoring and evaluation of the guidance.

Barriers to the use of the guidance were identified. These included points raised earlier, including the need for resources, greater flexibility in working hours, the difficulty of identifying the stakeholders and of involving clinicians, and the need for culture change within the NHS.

Members of the public hoped that the guidance would make it easier to tell whether public involvement and consultation had been carried out. It would be important to raise public awareness of the guidance and what it required of NHS boards.

WHAT SHOULD HAPPEN WHEN DISAGREEMENT REMAINS

There was general agreement that the NHS needs to take responsibility for its decisions, but that it may very often be necessary to continue the dialogue with affected groups or communities after a decision has been taken. This could often help to ameliorate the effects of the decision.

Many respondents suggested that there should be a formal appeal process in cases where there remained disagreement, or where the board’s decisions appeared to have discounted the concerns of the public or service users.
1 Background

THE 1975 GUIDANCE

When any significant change in NHS services is being planned, the NHS Board has to consult the public about it. Until April 2002, the guidance to Boards on when they should consult and how to do so dated back to 1975. It stated that the Secretary of State recognised the need for boards to review and amend their service provision and the great importance of maximising resources. However:

He is fully concerned to ensure that any proposals for closure or change of use are made fully known to interested parties before the decision is taken so that the decision is made, and is seen to be made, against a background of local consultation and after consideration of all local evidence.

In referring to "consultation", the guiding principle was that boards should consult all bodies with a "valid interest" and "in time to allow comments to be considered and taken into account before the board takes a final decision and before any proposals, revised where appropriate, are submitted to the Secretary of State". The guidance stated that it was for each board to determine the range of consultation necessary but that, as a normal rule, at least the following should be invited to comment:

- Local health councils
- Area professional committees
- Local authorities
- Staff associations
- Universities (where appropriate)

1 Scottish Home and Health Department, NHS circular: closure and change of use of health service premises (1975)
The guidance also emphasised the desirability of keeping local MPs informed of all major decisions in their area.

The regulations which set up local health councils in 1974: state that each health board should consult health councils in the preparation of its strategy plans for the provision of services, and on any substantial development or variation in any of the services for which the board is responsible.

**CODE OF PRACTICE ON OPENNESS**

A Code of Practice on Openness in the NHS in Scotland was produced by the NHS Management Executive in May 1995. It sets out basic principles underlying public access to NHS information in Scotland. In terms of consultation it says that health boards must consult local health councils and other interested parties on any plans to change the service which they purchase or plan for their residents.

**CONSULTATION AND PUBLIC INVOLVEMENT IN SERVICE CHANGE: DRAFT INTERIM GUIDANCE FOR CONSULTATION (2002)**

New guidance has now been drafted by the Scottish Executive Health Department and was issued in May 2002 in a document entitled Consultation and Public Involvement in Service Change: Draft Interim Guidance for Consultation. This went to NHS boards, trusts and other bodies with a covering Health Department Letter HDL (2002) 42.

This guidance took forward principles outlined in Chapter 5 of Our National Health: A plan for action, a plan for change, and elaborated later in the paper Patient Focus and Public Involvement, issued in December 2001, and applied them to the context of substantial service change.

---

2 The National Health Service (Local health councils) (Scotland) Regulations 1974, 1974 no 2177 (S200)
The guidance, it should be noted, is in draft form. It took effect immediately, but a commitment was made to revise it when reactions from the NHS, from other interested bodies and from the public had been received.

In order to inform this revision, the Department wished first to gather views across Scotland on the outline policy ideas and how they might be put into practice. Scottish Health Feedback and the Scottish Consumer Council were invited to carry out this consultation for the Department.
2 The consultation process

The draft guidance went out to a wide range of people and organisations within and outwith the NHS, and anyone has been free to feed their views directly back to the Department of Health. In addition, the Department asked the Scottish Consumer Council and Scottish Health Feedback to hold a series of discussion meetings around the country to get reactions.

There were 24 discussion meetings altogether:

- eight meetings with senior NHS and local authority directors and managers, with responsibility for service planning or public involvement
- 11 meetings with people from organisations representing the interests of patients, communities or the public generally, including organisations formed specifically to express views on particular service changes. These groups are referred to as the "informed public". One health council member or staff member was invited to each group.
- one meeting with NHS board chairs, one with NHS board chief executives, and one with trust chief executives
- two meetings, one with members of the Executive of the Scottish Association of Health Councils, who were either health council chairs or members, and one with health council chief officers (or staff deputising for them).
Each prospective participant was sent both a brief summary of the draft guidance and (except in the case of NHS managers, who had already received it through official channels) the complete document in advance of the discussion.

The purpose of the discussion meetings was to explore how helpful the guidance was seen to be, both to those working in the NHS and to patients and members of the public who might want to be involved in the decision making process. It also tried to identify ways in which the guidance could be improved.

Experienced, neutral facilitators conducted the discussion meetings.

**STRUCTURE OF THIS REPORT**

A topic guide was prepared for conducting discussions: this is reproduced in Appendix 1. The same guide was used for all types of group, except that it had to be shortened substantially for the discussions with NHS chairs and chief executives, where discussion had to be fitted into a shorter space of time.

Discussions in the groups took place under the headings set out in the topic guide, with flexibility to allow for the interests expressed. This report uses the same headings to report the views of participants.

It then draws out some of the main emergent themes from the discussions in a final section.
3 Past experience of consultation on service change

Participants were invited to reflect on their own experience of consultation on service change, whether this was positive or negative, and whether things had changed significantly over the last 10 years.

Key findings

- Poor practice in the past is beginning to change
- Consultation is often hampered by lack of resources, skills, time, and poor attitudes
- Lack of real influence or feedback in the past
- The public is becoming more involved and more demanding
- Effectiveness of consultation may still depend on key individuals
- Effective consultation should be based on underpinning public involvement

There was general agreement amongst participants that consultation had not been done well in the past. Health council staff and members commented particularly on poor consultation about acute services, while consultations on mental health services had sometimes been better. Members of the public generally felt that consultation had been tokenistic and superficial, with the public having little real influence. Too often consultation was seen as window dressing, and was not reflected in the final outcome. These failings were generally accepted and reflected by NHS managers, who had negative or, at best, mixed experiences of consultation. They admitted that change had often been presented as a "fait accompli", with the public being given limited opportunity to comment.
There was general recognition that consultation had often taken place too late, without any pre-consultation and allowing only limited time for the public to respond. Sometimes decisions had already been taken. In addition, the resources going into consultation were insufficient, in terms of lack of information about the proposals and the process for members of the public, and lack of skills, time and resources on the part of the NHS. This was not necessarily deliberate, but could be the result of staff not knowing how to go about the task effectively.

