



Factors that influence the way local communities respond to consultation processes about major service change: A qualitative study

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ABSTRACT

Objectives: In England, proposed service changes such as Emergency Department closures typically face local opposition. Consequently, public consultation exercises often involve protracted, hostile debates. This study examined a process aimed at engaging a community in decision-making about service reconfiguration, and the public response to this process. **Methods:** A documentary analysis was conducted to map consultation methods used in an urban area of England where plans to consolidate hospital services on fewer sites were under discussion. In-depth interviews ($n = 20$) were conducted with parents, older people, and patient representatives. The analysis combined inductive and deductive approaches, informed by risk communication theories.

Results: The commissioners provided a large volume of information about the changes, alongside a programme of public events. However, the complexity of the process, together with what members of the public perceived to be the commissioners' dismissal of their concerns, led the community to question their motivation. This was compounded by a widespread perception that the proposals were financially driven.

Discussion: Government policy emphasises the importance of clinical leadership and 'evidence' in public consultation. However, an engagement process based on this approach fuelled hostility to the proposals. Policymakers should not assume communities can be persuaded to accommodate service change which may result in reduced access to care.

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1. Introduction

Health care systems around the world face the challenge of meeting rising demand for care with diminishing financial resources [1,2]. Attempts to tackle this dilemma may involve reorganising health care, for example by consolidating services across a region on fewer hospital sites. In England, whilst decision-makers seek potential health

gains for patients by reorganising care, as well as cost savings, service change proposals often face public opposition. This commonly centres on concerns about future access to services [3,4]. Plans to alter Emergency Department (ED) services typically create the greatest concern [5]. Much of the public anxiety relates to the safety of centralised services and the potential risks that may be involved in having to travel further for care in an emergency [5]. Communities often argue that 'lives will be put at risk,' if such proposals go ahead [1].

Consequently, risk is part of the national discourse about service reorganisation, or reconfiguration. In the UK,

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reconfiguration is defined as ‘a deliberately induced change of some significance in the distribution of medical, surgical, diagnostic and ancillary specialties that are available in each hospital or other secondary or tertiary acute care unit in locality, region or health care administrative area’ [6]. It is a measure of change that directly addresses operational rather than structural change: hospitals may merge, form networks, or change their divisional or governance structures, without reconfiguring services. Spurgeon et al. point to parallels between the reconfiguration process and the literature about technological or environmental risks. Public perceptions about the risks involved in service reconfiguration are frequently at odds with the view put forward by ‘expert’ decision-makers, as is often the case with environmental hazards. They suggest that this may be because proponents and opponents of change operate within different paradigms of understanding about risk [4]. Sociologist Brian Wynne’s research about the intersection of lay and expert knowledge offers a means of explaining this. Informed by the contextual model of risk communication, Wynne acknowledges that individuals do not simply respond as empty containers for information [7,8]. Instead, the way the public process risk information is shaped by their previous experiences and personal circumstances [9]. Wynne argues that the public are likely to be sceptical, critical or hostile to scientific statements when ‘expert’ accounts of physical reality conflict with their knowledge and understanding [10].

In England, Section 242 of the NHS Act 2006 requires health care managers and purchasers – known as commissioners – to seek the views of affected parties, including patients and the public, if changes to local NHS services are being considered [11]. However, this consultation process often involves protracted, sometimes hostile local debates, leading to delays which some argue pose ‘significant risks to the delivery of safe services’ [12]. At the same time, there is a perception that the public do not in reality have an opportunity to influence the outcome of the decision-making process [5]. The Independent Reconfiguration Panel (IRP), provides the UK government with independent advice about reconfiguration proposals, when local agreement cannot be reached [1]. Local government representatives in affected areas may refer proposals to the Secretary of State for Health if they believe either that the consultation has been inadequate, or that the proposals are not in the best interest of the local population. The Secretary of State may then seek the advice of the IRP [12]. By mid-2012 the IRP had undertaken 19 full reviews of contested plans for health service change in England and offered written advice on several others [3]. The most frequent reasons for referral to the IRP are listed in Fig. 1 [1].

In light of these concerns, several groups have called for improvements in both the policy and process of public consultation about proposed service reorganisations [5,12]. To address this, government documents increasingly emphasise the role of ‘evidence’ and better consultation with the public, apparently assuming that if local communities are ‘involved enough’ and are presented with the ‘right evidence’ they will be convinced of the need to change [6]. However, Wynne and others have repeatedly shown that

Key reasons why reconfiguration proposals are referred to the Independent Reconfiguration Panel:[1]

- Inadequate community and stakeholder engagement in the early stages of planning change
- The clinical case has not been convincingly described or promoted
- Clinical integration across sites and a broader vision of integration into the whole health community has been weak
- Proposals that emphasize what cannot be done and underplay the benefits of change and plans for additional services
- Important content missing from reconfiguration plans and limited methods of conveying information
- Health agencies caught on the back foot about the three issues most likely to excite local opinion – money, transport and emergency care
- Inadequate attention given to the responses during and after the consultation

Fig. 1. Key reasons why reconfiguration proposals are referred to the Independent Reconfiguration Panel.

efforts to ‘educate’ the public by decreasing ‘deficits’ in their understanding typically fail because the ‘expert’ view conflicts with local people’s knowledge and understanding [4,13].

A limited literature examines the process of reconfiguring hospital services, especially the dynamics of local decision-making [5]. Two previous studies explored the views of a range of individuals engaged in reorganisation [5,6], but neither examined the public engagement process in detail. This paper presents the findings of a qualitative study examining the process of public engagement in an urban area where major changes to hospital emergency services were being proposed, and the local community’s response to this process. We have conceptualised the public consultation process as a process of risk communication. We have drawn on theories of risk communication as an analytical focus, including the work of Wynne, to examine the ways in which the public responded to the consultation process.

2. Methods

Documentary analysis was used to establish background details about the proposed service changes and the consultation process. This included drivers for change; how the reorganisation was governed and developed; as well as the methods used to involve stakeholders in the decision-making process.

In order to explore the factors that influenced the public response to the consultation process, detailed, individual data were required. These were gathered in one to one interviews – an approach which permits the in-depth exploration of each participant’s preferences, motivations and decisions [14].

2.1. Study context

Participants were all residents in an urban area of England referred to as ‘Greenville’. At the time, a public consultation was taking place locally about consolidating a range of hospital services on fewer sites, including emergency care. If the proposals went ahead, an urgent care centre for minor injuries and ailments would replace the Emergency Department (ED) at the local district general hospital, ‘Greenville Hospital.’ Residents would be required

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