TRANSCRIPT

Episode 10 – Urgent temporary service changes

Paul Parsons - I'm Paul Parsons.

Caroline Latta - and I'm Caroline Latta.

Paul Parsons - Welcome to Not A Consultation

Caroline Latta - Our podcast on all things patient and public involvement and NHS service change.

Paul Parsons - Hello, everyone. We spend lots of our time talking about big planned service changes, the kind that involves a big team, big budgets and takes months, if not years, to plan and progress. Those are the kind of projects that include detailed plans for how to meet our legal duty to involve patients, carers and local people at each stage of the process. Today, we're going to look at a very different type of service change.

Caroline Latta - Yes, today we're going to look at the unintended, the unexpected, the unplanned. We're going to be talking about service changes made urgently as a response to unforeseen changes in circumstances.

Paul Parsons - To help us explore this tricky area, we've invited two people with very different perspectives to discuss urgent service changes with us.

Caroline Latta - So here's that conversation. And we started, as we always do, by asking our guests to introduce themselves.

Clare Trenchard - Hi, I'm Clare Trenchard. I'm the associate director of communications and strategic partnerships for Midlands Partnership NHS Foundation Trust. And I've celebrated, very recently, my 20th year in the NHS all in communications and engagement type roles.

Peter Edwards - Hello, I'm Peter Edwards. I'm a lawyer and a partner at Capsticks, specialising in public law, governance and decision making. And I've been involved in a number of major NHS service change programmes, including successfully defending the NHS from judicial review challenges in the courts.

Caroline Latta - And a very warm welcome to you both. Clare, can I come to you first, you're going to tell us about an unforeseen incident at one of your trust sites. Would you start by describing the site where the incident took place and the services provided there, please?

Clare Trenchard - The George Bryan Centre is an inpatient unit on the borders of Tamworth and Litchfield. It was two wards. One was for working age adults with serious mental illness that had 19 beds. And there was a ward for older age adults, primarily with a diagnosis of dementia, but not exclusively, with 12 beds.

Caroline Latta - So what happened on that night? Back in February 2019?

Clare Trenchard - We had a fire in the wing that was treating working age adults late at night and the fire ended up destroying the whole of the wing. The on site response was quite incredible, as you can imagine. Our chief executive was on site within minutes. We had staff, not necessarily working at the George Bryan Centre, but who live close to it, all convened on the site. The ward that caught fire was evacuated in less than four minutes. The staff were commended by our board. They were up to date with their fire training, so everybody was kept safe. There wasn't a single staff or patient that was injured during

the whole evening, which was quite incredible. We've got drone footage of the devastation that the fire caused and you can't quite imagine being there and being on site. The people who were in the ward were taken to our next nearest hospital, which is 30 miles away by whichever staff had a car and could take them. The wing that wasn't on fire there were twelve people in that wing and they were cohorted in the lounge as per their fire training. And incidentally, one of the women who was in that ward on the night came to one of our engagement events and described feeling totally safe. And I think that is such a testament to our staff when you think what was going on literally behind the doors. So one ward was destroyed, the patients in the other ward were kept safe.

Caroline Latta — Gosh, Clare that's amazing. Really good to hear how the staff training and the fire safety training and all the governance kicked in so that everyone was safe. What were the other actions that you needed to take from your perspective? Because I imagine that dealing with the incident itself was just the start of it.

Clare Trenchard - Yeah, that's right. And on the night of the fire, those attending the actual fire dealt with the media on the ground. We had drone footage of local media, so there was real time coverage of the fire. The priority for the next day was to confirm with our key stakeholders that their patients were safe and there were a lot of questions around our staff and what we were doing to support our staff, which I thought was a real testament to the kind of stakeholders that we work with. So we established a stakeholder database of those stakeholders that we knew would be interested either in geographic terms or service terms, this is a mental health inpatient unit, and set up regular daily updates that went out to stakeholders, which the gap between increased over time. There were clearly decisions that the board needed to take about the remaining ward and we kept stakeholders up to date with those discussions and outcome.

Caroline Latta - What were the changes that were made right then and also the changes in the days and weeks that followed?

Clare Trenchard - So our St George's Hospital site in Stafford, we held an escalation ward empty for the system to use at times of pressure. So fortunately we had an empty ward at the St George's Hospital, which was almost equal to the number of people that were displaced by the fire.