Members of the public referred to the attitudes and assumptions of NHS staff as being unhelpful in the past. NHS staff admitted that boards had sometimes been arrogant in the past. Those involved in health councils felt that in the past there had been a lack of honesty about what could be changed. Decisions had often been taken for financial reasons, but NHS staff had not always been open and honest about this.

Health council members and staff pointed out that consultations had often been characterised by conflict in the past, including conflict between the board and the health council, but also between various groups within the public, who had differing perceptions of the public interest.

Both public and NHS staff felt that there had been some progress over the last 10 years, although the public described progress as having been slow and reluctant. NHS managers believed that consultation would only begin to be done better when the whole process of public involvement was being done more effectively and on an on-going basis. This was seen as being the foundation on which consultation could be done better in particular instances.
Members of the public considered that the public was becoming more demanding and proactive, and that this would push the NHS into consulting them more effectively, with the board being “dragged kicking and screaming” into more active involvement. Others noted that where consultation had been done well, it was often because of a key individual who made a difference to the process.

Those working in the NHS drew a clearer distinction between public involvement and consultation, seeing the latter as essentially episodic and coming into play when a major closure or controversial development was being proposed. This group felt that the guidance did not distinguish sufficiently between public involvement and consultation. Some NHS managers commented on the fact that they were beginning to learn from their colleagues in local authorities, who in many cases had more experience.
Groups were asked:

The Guidance implies that there should be a structured consultation process, including a formal consultation stage, for all "substantial" service changes. It then goes on to say that the word "substantial" should be interpreted using "common sense". Do you agree?

Key findings

• Definition of substantial needs to be clearer
• Definition of substantial depends on
  • the nature of the change
  • the cumulated effect of smaller changes
  • the position of the person defining substantial (whose common sense?)
• It may be clearer when formal consultation is required if there is underlying public involvement
• Need to allow for tailored approaches, rather than one size fits all

All the groups consulted were unhappy about the definition of substantial service change, although some chief executives welcomed the flexibility of this definition. They disagreed that this could be interpreted using "common sense", with significant numbers commenting that it was not clear whose common sense this should be. Health council members and staff were unhappy about leaving the definition of "substantial" to NHS boards.

The definition of what was "substantial" for any particular person would be affected by

• the nature of the change
• whether that particular change had an impact on that person and
• the context (for example, whether it was taking place in a rural or urban area, or whether it was a centralised or a local decision).
NHS and local authority managers commented that it might be possible
to consider how many people were affected by the change as a way of
gauging how substantial the change was. However, change in a small
community could have a substantial impact on that community, even
though relatively few people were affected.

Members of the public were also critical of this definition. They
mentioned that there could be circumstances where a series of small,
incremental changes could add up to substantial change. It was,
therefore, not easy to define whether a particular proposal was substantial
or not.

The public groups gave examples of occasions where there had not been
consultation. These included situations where the change might seem
small to the board, but was highly significant to the individual, for
example the withdrawal of consultant cover in a particular area. Another
element was where a change made by one health board had an impact
on people living in the neighbouring health board area, but these people
had not been involved in the consultation. Trust chief executives,
however, were concerned about the process of consultation being
triggered by relatively minor changes.

There was general agreement amongst all those consulted that
"substantial" service change would be easier to define if there was a
strong ongoing process of public involvement in place, underpinning
everything which the NHS board was doing. There was also a view,
expressed by a smaller number, that public involvement and consultation
should not be seen as distinct, but as part of the same process.

However, there was a recognition that it was important to be able to
define a particular proposed service change as being so substantial that it
required a particular process to be followed. NHS and local authority
managers in particular wanted a clearer definition, and saw the lack of
this as being an "essential weakness" of the paper. They wanted more
clarity and clearer guidance about the circumstances which constituted
substantial change.
Only one person attempted to define these circumstances, in a written submission. This definition suggested that a substantial change would involve either:

- Closure
- Reduction of opening hours
- Increased charges or
- Revised strategic goals

It was also mentioned that there are sometimes circumstances in which it is not possible to hold a formal consultation. For example, the change might be the direct result of a change in policy, for example at national level, which it was not possible to change. Examples of this would be changes to structures within the NHS, such as the changed responsibilities of NHS boards. Statutory provisions such as the Working Time Directive, clinical governance issues, and Royal College training accreditation might all impact on what trusts or boards were able to do. Change might be forced by a staffing crisis, or withdrawal of accreditation. In these circumstances there were no options on which to consult. NHS chief executives pointed out that where the reason for change was clinical opinion that a service was unsafe, it was difficult to share this knowledge with members of the public without causing concern.

NHS board chairs pointed out that the guidance was not drafted in a way which was relevant for special NHS boards. For example, HEBS found it hard to define what would be "substantial change" for them.
Health council members and staff suggested that rather than developing a definition of "substantial" service change which always led to a particular form of consultation, the important thing was to aim for the level of public involvement or consultation which was appropriate to the issue. Some smaller consultations need only involve particular patient or carer groups, while strategic issues need wider public consultation. Health council members suggested that health councils should be involved in the process of deciding what level of consultation was appropriate. They suggesting using the health improvement plan in each board area to plan forthcoming consultations.

Health council staff and members also thought that there should be more explicit mention of primary care providers and local healthcare cooperatives (LHCCs) in the guidance because of their role as agents of change at a local level.
5 Public involvement in the developmental stages of service change

The Guidance talks about *public involvement* in service change as something that should start early on in the development of proposals and continue right up to the taking of final decisions and suggests using a variety of methods. The document talks about *formal consultation* as something that should happen in the latter part of this process.

In the next part of the discussions groups were asked for their views about the process of public involvement as it is described in the early part of the flow diagram from Annex B to the guidance. This shows the following stages:

1. Substantial service change under consideration
2. Involving Health Councils and other stakeholders as early as possible
   (Consider possible methods of public involvement and the need for a pre-consultation exercise)
3. Finalise proposals

Groups were reminded that the guidance says that NHS boards "should develop proposals for service change in partnership with all affected groups and communities". They were asked whether they agreed with this, and how they thought it might be put into practice. They were also asked what they thought of the guidance given in the document and its annexes about how this should be done.
There was almost universal support for the importance of early involvement of a wide range of stakeholders, and of all the groups likely to be affected by the change, including those who might be hard to reach. The only reservations expressed about this were in relation to how "early involvement" should be defined. The point was made in some groups that some ideas for change arising within the NHS would never result in concrete proposals. There were circumstances in which some time might be needed to explore possible developments before involving the public. Some of the public groups felt that the process of early involvement should start earlier than suggested in the guidance. They felt that the public should be involved in decisions about whether any change was needed, and not only once that decision had been made.
Health council staff and members expressed some concern about early involvement leading to long drawn-out processes of consultation which could reduce public interest and enthusiasm for involvement. There was concern that NHS bodies might use lengthy processes to conceal how much scope for change really existed.

