

Questions

1. Do you agree that an expert panel is the most effective way to provide independent scrutiny? If not, what would be your preferred choice?

Information in the consultation paper does not provide the evidence required to identify why the expert panel is the most effective methodology.

The use of Decision Conference is more likely to be of value as part of the public engagement process.

The difficulties identified in the paper with a Scrutiny Body are agreed.

The use of an Expert Panel however is not viewed as the most appropriate approach. This is because this approach leads to a potentially adversarial relationship between the “Expert Panel” and health system ‘experts’. It suggested that a committee / commission model or a Citizens Jury might be preferable. This would enable both the Health System and the commission/committee group to benefit from leading expert advice, share and review evidence and hear the views of local population and interest groups and question these contributors. Some of this “evidence” would not just be applicable to an individual

Health Board service change (e.g. some of the basic evidence on maternity and accident and emergency or forensic mental health provision) but would be applicable across NHS Scotland and should only need to be heard once for Scotland in a five year period. Any supplementary local information could be dealt with on a case by case basis.

This would mean that the committee/commission would gain in depth understanding of the issues and be able to probe evidence.

The consultation paper queries under paragraph 16 for a decision conference how a representative group of local people could be drawn together for a decision conference. The same query might be raised in relation to a Citizens Jury. However it should be possible to get a representative cross section of the local population and community groups for this approach. After all a representative sample is required for the current option appraisal process recommended by the Green Book. Many local authorities and CHPs are developing Citizen's Panels and these would be a good source. Similarly there would be an important role for PPFs. Clearly the skills of an impartial and experienced Chair would be key.

One of the difficulties with an "Expert Panel" approach is the range of the panel expertise. Clearly in relation to clinical expertise a Health Board has much wider access to a range of expertise. If the "Expert Panel" commissions separate expertise there is then difficulty that these different experts will contradict each other. This remains a strong possibility, as it is unlikely that complex reconfiguration proposals will ever be clearly evidence-based in the same way as medical interventions can often be. There will always be the need for high levels of judgement and interpretation of the evidence and its application. Given this, it is proposed that the expert evidence is jointly commissioned.

In establishing an Independent Scrutiny Process it is essential that there is clarity as to when a panel/jury is commissioned. It must be for truly significant change to services or the natural evolution of organisations to meet change will be stifled leading to a diminution of services. If a panel approach is pursued it is essential that there are clearly agreed terms of reference which must ensure appropriate engagement with interested parties and assessment of evidence.

Further clarity is required as to why the ISP process would apply to only the NHS – why not all public bodies? If Boards become an elected body would the process of ISP apply?

2. Do you agree that the role of the panel should be to assess the safety, sustainability, evidence-base and value for money of proposals for major changes to local NHS services?

The difficulty with this heading is: how are these criteria defined and what is regarded as evidence? Health Boards plan ahead to anticipate potential changes hence the information provided may anticipate changes in safety or sustainability but it might be

difficult to prove this conclusively. Thus it may not be regarded as “evidence”. However, it would be inadvisable to wait until a service deteriorates or collapses before a change is made.

Criteria needs to be clearly defined providing specific measurements where possible.

Quality is not mentioned on this list. Under Annex 1 paragraph 6 patient centeredness is also outlined as a criteria and again this requires definition in detail as it may be defined by the general public as local access while for patients and clinicians it might relate to seamless care and ensuring the patient is cared for by the right professional first time in an emergency.

In relation to evidence base the recent ISPs in Ayrshire & Arran and Lanarkshire have demonstrated there is no conclusive ‘evidence base’ in research of health policy on service reconfiguration. This is because research generally relates to care / treatment models which can be delivered in a variety of service configuration

3. Do you agree that the chair should be a lay person appointed by Scottish Ministers?

Any chair should be subject to and should follow the processes used for the appointment to chairs of Tribunals

The proposition in this paper suggests that the Chair should always be a lay person. This would exclude a wide range of people who would have relevant experience in impartially reviewing research, which would be unfortunate. Surely the main test should be in relation to impartiality and the skill required for the role.

4. Do you agree that the panel should have a lay majority among its members?

As stated above a small panel approach is not supported.

However, if this is pursued then it is less important that the panel has a lay majority and more important from whom it takes expert advice, how it is able to interpret this expert advice and how it engages with the local community. Health care is highly complex and there is a risk of trying to simply very complex information. Hence it is essential that “expertise” of the lay panel is built up over time by either hearing evidence from a range of experts or having a sitting panel. Panel members will require training as well as gaining knowledge and understanding of the NHS.

