# CONSULTATION REPORT

Report of the Southwark Health and Adult Care Scrutiny Sub-Committee

March 2010

Southwark Council

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## 1. Introduction and background

1.1 During the 2009/10 municipal year, the health and adult care scrutiny sub-committee responded to a number of public consultations undertaken by the local NHS trusts. Aspects of this experience impelled us to request information from each of our key NHS partners on the expense of public consultations and their impact on final decisions.

1.2 While we did not plan within our work programme to review or comment on consultations generally, the evidence we obtained and the experience of participating as a consultee raised issues that we feel warrant a brief report. Our aim is to highlight examples of current good practice; to identify what further lessons may be learned; and to share our concerns.

### Statutory context

1.3 In addition to their pro-active thematic and performance related review work, health scrutiny committees have a statutory consultee role provided under the Health and Social Care Act 2001: NHS bodies are obliged to consult with health scrutiny on proposed variations or developments of health services that are deemed substantial. Members' views on both the substantive issue and the plans and process for consultation are significant and where health scrutiny committees believe that inappropriate or inadequate steps have been taken, they can ultimately refer their concerns to the Secretary of State or Monitor, where:

i. the committee is concerned that consultation on substantial variations or developments of services has been inadequate; [and/or]

ii. where the committee considers that the proposal is not in the interests of the health service.

1.4 Parallel to this report, scrutiny officers from Southwark and Lambeth councils along with staff from each of the key local NHS trusts are reviewing the way in which the sub-committee is notified about proposed service changes and are looking to identify a more effective approach for processing substantial variations and the requisite consultation with health scrutiny committees.

## 2. Key Evidence Considered

### Examples of good practice

2.1 At their 4 February 2009 meeting, members of the 2008/09 sub-committee received a presentation regarding the redevelopment of the King's College Hospital (KCH) Emergency Department (ED), for which the consultation ran from 16 January to 10 April 2009.

2.2 In view of the sub-committee's involvement in the earlier related decision to close the ED at the Maudsley Hospital, members raised concerns that there was no proposed provision for "a designated space within A&E which will provide a safe and segregated area for mental health service users who require assessment", and that this option was not included in the consultation, despite previous suggestions that it be added.

2.3 The sub-committee consequently recommended that "the needs of patients with mental health issues be carefully considered in final design factors and that no decision is taken until mental health service users groups are in agreement with the proposed changes." Members also made clear that they would like "to be satisfied that the issues raised by such groups have been fully addressed."

2.4 At our 29 July 2009 meeting, current members of the sub-committee requested an update on the proposed redesign of the ED, having heard that the proposals affecting mental health patients were being altered. It was reported that there had been considerable positive feedback on the overall model of care, but that responses about the provision for mental health patients (and for paediatric users) had generally been negative and that these comments had impelled a revision of the action plan. KCH had decided, for example, to expand the footprint of the new development into its Jubilee Wing, giving greater flexibility on how to provide for mental health and paediatric patients.

2.5 It was also explained that a mental health working group would be helping to plan patient flows, and working with the architects and user groups to effectively plan the ED redesign for mental health users.

2.6 At our subsequent 7 October 2009 meeting, we were informed that the redesign plans had been revised to include separate space for ambulatory and mental health patients; that the meet and greet area for all patients would be the same, but that mental health patients would then be directed immediately to a separate waiting area directly off the main atrium.

2.7 Members were also encouraged to hear that Southwark Mind had been speaking very favourably to the press about the proposed changes for mental health patients, and that the new plans had been unanimously well received. We believe that this outcome merits attention as an example of a genuine consultation.

2.8 While we recognise that health scrutiny committees have a statutory right to require information and attendance from senior council officers and staff, we would similarly like to highlight the consistent cooperation from all trust partners to send relevant senior officers and board members to attend scrutiny meetings in order to present proposed service changes and respond to member questions.

2.9 In response to a letter on behalf of the sub-committee requesting further information (17 August 2009), NHS Southwark arranged an informal meeting with several senior staff members from SLaM and the PCT regarding the restructuring of community drug and alcohol services. This was a useful means for conveying a professional understanding of the proposed changes and provided an opportunity to discuss what additional information could assist members in our consideration of the key clinical, financial and social issues.

2.10 We have also found considerable benefit from the opportunities to make site visits to affected trust premises, and have appreciated the willingness of LINk members to attend.

2.11 Recent letters from Guy's and St Thomas' and Kings College Hospital regarding the scale of impending changes due to changing financial circumstances are also strongly welcomed. Similarly, the short briefing from Susanna White, NHS Southwark chief executive, at our 7 October 2009 meeting about imminent cuts and consequent changes was a useful signal of the likely volume of forthcoming consultation issues.

**Lessons to be learned / further good practice to establish**

**Timing**

2.12 The sub-committee's experience as a consultee that has prompted the most concern relates to the consultation on the proposed re-structuring and relocation of drug treatment and addiction services based at Marina House.