There was recognition within the NHS of the benefits which early involvement could bring. These included:

- Good ideas generated by members of the public
- Helping to identify key issues
- Explaining constraints
- Creating trust in the NHS

5.1 NEED FOR GUIDANCE

The groups flagged up the areas in which they considered there might be a need for guidance about how to go about this public involvement. The following areas were discussed.

Who should be involved

There was a range of suggestions about the people who should be included. This included organisations such as local health councils, community care forums, user and carer forums, voluntary organisations, and community councils. Health council members and staff said that it was sometimes difficult to know which sector of the public should be involved. In some cases the informed input of service users was what was needed. In other cases it might be important to reach the wider public, or particular groups, such as ethnic minorities or young people. They noted that the degree of interest shown by the general public was highly variable: where a closure or withdrawal of service was proposed, people were far more likely to become involved. The degree of engagement also varied: those opposed to change were often more vociferous than those who accepted it.
It was also pointed out that it is important to ensure that there are ways for individuals to become involved. NHS board chairs commented on the importance of involving people from deprived communities, and noted that people who became involved were not necessarily representative of the wider public. The public groups suggested that particular attention should be given to communicating with people living in remote rural communities.

The group of NHS and local authority managers made the point that involving targeted groups should come earlier than is suggested in the guidance (Annex B), ie only after the production of the consultation document.

Some of those in the public groups thought that it might be useful to involve an independent facilitator to ensure that appropriate and relevant people were being involved. This reflected a degree of distrust in boards' ability to do this themselves.

The managers' groups and the public groups commented on the fact that there is little reference to consulting staff. They also noted that it could be difficult to involve consultants in public involvement activity in their areas of expertise. Members of the public group referred to the reluctance of GPs to become involved in public involvement and consultation about their services.

**Time**

There was a recognition by NHS and local authority managers that timescales must be realistic, but they must also fit in with planning cycles. It might be helpful to draw up a timetable for the process. One participant commented that in the course of a complex consultation process lasting 18 months, three quarters of the time had been spent on what could be called "early public involvement". The public groups thought that there should be more detail in the guidance about how much time to allow for the early stage. There needed to be sufficient time for people and groups to respond.
Information
Members of the public felt that adequate, clear and timely information must be available to all those being involved at an early stage, and this should be recognised in the guidance.

Relationship of public involvement to formal consultation
NHS and local authority managers did not think that the relationship between ongoing public involvement and consultation on specific changes was made clear enough. They felt that, if anything, the draft guidance did not put enough emphasis on the importance of ongoing public involvement. This is probably largely a criticism of the chart in Annex B, of which only the second step relates to early public involvement, while there are several steps following on from the finalising of proposals.

Involvement of local politicians
In addition to the wider public, NHS and local authority managers referred to the importance of including local politicians in the early involvement activity. MSPs, in particular, were mentioned as being key players, sometimes having the power to derail proposals which had emerged following extensive public involvement.

Relationship to local authorities and other partners
Some participants in the managers’ and public groups referred to what they considered a major weakness in the guidance – its failure to refer to joint working in the context of the Joint Futures policy and community planning. For some boards, whose boundaries are not co-extensive with local authorities, there were particular difficulties in joint working, but participants recognised the strengths which it could bring. These included adopting common approaches and frameworks, and pooling resources. There was also the possibility of using the networks
Consultation and public involvement in service change of people with an interest in becoming involved. The managers group suggested that there was much experience in public involvement in these other policy areas which could be drawn on. This was not reflected in the guidance.

Feedback
The public groups felt that the guidance should include a reference to the importance of feeding back to those who had been involved in the early stages of the process, so that they knew about progress with the consultation.

In addition to the points made above, members of the public referred to

- the need for clarity about the constraints within which proposals were being made
- the drain on the resources of small organisations of becoming involved in consultation exercises
- the need to use the local press effectively
- the danger of generating too much data which would never be used

Additional points made by NHS and local authority managers included the following:

- Early involvement should not necessarily lead up to a formal document or finalised proposal, as suggested by the guidance. There should be a range of formats, to make the proposals accessible to as many people as possible.
- Proposal documents should be piloted for readability.
5.2 CONTENT OF GUIDANCE

The public groups were broadly in support of what the guidance says about public involvement, with the reservation that there was a need for more specific guidance in relation to some of the areas mentioned in the previous section. NHS chairs generally felt that the annexes were helpful.
In the next part of our discussion, groups were asked for their views about the formal consultation part of the process, where definite proposals or options were being put forward in written form and possibly other ways too. Their attention was directed to the remainder of the flow chart in Annex B, which is as follows:

Groups were asked what they thought of the guidance given in the document and its Annexes about how this formal consultation should be done, and how this guidance might be improved.
Groups were asked what they thought of the guidance given in the document and its Annexes about how this formal consultation should be done, and how this guidance might be improved.

**Key points**

- Most groups broadly approve
- As in the earlier stage (section 5 above) more detail needs to be given about
- Timescales
- Who to involve
- Information provision
- Feedback
- Clearer distinction between public involvement and consultation needed
- Guidance may not be strong enough to provide legitimisation of decisions or legal protection
- Desire to avoid repeated rounds of consultation

The majority of groups broadly approved of the guidance provided in this section, though groups had detailed comment to make on the content. One group of NHS and local authority managers was quite critical of the guidance on the grounds that it was unambitious. This group considered that in their area they had gone well beyond the guidance, and that an opportunity to provide leadership had been missed.

NHS chief executives were concerned that the guidance could lay boards open to pressures for repeated rounds of consultation. For example an extensive public involvement process could lead to the agreement of a preferred option. However, the board could then come under pressure to consult fully on that, even though it had undertaken extensive public involvement in the earlier stages.
Once again, groups felt that there was a need for greater clarity about issues such as timescales, who to involve and how to provide information to those taking part in the consultation. Similar comments were made as in relation to the early public involvement stage. Both the public and managers were worried that three months might be too short a timescale for consultation, particularly for groups in the voluntary and community sector who needed time to consult with their members. At the same time, they recognised that it was not good practice to extend consultations over too long a period. There was support for some flexibility in the time scale, rather than the guidance being prescriptive about this. The time needed would vary depending on the issue being consulted on and the time of year so as to allow for holiday periods. Managers noted that it was also important not to underestimate the time required for analysing the opinions and information gathered through the consultation process.

Managers again raised the issue of who should be consulted, and in particular felt they needed more guidance about how to involve members of the general public. Two groups suggested that targeted approaches should be supplemented with surveys or panels covering a broader, ideally random, cross section of the population. The health council groups felt that health councils had an important role in guiding the board on whom to consult, and on the level or scale of consultation required.