Paul Parsons - It's late at night, there's smoke in the air, sirens, blue, flashing lights, fire crews, police, lots of people. And you said staff turning up to help. That must have been an incredibly scary experience. What was the effect on the people who were there?

Clare Trenchard - I think in true NHS style, everybody kind of rose to the challenge. So the primary concern was for the safety of the people who we cared for and getting them to a safe place. So anybody that was there with a car who was prepared to take people to Stafford. So I know one person, I think, did two or three journeys, one person at a time, because people that were part of the fire who were in the ward were really distressed. And if you imagine they were in an inpatient setting indicating that they were already experiencing some acute mental illness and they were now having to deal with the distress of being moved. So in the dark, late at night, 30 miles away, I think the staff that were on duty were just magnificent. And the board commended their bravery. On the evening of the fire, the ward was evacuated in less than four minutes and people were kept safe.

Paul Parsons - We began by talking about the changes that were made in direct response to the fire that night, what happened in the days and weeks afterwards.

Clare Trenchard - There were already concerns about the George Bryan Centre. It was 30 miles away from a major site. It's on the site of a community hospital. The ability for MPFT as an organisation to cross cover wards if there was staff sickness was challenging. Given the national impetus to put community care first, there was already consideration about the George Bryan Centre and what we should do with it and what is the long term vision of our mental health services. So the older adult, we enhanced our community service almost immediately. So the board then had a decision to make about

the remaining ward at the George Bryan Centre, which now lost the ward that was able to provide support and cover in the case of either an emergency or staff sickness. So we now had twelve individuals being supported in a site 30 miles away from our major site. The board decided that it was not safe to retain that ward. So on a temporary basis, it agreed that it would close that ward and that happened in a phased approach. So this was a short stay ward, maybe three weeks at most. So as the patients were coming up for discharge, they were taken to an alternative placement, discharged from the unit, and within a matter of, I think, six to eight weeks, the remaining ward was temporarily closed.

What then happened with the staff was they were either redeployed to the St George's Hospital site to support the inpatient beds there, or redeployed into the community. We added an older age specialist to our community services. We supported those who had previously worked in a ward with training, because working in the community is very different from working in a ward. And we supported our community services with some training on supporting people of an older age. We also, from the ward were able to deploy a clinical psychologist with a specialist in older age and a therapy lead. So all clinical staff were either redeployed to St George's or the community services to enhance that offer.

Paul Parsons - You mentioned earlier on that you did an immediate stakeholder analysis and created a database of your stakeholders. Give us a flavour of who was on there.

Clare Trenchard - As you can imagine, there was quite some political interest and what was really reassuring for somebody working in mental health services whose bread and butter is actually challenging stigma, there was an incredible amount of support for our mental health services and for improving the health and wellbeing of the populations. And people were very supportive of the organisation and its services. So that's the first thing to say. We already had working relationships with the local MP, the Overview and Scrutiny Committee chair and officer. The League of Friends, who supported both the George Bryan Centre and the Community Hospital on whose site it sat, set up a fundraising campaign immediately and ring fenced for the George Bryan Centre. And actually we involved the League of Friends in the planning group that designed the engagement that followed. So they were great advocates, again of mental health and it was a really great opportunity. There were some voluntary and community sector

organisations based in Tamworth that were really keen to support a community offer around mental health. So we kept them up to date with what was happening in the George Bryan Centre. Clearly, the NHS and local authority partners as part of the Integrated Care System, or STPs as it was then, were key to keep involved and a number of individuals actually who came forward offering to help.

So out of what was very distressing and very difficult, there were some new relationships built and existing relationships confirmed.

Paul Parsons - Excellent. Thank you very much. Peter, I wonder if we could come to you. Clare's described there the surprise, an unforeseen circumstance where a service that a trust is providing ceases to be able to run, in this case through a fire in the building. What are a trust or a commissioner's legal responsibilities in that situation when something unforeseen happens which affects the running of a service?

