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.

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

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 Scottish Consumer Council and Scottish Health Feedback held a series of discussion meetings around the country to get reactions to the guidance.

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
- eleven 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
- one meeting with members of the Executive of the Scottish Association of Health Councils, who were either health council chairs or members, and one meeting with health council chief officers (or staff deputising for them).
Each 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.

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 beginning to take 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.
DETAILED COMMENTS ON THE DRAFT GUIDANCE

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, 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-refer 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.