Members of the public groups again raised the issue of information. They felt that the NHS should give more attention to the range of formats which were produced, and the different media which could be used, such as videos, radio, TV CD-ROMs, and so on. NHS boards needed to think strategically about their communication strategies, and consultation exercises should be part of these strategies. It was important that groups were not excluded from consultation because of difficulty with reading consultation documents. Information should be honest, and clear about any constraints. Some of the public groups went so far as to suggest that information should be prepared or overseen by an independent body.
Some groups referred to the value of NHS staff going out into the community to communicate directly with members of the public. The health council groups felt that there should be clearer guidance about the kind of information required. They felt that the requirements of the 1975 were clearer, for example in relation to

- the clinical benefits of the proposed change
- the staff implications of the change
- the exact nature and location of future services.

The public, health council and managerial groups all mentioned feedback. One group of managers said that the guidance should require the NHS to feed back to those consulted in such a way that they could recognise that their comments had been registered and taken account of. The public were concerned that the guidance gave the impression that consultation was essentially a linear process, with feedback being provided at the end, whereas the reality was that there should be a succession of feedback loops throughout the process.

The health council groups emphasised the importance of evaluating the consultation process. Annex B does not say who should carry out this evaluation. They felt that an independent body should carry out this evaluation.

Groups again raised the question of the relationship between public involvement and consultation, with the NHS chairs saying that the distinction in the guidance was not clear enough. They suggested that the word "consultation" should only be used for the formal process needed in relation to substantial service change. NHS and local authority managers again said that when the ground had been prepared by good public involvement there should be fewer surprises when the formal stage of consultation was reached. One group illustrated this point by saying that they had involved the public in the process of option appraisal, and this had proved to be worthwhile because it had made the whole process more transparent.
Health council members and staff were concerned about the lack of prescription in the guidance. They were concerned that this open-ended approach would make it hard for a board to reach final decisions which could not be challenged by, for example, MSPs. One participant was concerned that the guidance should provide an assurance to an NHS board that they could not be challenged in court for not having carried out a consultation exercise effectively (under judicial review). At the same time, the health council groups were in favour of a wider range of models for involvement or consultation being set out. They were afraid that giving a detailed model for a consultation process (as in Annex B) would encourage boards to use this model when it was not the most appropriate one.

Additional points raised by NHS and local authority managers were

- The danger of consultation overload
- The importance of practicalities in the consultation process, such as holding meetings at convenient times and providing crèches and transport.

Additional points raised in the public groups were

- There was no mention of advocacy in the guidance
- The guidance should say that the appraisal process by which decisions were taken should be explained to the public
- The guidance should be more mandatory.

Specific points raised by the health council groups included:

- A reference in paragraph 3 of Annex A to members of the public
- Annex B should have an initial box asking whether there should be a consultation at all.
7 What should happen when disagreement remains

If disagreement remains after consultation has been carried out, how should NHS boards proceed?

Key points

• Be clear and honest about constraints from the start
• Be open and transparent about decision making process
• NHS must take responsibility for its decisions
• Continue dialogue after decision taken
• Consider an appeal process

Members of the public felt that there was nothing in the guidance to help in this situation, and felt that there should be. However, both public and managers tended to agree that the important thing was to conduct the consultation in an open and honest manner, being particularly careful to ensure that the public understood the constraints, particularly any financial ones, within which the decision had to be made. The board must give a full explanation of how and why decisions have been reached, and should be clear from the start about how decisions will be made. It should be able to show how it had taken account of the various interests involved. The managers felt that the guidance should be more explicit about this. One of the managers' groups suggested that an independent person should compile the feedback from the consultation. Reference was made to the protocol for "ethical decision making" which has been developed in Highland.

NHS and local authority managers felt that NHS bodies must ultimately be prepared to reach decisions which not everyone would agree with. This was particularly the case if the decision involved the interests of people who might not have had a strong voice in the consultation process, for example offenders with mental health problems. They felt

that if disagreement remained after the consultation process, it was probably a sign that the consultation had not been carried out well. Unanimous or near unanimous opposition suggested that the board should think seriously about proceeding.

One group of managers suggested that negotiation on the details of an option could often lead to wider acceptance. Managers also emphasised the importance of continuing to be responsive to public concerns after the decision had been made and during the process of implementation.

Health councils commented on the possibility of people's views changing in the course of consultation. They gave the example of the closure of hospitals for people with learning disabilities, where initial opposition had been followed by a recognition of the improved quality of life for former residents.

Several groups were unclear about whether there was or should be a review or appeal process. Some people in the public groups suggested that where disagreement remained the decision should be referred to the Scottish Executive, while others were in favour of an independent arbitrator. One group of managers were in favour of a clear appeal process with timescales built in. They were keen that MSPs should be willing to accept the results of the process and not attempt to overturn or bypass the decision-making process. Health councils thought that if a board decision was opposed to public opinion, there should be a procedure for review or appeal, going to the Scottish Executive. This recognised the current reality that petitions could be made to the Scottish Parliament.

One public group suggested that an impact assessment should be carried out for any group disaffected by the decision, with remedial action being taken to minimise the negative impact.
The flow chart suggested that there were various possible methods that might be used to get the views of the public. In Annex C of the guidance there was a whole list of different methods that boards might consider. Groups were asked to consider – without getting into detailed discussion of individual methods – what they thought of the general principle of encouraging boards to choose from a range of methods like this. They were also asked whether there were any particular methods they would rule out, or any other methods not listed that they thought would be particularly valuable.

**Key points**
- Range of methods broadly welcomed
- More guidance needed on how to use methods effectively
- Guidance should refer to underpinning principles
- Reservations about public meetings and hearings
- Enthusiasm for electronic media and use of local press

Members of the public and managers broadly welcomed the range of methods presented in the guidance. The public groups felt that it might be useful to give some examples of when particular methods had been used. It should also be clear from the guidance when a particular method was less likely to be suitable, for instance in rural areas with smaller concentrations of population. Health councils were in favour of encouraging boards to choose from a range of methods, but had some reservations about the range of methods included which they felt was somewhat arbitrary. They thought that it was unnecessary to include Annex C, and that it would be better to refer to other documents or toolkits.
Using methods effectively

Health councils suggested including some examples of the use of different methods. This could lead to the creation of a database of good practice similar to that held by the Nuffield Centre on good practice in community care.

Members of the public commented that the use of the word "choose" suggested that one method was enough, whereas a range of methods was preferable. The managers suggested that some guidance should be provided about situations in which it would be useful to combine several methods, both in order to reach different groups of people, and also to provide triangulation, i.e. a way of confirming the validity of the approach taken. In addition, different methods might be appropriate at different stages of the process.

The public groups pointed out that effective use of the methods involved appropriate training for NHS staff as well as practical support and training of members of the public. Managers in the NHS and local authorities agreed that skilled people were needed to use the methods. Health councils also mentioned the need to keep going with public involvement even if at first it proved difficult to reach the relevant people.

The managers' groups referred to the public involvement toolkit recently produced by the Involving People team, and felt that there should be reference to this in the guidance.