5. Do you agree that the panel should assess the evidence and options during the process of public engagement prior to consultation, and provide a commentary on these that would be available to the Board and to Ministers in reaching decisions?

It is agreed that the independent assessment should take place first but also that if a commission/committee or Citizens Jury model is used this might consider public feedback and hence mitigate some aspects or shorten the period of public consultation.

Public consultation as currently implemented (i.e. by public meetings) is not a useful model. This is because complex messages about health care are hard to simplify for easy mass communication. Public meetings are a very difficult format to have in depth or complex debate. Engagement with smaller groups is easier but this may mean that smaller groups express views at the end of public consultation which are at odds with the “public” or “media” coverage.

There is also a concern about the potential time periods involved in an ISP approach followed by a public consultation particularly if an agreement is not reachable between a Health System and the ISP prior to the consultation. There is also a difficulty if new information is raised during the public consultation as to whether the ISP is reconvened at the end. This could lead to an iterative approach that is time consuming, expensive in staff resources as well as demoralising. Hence a model of joint enquiry or Citizens Jury hearing evidence is preferred. This Jury could also be lay and professional and might lead to a consensus and shared view. This will be more reassuring for the public and more decisive.

6. Do you have any other comments on how independent scrutiny should be carried out, or on the guidance on “Informing, engaging and consulting the public in developing health and community care services” at Annex 3?

Throughout the consultation paper, Annex 3 is referred to as containing the current national guidance on informing; engaging and consulting the public in developing health and community care services. However, this document has not as yet been formally issued to the Service.

The extant guidance, issued by the Scottish Executive Health Department as a draft in 2004, was, during the course of 2007, the subject of discussion by the Designated Directors for Patient Focus and Public Involvement and of review by a sub-group of their members. Arising from these discussions, revised draft guidance was developed, similar to that in Annex 3, but this has not been formally issued.

One of the most challenging aspects of revising the 2004 draft guidance was attempting to define what constitutes “major change” and, to assist in this task, the Scottish Health Council was asked to give this consideration and to develop a set of possible criteria.

Although reference is made to this in paragraph 12 of Annex 1, there is no mention of it in Annex 3, a key omission as much of the decision-making around what extent of informing, engaging or consulting needs to take place rest on this.

Turning to Annex 3 itself, it would be helpful and provide greater clarity if distinction could be made between the processes of informing, engaging and consulting. The document first mentions “major impact” in paragraph 7. It is then not clear as it continues whether the remainder of the document applies to major change. For example, paragraphs 15 and 16, headed “Planning”, could related to circumstances when there is no major change envisaged; however, paragraph 15 refers to an “engagement process” whilst paragraph 16 refers to a “consultation process”. It is important that there is clarity in the terms used.

Achieving clarity may be assisted if the document included at an early point the criteria being developed by the Scottish Health Council (referred to in Annex 1) that aim to assist in deciding whether a service change is “major”, followed firstly by the informing and engagement processes to be followed when is it deemed not to be major, and secondly by the processes to be followed, when it is. This may be amplified by an algorithm. Whilst it is accepted that it is not possible to cover every eventuality, the document does helpfully refer to the roles of the Scottish Health Council and of the Healthcare Policy and Strategy Directorate in providing Boards with assistance in reaching decisions on processes.

It is noted that there is sometimes a conflict of interest between patients and community opinion, for example in citing mental health provision. Also patients who use the service, for example cancer patients, may be happy to travel further to a service which understands in detail the care they require (the patient is seen by a group of professionals in an emergency who they have had previous contact with). This may not be viewed by the general public who have not undergone cancer care as a local enough service.

Finally, given the resource in terms of staff input and length of time required from ISP and public consultation it is essential that the ‘bar’ of what is considered to be a ‘major’ change is set high. Alternatively a more efficient and collaborative methodology is required to reduce the timescale and resource implications.

7. Do you have any other comments on either the consultation process or your preferred choice?

Scottish Health Board and the Scottish Health Council have extensive experience of undertaking and reviewing public consultations and the lessons from these should be considered. Health services are highly complex systems and the debates around service provision cannot be communicated through public meetings or by simplified messages through the media.

This is demonstrated by the findings that representatives of the public who have been

engaged in detail about background to services and potential changes have a much more sophisticated understanding. Therefore a system is required which builds trust in an independent model of scrutiny under which representatives of the public can hear detailed and complex evidence and reach a view on behalf of the local population.

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