2.13 This issue first came to the attention of this sub-committee at its July 29 2009 meeting. One member had become aware by chance of a consultation document posted at the Marina House premises, prior to any notification of the proposed changes to the sub-committee or local elected representatives. The paper was later identified by officers as a pre-consultation document, designed to seek the views of current users. It took as its premise, however, that Marina House would no longer be a location for addiction counselling and the related treatments currently provided, and included the following statement: "We are not consulting on whether or not we should provide all SLaM drug and alcohol services from one site instead of two." It therefore seemed evident that a decision had already been taken without appropriate consultation.

2.14 The above citation also reflects an apparent officer misperception, that as the re-structuring intends a change to the location of some services and not to the actual services provided, it was not considered necessary to bring the issue to the sub-committee. This is contrary, however, to the Department of Health guidance on section 7 of the Health and Social Care Act 2001 (now section 244 of the NHS Act 2006), which outlines four key issues that should prompt officers to confer with scrutiny members when deciding whether proposed changes are substantial and what could comprise the appropriate scope of consultation. The first of these issues is change to "service accessibility", which in this case would be affected by the relocation.

2.15 We therefore wrote formally to NHS Southwark, requesting - at the earliest opportunity - details of the scope and timeframe for the discussions with service users; and the estimated timing for formal consultation with the sub-committee, with the view to decide whether the changes would be deemed a substantial variation, and to agree an appropriate consultation process.

2.16 Officers highlighted at the sub-committee's subsequent 7 October 2009 meeting that the purpose of the related agenda item that evening was to seek the sub-committee's agreement on the proposed consultation, as had been agreed by the PCT Board at their 24 September 2009 meeting.

2.17 Following the discussion, we agreed with officers that they undertake as follows:

i. to clarify the wording used in the proposals, and clarify the consultation options;

ii. to outline the proposed length of the consultation period;

iii. to provide a list of the groups and individuals with whom the PCT will consult, and a list of the groups that are likely to be impacted by the changes;

iv. to address the concerns raised in the September 24 2009 letter from Councillor Noakes to the PCT Board.

2.18 Despite further contact, we first received a copy of the revised consultation document at the sub-committee's next meeting (18 November 2009) which was also when we first learned from officers that this had been published and that the consultation period had been finalised and had in fact started.

2.19 We therefore emphasised that we should be made aware of proposed changes as early as possible. This would be in keeping with Department of Health guidance but, more significantly, the sooner members are informed about problems that are likely to trigger changes and about proposals themselves, the more likely we will be inclined to respond as constructively as possible rather than critically.

2.20 To be promptly and properly informed would also help us to effectively respond to related issues of difficulty with service users, and to feed back to the trusts evidence of any issues of sensitivity.

2.21 Given the prospect of immense changes necessary by each of our local NHS partners, we would likewise request that the sub-committee is made aware of any changes being considered as early as possible to give us time to consider the extent to which we wish and are able to become involved. This will allow members to assess where we can best add value to such decisions and agree on suitable criteria that the sub-committee can use for selecting those issues which they can most effectively influence.

**Basic data**

2.22 In order to effectively respond to service user and related constituent issues, there is a span of core information that would help us to more swiftly understand and assess the likely impact of the proposed changes. At times this has either been absent or unclear in consultation documents and related briefing papers. We would therefore request that basic information, such as the following, be consistently included and clear:

- An outline of who and how people are expected to be affected, including a list of the likely most affected wards or areas in the borough; the predicted number of residents / service users affected; and whether particular communities or age groups etc will be impacted more than others;

- An outline of any specific research/ surveys undertaken or commissioned by the trust that underpin or have significantly influenced the consultation options; including any that have been critical of the proposals or equivalent proposals elsewhere;

- An explanation of whether the changes result from policy or financial imperatives etc;

- An equalities impact assessment.

**Consultation content and genuine options**

2.23 At its 24 June 2009 meeting, the sub-committee was briefed on the report that synthesised and analysed the consultation feedback on the Transforming Southwark's NHS strategy, regarding a five to ten year strategy about the shape and constellation of local health services. We also used this as an opportunity to discuss aspects of the consultation methodology.

2.24 While members realised that the objective of the consultation had been to obtain feedback on the proposals at a broad strategic level, we believe that the consultation survey was overly simplistic, to the effect that this undermined the consultation's validity:

- Many of the survey questions were very general and devoid of context, to the extent that they seemed designed to elicit responses that could only favour the proposals;

- The survey failed to substantiate why respondents supported or doubted the merit of the proposals: For instance, where as many as 30% of respondents stated that they did not know whether the proposals would improve local healthcare, and approximately 8% believed that improvements would not be achieved, no further questions were asked to establish the reasons behind such reservations;

- As the consultation presented new plans about where and how to allocate resources, the survey should have made clear what alternatives exist, and particularly what services may be reduced or relocated.

2.25 As stated in the consultation report, respondents were not asked about their preferences for intermediate care, and this issue was deliberately omitted from the proposals and survey: "Intermediate care is due to be further reviewed and thus has not formed a major part of this consultation." (p. 63). In effect, the issue of intermediate care was left in a vacuum and respondents were left insufficiently informed about the broader outcomes of the proposals, and the implications for a key element of healthcare. We expect that the respondents could have answered in a significantly different way, had the relevant proposals for intermediate care been incorporated.