Managers also commented that sometimes public involvement activity is classified as research and as such requires to have the approval of a local ethics committee. It would be useful to have some direction on when this was needed in the guidance.
Underlying principles
Members of the public groups felt that there should be notes in the guidance on partnership working, the use of existing local networks and the importance of using methods which were accessible to all. The managers’ group commented that section 9 of Annex C, which is headed "Making results more representative" was not a method, but should be a principle underpinning all public involvement activity.

Unpopular methods
Managers had reservations about the use of large public meetings. There was a danger that these would exclude minorities and vulnerable groups, and attract people with strong but not necessarily representative views. They warned of the danger of having votes at such meetings.

Members of the public disliked public hearings at which a health body would speak, but without the public having a right to speak. They had reservations about citizen's juries, feeling that some people would lack the confidence to take part.

Other methods not listed
Members of the public groups mentioned the value of face to face contact with those affected by change, and the power of listening to people's own stories. They also suggested that the following should be included:

- surveys
- mailshots
- community newspapers
- electronic means of communication such as fax, email etc
- opinion meters in chemists' shops
Managers within the NHS and local authorities mentioned the following as having a role:

- electronic methods such as text messaging, emails, web discussion groups and video box;
- use of tapes for people to record and send back views (specially relevant for some "hard-to-reach" groups, e.g. those with visual impairment, dementia, learning disability, severe physical disability, or with literacy problems);
- stands at local event such as sports games;
- surveys, to show how representative a view is, and allowing analysis of results by area, age, ethnicity, gender, service experience etc;
- delphi questionnaires to assist with priority setting;
- local media including newspapers and newsletters;
- nominal group techniques;
- option appraisal methodology;
- use of frontline workers and advocates to help get the views of older people and vulnerable groups;
- working in collaboration with local authorities, sharing their resources such as databases of participants;
- use of more generic groups (that may include elected members) such as tenants associations and community councils;
- talking to individuals in their own environments.

Other points that were noted included:

- the need to involve staff as well as the public;
- inclusion of reference to how best to inform the media to ensure fair and truthful reporting;
- inclusion of the need for ongoing involvement and methods of capturing views on a day to day basis;
- the importance of setting up a network;
- the guidance does not include ways of engaging with children and young people;
- The particular use of the term "health forum" in Glasgow, where it tends to be associated with a campaigning group (usually an anti closure group).
9 Pros and cons of public involvement

Groups were asked whether they saw public involvement as a valuable activity, and then whether there was any downside to it.

Key points

- General support for the value of public involvement if done well
- Restatement of key factors in effective public involvement
- Main drawbacks seen as the danger of over-consultation or tokenistic involvement

All the groups believed that, if done well, public involvement was a valuable activity. This question was scarcely discussed at all by the health council groups, as it was taken as read that public involvement is a valuable activity.

Many of the points made earlier were re-iterated. Managers believed there were three key factors: time, skills and resources. It was particularly important to be realistic about resources, and they identified the cost of clinicians being involved as a cost which was not always recognised. Members of the public emphasised once again the importance that the process was transparent, honest and inclusive. They spoke of a virtuous circle which could be created when public involvement was done well and on an on-going basis. Everyone involved was more likely to participate enthusiastically if they could see the benefits of doing so. In contrast, where public involvement was not done well, this constituted a disincentive to taking part in the future. Members of the public said that public involvement should only be undertaken when there was the possibility of change as a result of the involvement.
The public groups suggested that there should be a commitment to ongoing evaluation of public involvement activities. Some groups emphasised that public involvement must be a continuous process, and one argued again the need for some independent oversight of the process.

The features that were described as the disadvantages of public involvement were not so much disadvantages of involvement itself as dangers of poorly planned or executed public involvement.

Both members of the public and managers mentioned the danger of over-consultation, leading to an overload on those being involved and the possibility of confusion as to what was being consulted on. The danger of over-consultation also arose if involvement activity was being done in a routine fashion, and could be perceived to be merely rubberstamping decisions already taken.

Managers were concerned that public involvement might have the effect of raising unrealistic expectations about what the outcome might be.

Managers also expressed concern about how to ensure equity in the outcome of public involvement exercises. This raises two questions: firstly, how decisions can or should be made following public involvement, and secondly, how NHS staff can have confidence that members of the public really know what is in their own best interests.
10 Anticipated impact of revised guidance

Groups were asked whether they thought that NHS Boards could and would make public involvement happen in the way envisaged in the guidance, and what effect the guidance would have on the way they went about it.

Key points

• The groups of managers believed there was willingness and political will to put public involvement into practice
• Members of the public had mixed views about NHS commitment to public involvement
• Mixed views on the effect of the guidance
• Presentation and distribution could heighten impact of guidance
• Guidance neglects staff
• Monitoring and evaluation of the guidance will be very important
• Barriers to use of guidance identified

All the groups of managers agreed that there was a willingness to take forward public involvement, backed up by the political will to promote it. They felt that this should be taken forward jointly with local authorities. However, they thought it important to be clear about the possible barriers to putting it into effect. These included points raised in earlier sections of the report, including the need for resources, greater flexibility in working hours, the difficulty of identifying the stakeholders and of involving clinicians, and the need for culture change within the NHS.

NHS chairs and chief executives were broadly supportive of the guidance, and accepted that boards would have to deliver on this agenda. Chief executives liked the flexibility of the guidance.
Members of the public groups were more sceptical about the ability of the NHS to engage with the public, and spoke of the need for a major culture change before this would be achieved. They felt that public involvement often depended on one key individual promoting it. Some people in the groups were more optimistic, and were encouraged that public involvement was being promoted at national level. Some, however, considered that more would be needed for the guidance to have an impact. This might include making the guidance more directive, providing for independent monitoring, evaluation and assessment of public involvement activities, and the imposition of sanctions for failure to carry it out.

Health councils commented on the fact that the impact of the guidance was likely to be very different in different parts of the NHS. While there might be a commitment to public involvement at board level, some parts of the organisation and some kinds of professionals would find this more difficult. Acute trusts, middle managers and clinicians were particularly mentioned in this respect.

The managers were divided about the effect of the guidance. One view was that the guidance did not add much to what was already happening, and therefore the impact would be minimal. At the same time, this group felt that the guidance was not enough for people who were not already carrying out public involvement work. The other view expressed was that the guidance would be useful, would increase the transparency of decision making, provide a structure, and lead to more consistency in practice. They pointed out that guidelines for major consultations were of less relevance to smaller scale exercises. They were also concerned that there was very little reference to staff in the guidance. As discussed earlier, they were not happy with the lack of a clear definition of "substantial".
Overall, the managers felt that the guidance should lead to more opportunities for the public to have an influence on service change. They were not certain that the guidance would make it any easier to reach decisions acceptable to all those who had been involved.