Peter Edwards - Sure, as with any proposed service change, there are two separate legal duties that are in play. So the first of those is the duty of public involvement. And broadly speaking, there are similar public involvement duties for both commissioners and providers. So Clare's example, that is a duty under section 242 of the National Health Service Act. And interestingly, there is no reference in section 242 to urgency or emergencies or anything of that sort. It is simply a duty to involve the public when you are planning services, developing proposals for changes in those services and making decisions about those services. But we do have reference to urgency in the recently issued statutory guidance in respect of the public involvement duty. That's the guidance known as working in partnership with people and communities. And that has a section that deals with decisions in urgent situations. And it makes the key point that when you're considering how the public involvement duty will operate in those scenarios, you've got to consider it alongside the public interest in maintaining continuity of care and protecting the health, safety and welfare of patients and staff. So very much the initial response areas that Clare focused on in her example. And that guidance goes on to say that it will only be reasonable to justify carrying out a limited or indeed no public involvement exercise on grounds of urgency when the lack of time was genuinely caused by an urgent situation or where there's a genuine risk to the health, safety or welfare of patients or

staff. So I think that gives a sort of feel for how the public involvement duty will operate in these urgent scenarios.

We've then got the second legal duty, which is the specific duty to consult with Health Overview and Scrutiny Committees when there are proposals for substantial developments or substantial variations in the health service in a particular area. And those provisions, the legal duty to consult with health scrutiny does contain specific provisions around urgency. And basically what that says is that the duty to consult does not apply to any proposals on which the responsible NHS body is satisfied that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff. So clearly, what's contemplated here is that in those, hopefully few and far between, really urgent situations where there is a risk to safety or welfare, then the obligations that would otherwise apply are either scaled back significantly or removed in their entirety.

Paul Parsons - Thank you very much. And the mention of urgency or a genuine emergency in the new statutory guidance, that's a step forward from what was in the previous guidance, isn't it?

Peter Edwards - Yes, and I think it's a recognition of what the legal position has been for some time. So there is case law going back through several iterations of the public involvement duty, essentially says that the NHS can't delay its decision making until such time as urgency has been created effectively artificially in order to avoid the need for either public involvement or consultation with health scrutiny. So it's drawing a distinction between, as you say, those genuine situations where something completely unexpected, like a fire or a flood has happened, and perhaps the slightly more typical scenarios where long term staffing challenges, for example, ultimately reach a point at which something needs to be done. But it can't be said that there is a genuinely urgent situation when something has been in contemplation for a lengthy period of time. I was involved in a case recently that looked at issues of urgency and the degree of public involvement that would be required. That certainly cast some light on those issues. So this was a case in Lincolnshire and it concerned the designation of Grantham and District Hospital as a COVID free green site during the pandemic. And there was urgency in making that

change, in the sense that there was a national desire to try to restore services as quickly as possible in a COVID, safe way.

But that was not the same kind of urgency as in Clare's example. So the lead in time for implementation of the changes in Grantham was several months and that would have allowed an opportunity for some degree of public involvement. And that was very much the view that the Court adopted in that case. So the Court recognised that there could be situations where temporary or emergency measures may require, they said, a lesser degree of public involvement than would otherwise be the case. And that would particularly be true if decisions were being made on a provisional basis for a short period of time with an opportunity for review. But even in those cases, there was an expectation that there would be some attempt to involve the public in a meaningful way.

Paul Parsons - Thank you.

Caroline Latta - I was going to ask you, Clare, if you were to give advice to anyone else facing a similar type of situation, what would your advice be?

Clare Trenchard - I think the advice would be, as with all things, is to be open and honest with your stakeholders and to engage those people who ordinarily may be in conflict with you. So the League of Friends did start a petition to save the centre following our temporary closure of the ward that remained. And I took that as people really interested in the services and really supportive of the services, so I wanted to work with them. So I think one other piece of advice would be to work with those people who are interested in your services, even if they are petitioning to keep something open, that you're in a process to decide what you're going to do with it. My other piece of advice, I think, is to involve the people that have got direct experience of your service, either as a patient or as somebody who cares for somebody in your service, and to use them as your advocates and to help guide your thinking about the next steps post crisis.

Paul Parsons- Thank you very much. Peter, if you were advising somebody who was putting this in their contingency plan, what would be the main considerations you'd get them to think about?

Peter Edwards - I think the key consideration is to ensure that public involvement and consultation is identified as just as important a work stream for that contingency planning, as patient safety, continuity of care, workforce, estates issues, rather than simply sort of bolting it on as a bit of an afterthought. Because not only will that mean that you're legally compliant, but I think, more importantly, it'll actually mean that better decisions are made for the future of the services that are being considered.