2.26 Regarding the content of the consultation document on the re-structuring and relocation of drug treatment and addiction services, we sought assurance from officers at our 7 October 2009 meeting that the document would reflect the needs of the local communities and not lead respondents to a preferred answer.

2.27 We queried again in November what outcomes from the consultation would be necessary to make officers rethink the preferred option, and were told that a different way of re-structuring the services would need to be proposed that still delivered the savings. While we acknowledge that the changes are impelled by the need to achieve savings to the value of £340,000 from SLaM, and to redirect appropriate elements of the services back into primary care, we were concerned to learn that only one of the options outlined in the consultation document was actually viable and could potentially achieve these outcomes.

2.28 We think it should be basic that consultation documents are clear about a trust's proposed changes and equally clear about what viable alternatives or variations on the changes have been identified that could achieve similar outcomes. The range of feasible options should also be outlined as objectively as possible, without leading respondents to a preferred answer.

2.29 Moreover, alternative proposals should not be presented as options, where a trust does not in fact believe such an option to be practicable – unless this is transparent in the consultation document and respondents are invited, for example, to identify how such alternatives could be made viable.

2.30 As referred to above, we are grateful to have been informed early of the scale of savings that our NHS partners are compelled to achieve over the next financial year and onwards. Particularly in such cases, where the spectrum of services to be affected is so broad, we would like to receive details of where savings achieved beyond the requisite budget percentage will be re-directed. For example, where savings in one service area are achieved above the obligatory 10% at Guy's and St Thomas' - for instance to the value of 25% - how would the 15% 'surplus savings' in this case be re-directed?

2.31 We would similarly be grateful for an outline of the feasible trade-offs that would affect the consultation proposals, such as options to extend patient waiting times for certain treatments rather than relocate services.

**Consultation feedback**

2.32 While we have particularly welcomed the revisions to the King's hospital ED re-design that resulted from the consultation, members of the sub-committee first heard of these improvements for mental health patients via the local media, and subsequently sought further details from officers.

2.33 At our 20 January 2010 meeting, we agreed with officers that, at the Southwark PCT board meeting the following day, the sub-committee's request be relayed that the decision regarding the re-structuring of drug and alcohol services be delayed for a few days, to give the Health Secretary, Rt. Hon. Andy Burnham MP, the opportunity to respond to the related letter of January 14 2010 from the Rt. Hon. Tessa Jowell MP. To date we have not been informed whether the board agreed to this request and/or of the board's final decision regarding the re-structuring.

2.34 We recognise that the King's ED plans were subject to the assessment and input of streamed steering groups, as well as project and trust board approval before their finalisation, and that such processes can duly prolong the usual decision period. We believe it would be an appropriate courtesy, however, that we receive written notification of trust decisions on consultation issues for which we have submitted a written response, within a few days of the decision having been made. These should also include replies to the sub-committee's key recommendations, in particular where these are refused.

**Recommendations:**

1. That the sub-committee be informed of proposed changes to health services by the local NHS trusts as early as possible, in order to have a reasonable opportunity to contribute to plans for consultation and to be able to respond effectively to constituent queries.

2. That consultation documents or related briefing papers to the sub-committee include the following information:

   - An outline of who and how are people expected to be affected by the proposed changes, including a list of the likely most affected wards or areas in the borough; the predicted number of residents / service users affected; and whether particular communities or age groups etc will be impacted more than others;
   - An outline of any specific research/ surveys undertaken or commissioned by the trust that underpin or have significantly influenced the consultation options; including any that have been critical of the proposals or equivalent proposals elsewhere;
   - An explanation of whether the changes result from policy or financial imperatives etc;
   - An equalities impact assessment.

3. That consultation documents are clear about a trust's proposed changes and equally clear about what viable alternatives or variations on the changes have been identified that could achieve similar outcomes.

4. That the range of feasible options be outlined as objectively as possible, without leading respondents to a preferred answer.

5. That consultation documents do not include options for the proposed changes, where a trust does not believe the option(s) to be practicable.

6. That the sub-committee be invited to help shape service change options, where these are not impelled purely by clinical considerations, and in particular where they involve trade-offs with other services, or service levels, etc.

7. That the NHS trusts are more pro-active about informing community councils of proposed changes that would affect their local communities, and ensuring that the issues are aired in public.

8. That the NHS trusts inform the sub-committee of consultation outcomes and provide feedback on the sub-committee's response recommendations, where this is reasonable, and particularly where these are refused.

**Health and Adult Care Scrutiny Sub-Committee**

Councillor Lorraine Zuleta (Chair)
Councillor Dora Dixon-Fyle (Vice-chair)
Councillor Aubyn Graham
Councillor Michelle Holford
Councillor Lorraine Lauder
Councillor Jonathan Mitchell
Councillor Caroline Pidgeon