NHS chief executives felt that it would only be possible to say whether the guidance was helpful after it had been used, particularly in cases where there was a high level of disagreement.

The managers and the public groups thought that the impact of the document would depend on its presentation and distribution. They thought it should be made more accessible and distributed more widely so that members of the public would also know what NHS bodies were being expected to do. The managers would like to see worked examples on the SHOW website. Members of the public would like to see examples of positive service change rather than simply closures.

Members of the public hoped that the guidance would make it easier to tell whether public involvement and consultation had been carried out. Health council groups agreed with this, saying that they had already used the guidance to challenge boards on failures to consult, or inadequate consultation. The public groups were not sure that the guidance would make it any easier to reach decisions. Some commented that children should learn about public involvement at school.

Health councils were particularly concerned about the process whereby boards would be held to account for its delivery. They thought that the health councils should be involved in the Performance Assessment Review of activity in this area. This right should be written in to the guidance. NHS chief executives agreed that boards should be held to account, but felt that they should be accountable for following an appropriate process, even if disagreement or controversy remained.
The health council groups mentioned the importance of adequate resourcing of this activity. Some participants thought there should be ring-fenced funds for this work. NHS chief executives also had concerns about the resource implications, particularly in relation to staff time. Public involvement could take up the valuable time of management and clinical staff.

Annex D was approved by some members of the health council groups, particularly its requirement to produce a consultation plan.
11 Ways in which guidance could be improved

Key points

- Guidance should be statutory
- There should be commitment to review guidance
- There should be independent evaluation of the NHS board’s public involvement activity
- More clarity about stages and levels
- More reference to local authorities and the voluntary sector
- Cross refer to other documents
- Suggestions about length, flexibility, resources, specific groups, resources, feedback

Members of the public were unclear about the status of the guidance and felt that it should be statutory. They also thought that there should be a commitment within the guidance to reviewing it after a stated period. The public groups also tended to return to a theme raised earlier - that of independent evaluation of NHS boards’ performance in public involvement activity. The suggestion was made that an independent commission should be established to do this, while other groups suggested that an ombudsman, or other independent body should have a role.

Other suggestions made by the public groups included specific reference to particular groups, such as carers, people with special needs, and those who were not members of established groups. Managers were concerned about how to engage with young people, children and those from ethnic minorities.
Both managers and members of the public referred to the need for more comment in the guidance on the importance of joint working with local authorities and the voluntary sector. They also thought there should be more in the guidance about the importance of good communication, and more about resourcing and the training which might be needed by the public. One group would welcome guidance on whether members of the public should be paid for their involvement. Managers wanted to see a stronger introduction, and this was echoed in the public groups, which wanted more about the value of consultation.

The managers’ groups were more likely to be critical of the guidance. Some groups were critical of its style and impact, with one describing it as “middle class, white and boring”. One group of managers and the health council groups felt the need for more clarity about the distinction between public involvement and consultation, and about the sequence of the stages, and the levels of involvement. One managers’ group suggested that there were three levels: ongoing involvement on the generality of service issues; early involvement in consideration of specific service changes; and formal consultation. One group felt that there should be better cross-referencing to other documents, such as Patient Focus and Public Involvement, and presumably, although this was not specifically mentioned, the toolkit on public involvement produced by the Involving People team. This could avoid the guidance having to go into detail about methods which could be found elsewhere, and would mean that the document could be much shorter. One group would have liked more flexibility about how to address local situations.

Similarly, NHS chief executives referred to forthcoming guidance on local health plans, and the importance of ensuring that the different sets of guidance related to each other, for example in terms of the underlying principles and the approaches which could be taken to public involvement.
Similarly, NHS chief executives referred to forthcoming guidance on local health plans, and the importance of ensuring that the different sets of guidance related to each other, for example in terms of the underlying principles and the approaches which could be taken to public involvement.

Health councils would like more about what would happen if a board failed to deliver, and would like more examples of practice in the guidance. They also sought more guidance in areas where more than one health board was involved, for example in relation to the recent purchase of HCI as the national waiting times centre.
This consultation exercise suggests broad support for the approach taken in the draft guidance, but highlights several areas in which the guidance could be improved and strengthened. Some of the responses suggest that there is an increasing commitment to effective public involvement, and that this will be taken forward in line with the guidance. Some respondents thought that, while the guidance was broadly taking the right approach, its impact would be limited, as people were already acting in the ways proposed.

There was a view, expressed throughout the consultation process, that where there is ongoing effective public involvement, this provides a sound base on which particular consultation exercises can be built. The process of public involvement itself is also likely to make it clearer when a more formal consultation exercise is needed, and may also engender levels of trust which will make it easier for members of the public to accept the often difficult decisions which boards have to make.

FLEXIBILITY VERSUS PRESCRIPTION
The main concern about the guidance related to its open-ended, flexible nature, and the consequent need to interpret it and make judgements about what was required in a particular situation. Those consulted welcomed the flexibility but remained sceptical, or even suspicious about how it could be manipulated in practice. Public groups were suspicious that NHS boards and trusts would use the flexibility to do less than the spirit of the document called for. NHS groups were concerned that special interest groups might use it to try to force boards into unnecessarily elaborate exercises for relatively small issues, or to challenge the results of consultations. NHS and health council groups were apprehensive that politicians would be able to exploit the openness of the guidance to challenge the validity of any decision they wanted to oppose, since it would always be possible to find some aspect of the guidance where the high aspirations expressed had not been fully met.
Three possible approaches to this were suggested. One is to make the guidance more prescriptive, and to define more clearly the requirements which a NHS board must fulfil in these circumstances. There was not much support for this approach, although there was demand for more clarity in the definitions of "consultation", "early" involvement, and "substantial" change.

The second approach is to retain the flexibility in the guidance but to provide fuller guidance about how to carry out both public involvement and consultation more effectively. The goal would be to ensure that public involvement takes place at all levels within a board, and that the way in which the public is involved is appropriate to that situation. This approach would be less prescriptive about what must happen, and encourage boards at all times to use methods which are appropriate in scale, and in the range of those involved or consulted, to the issue at hand.

The third approach would be for the guidance to specify processes which would help to ensure that sound judgements about how to involve people or to consult were made. This might involve the health council having a role advising on methods or on who to consult, or it might involve an independent body having a role in undertaking key parts of the process, or in monitoring the activities of health boards in this area.

TERMINOLOGY
The use of the words "consultation" and "public involvement" caused some confusion in the guidance, as consultation can be seen as a form of public involvement, but has sometimes been used in the guidance as if it is distinct from public involvement. Many of the methods which can be used to involve the public could also be described as ways of consulting the public, for example through written consultation exercises, surveys, public meetings or inviting comment through web-based forums or online questionnaires. However, consultation, or "statutory consultation"
is used in this document to suggest a particular more formal type of public involvement, appropriate in cases of “substantial” service change.