Clare Trenchard - And can I support Peter in that? Actually, this was a real opportunity to raise the profile of good engagement internally, so there was some resistance to undertaking a process which I had to combat internally. So actually, using this as an opportunity to demonstrate good practice was the route that we took, because as a mental health organisation, we are very committed to involving the service user in improving our services. We've got an Involvement for Impact framework. It's the right thing to do, the CQC expects it. So actually there is the real opportunity to raise the profile of engagement as a discipline through something like this. Part of our learning actually, was doing engagement well relies on having good data about the people who use our services. And one of our learnings was we didn't and actually make sure you've got really good data about the people who use your services because you might need it one day and you want to make sure that your engagement is representative of the people who use them.

Paul Parsons - Yeah. Thank you. That's a drum that Caroline and I bang all constantly, because we're always at the sharp end of these things when you've got a change to make and there's no data about the people you need to involve. So, yeah, it's a challenge.

Caroline Latta - A fire evacuating a building, blue lights flashing in the night sky and all of it captured on film by a drone. Hands down that has to be the most dramatic case study we've had.

Paul Parsons - Definitely. And lots to learn from it too. I think it's helpful to break it down into smaller chunks if we can. The incident, the response, and then what happens in the longer term.

Caroline Latta - So the incident here was a serious fire, wasn't it? But it could be anything that means services unexpectedly and immediately need to be suspended.

Paul Parsons - Absolutely. A flood ceiling collapse, serious loss of power or anything else that happens unexpectedly, meaning that you can't continue providing your services. The immediate concern is clear in every one of those cases, the safety and welfare of patients and staff. And on the night of the George Bryan Centre fire, everyone was evacuated in under four minutes. Patients in the other wing were brought together safely. It was incredible to hear about everyone coming together and making sure that the patients were kept safe.

Caroline Latta - Then there's the question of how we respond.

Paul Parsons - Yes. These incidents lead to a need for immediate service change. The NHS can't just stop providing critical services, so mostly we've got to move where the service is provided from. Sometimes that's on the same site, sometimes it's not. And if it's not, you have a change of location, which counts as a service change. And in the case of the fire at the George Bryan Centre, patients were being treated at one location and they were transferred to a site 25 miles away. The trust vacant ward at that site meant that patients didn't need to be dispersed around various sites.

Caroline Latta - One location will definitely have made the immediate job of transferring people and telling families and carers where they were going much more straightforward.

Paul Parsons - When the world wakes up the next morning we've implemented a service change. It might be temporary, but we still have to tell people. And Clare's description of the plan they put in place was really first class.

Caroline Latta - It's hugely important to have a living, breathing stakeholder database that's regularly kept up to date. It's an invaluable resource in situations like the George Bryan Centre fire. I wouldn't like to be in the position of having to create one in an urgent situation, and in this case, it reaped huge benefits as the relationships were already in place. The League of Friends involvement in fundraising and helping design the engagement reaped huge benefits as they provide legitimacy and reassurance to other stakeholders.

Paul Parsons - What happens longer term is, of course, not unplanned, so normal service change processes will apply there. On the policy front, it's important that we remember that there is still no definition of urgent change. It's all about being pragmatic. It is, though, clearer now than it's ever been. As Peter told us, all we've had before were the scrutiny regulations telling us that in urgent situations where patient safety or staff welfare were in question, we didn't need to consult HOSCs on a service change. Now, we've got a section in the statutory guidance specifically on decisions about service changes in urgent situations that tells us "it will only be reasonable to justify carrying out a limited or no public involvement exercise on the grounds of urgency when the lack of time is genuinely caused by an urgent situation or where there is a genuine risk to the health, safety or welfare of patients or staff." And as a final note, we have to remember Peter's advice that this doesn't provide NHS organisations with a get out of jail free card on leaving patient and public involvement till the last moment when they could and should have been involving people earlier or to a greater extent.

Caroline Latta - Thanks to Clare Trenchard and Peter Edwards for joining us to talk about urgent service changes. If you'd like to read more rather than hear more, then head over to WeAreStand.co.uk to read Paul's briefing.

Paul Parsons - We'd love to hear if you've had an experience of an urgent service change. Join the conversation by following us on Twitter @NotConsultation or emailing us at listen@notaconsultation.com

Caroline Latta - So that's it for this episode. There's loads more learning in our other episodes, all available on our website, notaconsultation.com.

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