There was also a high level of concern about the failure in the guidance to define what is meant by substantial service change, leaving this to the “common sense” of the NHS boards.

The final aspect of terminology that was commented on in the course of the consultation was “early involvement”. Views were expressed that it was not clear how early this should be. Once again, if there is an ongoing process of public involvement it should be easier to recognise the point at which people from outside the NHS should become involved.

**USING EXISTING MATERIAL AND NETWORKS**

Many of the comments made about the draft guidance suggest that it could make better use of other materials and networks. For example, most of those consulted were happy with the range of methods listed in the guidance. However, some suggested that it would have been better to have referred to the toolkits already in existence which contain more detail and more guidance on when it is appropriate to use a particular method, and how to do so effectively. These toolkits include one produced by the Involving People team in the Scottish Executive, one produced by CoSLA, and a compilation of public involvement resources drawn together for the Community Planning Taskforce at CoSLA. While there may be merit in including some examples of methods, as has been done in Annex C, it should be made clearer that the list is not inclusive, and that there are other guides which may be of help in selecting methods for particular situations.

Similarly, there are other people who can help make the process of public involvement work effectively. This includes people working in local authorities and in voluntary sector organisations. Many local
authorities have set up citizen panels and other similar methods for consulting and involving their local communities. NHS boards could usefully tap into these networks, through collaboration with their local authority colleagues.

**KEY FACTORS FOR SUCCESS**

Much of the discussion in the groups tended to return to the factors which were considered essential to effective involvement. The draft guidance covers some of these factors in the section on requirements for a valid consultation (sections 23 - 33). It might be useful to include some reference to other documents which describe the principles which should underlie public involvement, and the particular factors which need to be addressed. In addition, it might be useful to add some headings to the section on requirements for a valid consultation, to take account of some of the comments made. For example, this might include:

- Feedback to those who have been involved or consulted
- Support for those who need it in order to participate

In relation to feedback, some of the members of the public consulted were concerned that the diagram in Annex B was linear, when they felt it should contain feedback loops to show how proposals could be shaped and modified by the input of those consulted.

Many of those consulted spoke about the importance of knowing who to involve and consult, and how to involve over-consulting particular people or groups. There are a few references in the guidance to this, for example in Annex A section 3. It might be useful to have a short section on how to decide who should be consulted, and to refer to other guidance which deals with this. There could also be a reference to organisations which can help in identifying those who should be consulted. This might include local health councils, as well as the Involving People team at the Scottish Executive.
Many of those consulted referred to the costs of effective public involvement, and more generally the resources required in terms of staff time and training. NHS chief executives were particularly concerned about the implications of the guidance for the time which staff would have to spend on public involvement and consultation. While this is an understandable concern, it is probably not something which needs to be addressed in the guidance.

REVIEW OF DECISIONS; EVALUATION AND MONITORING OF PUBLIC INVOLVEMENT AND CONSULTATION

Health council members and NHS and local authority managers thought that it might be useful to include some guidance on how decisions should be reviewed if they were challenged by those who had been involved.

This point is related to the question of how the NHS board's activity in this area will be monitored and evaluated. This monitoring and evaluation could be commissioned by the board from an independent agency to review their practice. Equally, looking at a board's track record in public involvement will be an important part of the performance assessment process.

One possibility would be to add an appeal or review process, for example allowing appeal to the Public Services Ombudsman. Alternatively, members of the public who were dissatisfied with the outcome of a consultation could be informed about how and when the performance of the board will be assessed and how they could have some input into this process. For example, if the proposed Scottish Health Council is to have a key role in reviewing the public involvement activity carried out by the board, then members of the public could submit their concerns to the Scottish Health Council, probably through its local office.

Whatever policy solution is preferred it is important that members of the public know what they can do in cases where they remain dissatisfied, and are clear about the responsibilities of the various agencies involved.
PRESENTATION AND STYLE
Some comments were made about how the guidance could be improved, for example by starting with a stronger positive vision statement about public involvement and consultation. It is also important that this is a document which is accessible to the wider public, and it may be useful to produce it in a less formal style.
CONSULTATION ON THE REVISED GUIDANCE ON CONSULTATION AND PUBLIC INVOLVEMENT IN SERVICE CHANGE

Topic guide

As you know, the reason for this discussion group is to find out what you think about the new Draft Guidance on "Consultation and public involvement in service change". You should all have had a copy of this yellow paper, which gives a brief summary, and the full document.

Because the Guidance document is quite long, we can't go through it in detail. What I want to do is concentrate on the main messages in it and the main issues it raises in your minds.

PAST EXPERIENCE

Q1: From your experience, what does "consultation on service change" bring to mind?

Is this experience positive or negative? in what ways? Have things changed significantly over (say) the last 10 years?

For what kinds of service change should there be a structured process of consultation?

Q2: The Guidance implies that there should be a structured consultation process, including a formal consultation stage, for all "substantial" service changes. It then goes on to say that the word "substantial" should be interpreted using "common-sense". Do you agree?
Can you give any examples of service changes in the recent past where there was no consultation, but you think there should have been? Can you give any examples of service changes in the recent past where you think consultation was not needed?

The process of public involvement in the context of service change

The Guidance talks about Public Involvement in service change as something that should start early on in the development of proposals and continue right up to the taking of final decisions. It suggests using a variety of methods. The document talks about formal consultation as something that should happen in the latter part of this process.

In the next part of our discussion I would like your views about the process of public involvement as it is described here. (Show the flow diagram from Annex B on flip chart.)

I want to concentrate first on this part of the process (point to items 2 and 3 on flow chart - "Involve Health Councils … etc" and "Finalise proposals").

Q3: The Guidance says that NHS Boards "should develop proposals for service change in partnership with all affected groups and communities".

Do you agree with this? How can it be put into practice?

What do you think of the guidance given in the document and its annexes about how this should be done?
In the next part of our discussion I would like your views about the formal consultation part of this process, where definite proposals or options are being put forward in written form and possibly other ways too. (Point to part of flow chart from “Produce consultation document” down to “Receive comments and consider alternative suggestions … etc.”)

Q4: What do you think of the guidance given in the document and its Annexes about how this formal consultation should be done?

How might this guidance (on formal consultation) be improved?

Now looking at this final part of the process (“Make decision” onwards): NB if your copy or that of any of the participants contains an item “Expert group” just before the item “Scottish Ministers”, this is a mistake - it was in an early version produced by the Scottish Executive - we also sent out a few copies of the wrong version. If anyone queries it, just say it is a mistake and should not be there.

Q5: If disagreement remains after consultation has been carried out, how should NHS Boards proceed?

Methods for public involvement

In the flow chart it suggests at various points that there are various possible methods that might be used to get the views of the public. (Item 2 “Involve Health councils …etc.” and about halfway down “(Consider other possible consultation techniques)”.) In Annex C there is whole list of different methods that Boards might consider. (Put up flip chart of Annex C headings at this point.)

Are there any particular methods you would rule out?

Are there any other methods not listed that you think are particularly valuable?
Q6: Without getting into detailed discussion of individual methods just now, what do you think of the general principle of encouraging the Board to choose from a range of methods like this?

Are there any particular methods you would rule out?

Are there any other methods not listed that you think are particularly valuable?

Overview

Now I want to broaden the discussion out to look at the whole idea of public involvement as it is described in the Guidance.

Q7: Do you see this kind of public involvement as a valuable activity?

Q8: Is there any downside to this kind of public involvement?

Q9: Do you think NHS Boards can and will make public involvement happen in the way it’s envisaged here?

The effect of the Guidance

Q10: Overall, what effect do you think the Guidance will have on the way that Boards go about involving the public in service change?

Q11: Overall, what effect do you think the Guidance will have on the extent of public influence on service change? And is this a good thing or a bad thing?
Q12: Do you think the guidance will make it easier to reach decisions which can be accepted by all those who have been involved?

Q13: Do you think it will be clearer than at present whether the Board has carried out public involvement and consultation to the required level?

Q14: How might the Guidance be improved? (in ways other than those already covered in discussion)

Q15: Are there any important issues that the Guidance doesn't cover?

7 June 2002
Appendix 2: Organisations taking part

ARGYLL AND CLYDE HEALTH BOARD AREA

Informed public
- Ardhattan Community Council
- Inverclyde Council on Disability
- Phoenix Community Health Project
- Helensburgh, Lochaber and Lomond District Community Care Forum
- Inverclyde Patients' Forum
- Representative involved in the consultation of the review of maternity services (Argyll and Clyde)
- Community Care Forum including Elderly Forum and Hospital Forum (Gourock area)
- Local Health Council

NHS and LA managers
- Argyll and Clyde NHS Board
- Argyll and Clyde Acute Hospitals NHS Trust
- Renfrewshire and Inverclyde Primary Care NHS Trust
- Inverclyde Council
- Renfrewshire Council
- Argyll and Clyde Health Council

BORDERS

Informed public
- Local Health Council
- Community Councillor
- Health Promotion Worker
- Borders Supported Living Service, Penumbra
- Peebles and District Community Council
- Elder Council
- Borders Voluntary Community Care Forum
- Representative of the Chronic Disease Management Health Panel
NHS and LA managers
- Borders NHS Board
- Borders General Hospital NHS Trust
- Borders Primary Care NHS Trust
- Scottish Borders Council

FIFE

Informed public
- Local Health Council
- Miscarriage Association
- Voluntary Sector Health VONEF
- Fife Advocacy
- Leslie Community Council
- Representative involved in the consultation of Randolph Wemyss Hospital and involved in consultation on behalf of Asthma Group

NHS and LA managers
- Fife NHS Board
- Fife Acute Hospitals NHS Trust
- Fife Primary Care NHS Trust
- Fife Council

FORTH VALLEY

Informed public
- Local Health Council
- Clackmannan Community Panel representative
- Representative of the Stirling Assembly involved in Acute Services Strategy
- Stirling Health & Wellbeing Alliance
- Falkirk Voluntary Sector Community Care Forum
GRAMPIAN

Informed public
- Local Health Council
- Star Campaign (closure of Tornadee Hospital and Roxburgh House)
- Chalmers Hospital Campaign Group
- Community Care Project
- Quarriers Epilepsy
- Mental Health Reference Group
- Local Health Care Co-operative
- Service User Project
- Mile-End Primary School (involved with Young Advisors Group for consultation on the new Sick Children's Hospital)
- Friends of Inch Hospital
- VSA Carer Centre

GREATER GLASGOW

Informed public
- Local Health Council
- Centre for Independent Living
- East End Health Action, Dalmarnock Initiative Base
- CASE Project (elderly services and primary care issues)
- Family Council, Yorkhill Hospital
- HS Forum SE
- North Action Group (involved with service changes at Stobhill Hospital)

NHS and LA Managers
- Greater Glasgow NHS Board
- North Glasgow University Hospitals NHS Trust
- South Glasgow University Hospitals NHS Trust
- Yorkhill NHS Trust
- Greater Glasgow Primary Care NHS Trust
- South Lanarkshire Council
- East Dunbartonshire Council
- Glasgow City Council

HIGHLAND

Informed public
- Local Health Council
- Caithness & North Sutherland Health Forum
- Highland Users Group (HUG)
- DASH/PACS
- Highland Community Care Forum
- Age Concern Scotland
- Inverness Osteoporosis Group
- An individual involved with the East Highland LHCC and the Putting Patients First Forum

NHS and LA managers
- Highland NHS Board
- Highland Acute Hospitals NHS Trust
- Highland Primary Care NHS Trust
- Highland Council
- Highland Health Council

LANARKSHIRE

Informed public
- Local Health Council
- PHACTS
- Lanarkshire Community Care Forum
- South Lanarkshire Carers Network
- Member of the User and Carer Involvement Team
- East Kilbride LHCC
- Cumbernauld and Kilsyth LHCC
- Lanarkshire Kidney Patients Association
- CASE
- Clydesdale United
- Individual involved in Learning Disability Consultation
- Princess Anne Care Line

**LOTHIAN**

**Informed public**
- Local Health Council
- AIMS
- Gracemount Community Education Office
- Be Well
- Midlothian Community Care Forum
- Public Reference Group for Health, North West LHCC
- Windsor Park Residents and Tenants Association

**NHS and LA managers**
- Lothian NHS Board
- West Lothian Healthcare NHS Trust
- Lothian University Hospitals NHS Trust
- Edinburgh City Council
- West Lothian Council (written comment)

**TAYSIDE**

**Informed public**
- Local Health Council
- Dundee Age Concern
- Princes Trust Carers Centre
- The Action Groups to Save Stracathro
- Parents for PRI and Hands Off PRI
• Representatives of a Campaign Group involved in the future of Stracathro Hospital
• Lay assessor on Clinical Standards Board

**NHS and LA managers**

- Tayside NHS Board
- Tayside University Hospitals NHS Trust
- Tayside Primary Care NHS Trust
- Dundee City Council
- Perth and Kinross Council
- Angus Council (written comment)

**WESTERN ISLES**

**Informed public**

- Local Health Council
- Community Councillor
- Representative of Learning Disability Partnership
- Local Councillor involved in a campaign regarding the closure of a local hospital
- WI Care User Supporters Network
- Voluntary Sector Care Forum
- Children NCH
- Cul Taic, Cancer Support Group
- Cearns Community Project
- Alzheimer Scotland

**NHS and LA managers**

- Western Isles NHS Board
- LHCC representative
- Comhairle nan Eilean Siar (Western Isles Council)