Patient and public priorities regarding the organisation of emergency hospital care

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Declaration

I, Helen Sarah Barratt, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Abstract

Proposed changes to hospital services, such as the closure of Accident & Emergency departments (A&E), often create high profile, contentious debates. Whilst clinicians tend to focus on potential health gains for patients, public concerns may include non-clinical factors such as ease of access to services. Previous research has largely concentrated on policy issues and little is known about the priorities and preferences for emergency hospital care amongst the public at large.

The first study in this thesis explored a process carried out to engage the local community with proposals to reconfigure hospital services in North London. This included mapping key areas of concern for the public and critically reviewing the impact of the methods used in the public engagement process. Study 1 demonstrated that the techniques currently used draw on traditional approaches aimed at improving the public understanding of science. This includes an apparent assumption of 'public ignorance' in matters of science and technology, and the belief that science offers a uniquely privileged view of the world.

The second study involved a series of in-depth interviews examining priorities for emergency care in more detail. Interviews were conducted with four groups of participants: patients with a chronic condition; parents of young children; older people; patient representatives and community groups campaigning against service closures. Interviews were carried out in an area where a reconfiguration was being discussed and an area where it was not. The analysis drew on theories relating to risk perception and risk communication. It demonstrated the importance of the widespread belief that timely access is associated with better outcomes, as well as the way in which the public's assessment of service quality influences their response to reconfiguration proposals.

Finally, the implications of my findings for current debates about public involvement in health care decision-making are discussed.

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PART I: INTRODUCTION

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Chapter 1: Reconfiguration and public involvement in health care decision-making within the NHS

Health care systems around the world, including the National Health Service (NHS) in England, currently face the dual challenge of meeting rising demand for care with steady or diminishing financial resources.[1, 2] One issue to be addressed is how best to configure hospital-based services and strike a balance between the high costs of the hospital sector, new forms of medical care and shifting demographic factors.

However, proposals to reorganise NHS hospital services are usually contentious. Initiatives aimed at improving productivity, such as merging, downgrading, or closing hospitals, commonly meet with opposition from staff, the public, and politicians. For example, in 2001 Dr. Richard Taylor won a parliamentary seat on the strength of his campaign against the decision to close acute services at Kidderminster Hospital in Worcestershire.[3] More recently, plans to centralise surgical services for children with congenital heart disease have prompted opposition across the country.[4]

Whilst clinicians tend to focus on potential health gains and improved outcomes for patients, public concerns may include non-clinical factors such as ease of access to services and loyalty to a local institution. For patients and the public, safety appears to be highly correlated with travel time to the Accident and Emergency (A&E) department.[5] Hospitals are also thought to serve a range of functions in a local community, including clinical, economic, social and cultural roles.[6]

NHS commissioners have a statutory duty to consult the public about major service changes, but such processes frequently receive criticism: there is a perception that consultation processes are not genuine and that the public do not have an opportunity to influence the outcome. Additionally, clinicians and commissioners may be dismissive of concerns about safety and access amongst the local community.[7]

The process of public consultation about major service changes is the focus of this thesis. I will pay particular attention to patient and public views about A&E services. Although many reconfiguration proposals involve a range of acute services, including maternity and paediatrics, as well as primary care and community services, it is often plans to alter local A&E services which create the greatest level of concern amongst local residents.[7]

This chapter draws on a range of relevant empirical and theoretical literature, as well as policy documents. I will first explore the key drivers that often underpin proposals to reorganise acute services and seek to critically evaluate the evidence that is typically used to make the case for change. I will then go on to describe the existing empirical literature about the process of reconfiguration, including the role that public consultation plays in this. Finally, I will set the public consultation process about major service changes in the context of the wider international literature about public involvement in health care decision-making. In this section, I will address both the policy background behind efforts to increase public involvement, as well as the theoretical literature about models of public involvement.

Several terms have been used to describe changes to hospital services, such as 'rationalisation' or 'retrenchment.' The term used here is 'reconfiguration' which Spurgeon *et al* define as follows:

> 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.[5]

As they note, the term may be associated with hospital mergers or the formation of structured networks for specific services. However, it is a measure of change which directly addresses operational rather than structural change: hospitals may merge, form networks, or change their divisional or governance structures, without reconfiguring services.[5] In England, closure of entire hospitals is the exception rather than the rule at the moment, but reconfiguration proposals do often involve a reduction in the range of services that is currently provided in an area and the strength of local opposition is typically related to extent to which services are seen to be being withdrawn or made less accessible.[8, 9]

Drivers for change

The financial pressures facing the NHS in England include upward pressure on costs, as a consequence of new technologies and rising public expectations, in tandem with downward pressure from previous periods of economic recession and political unwillingness to increase taxes. These drivers are common across many developed nations and the most frequent response is to seek ways of limiting costs.[10]

At the same time hospitals have been affected by long term changes in how health care is provided for patients including increases in day case procedures; reductions in lengths of stay in hospital; and an expansion of the work undertaken outside hospitals, for example, in the management of chronic disease.[11] With some services now being provided in people's homes and in primary care, and others being concentrated in specialist centres, some consider the viability of district general hospitals (DGHs) to be in doubt.[9]

As Spurgeon *et al* note, there is a large literature describing the factors that influence the configuration of services.[5] Many of these are common to health care systems across the world, even if they are causally related to each other in different ways in different contexts.[10] Against the backdrop of these factors, each organisational change will have its own history and unique blend of local circumstances.[12]

Several authors have proposed models to illustrate the key drivers of reconfiguration, and the way these inter-relate. For example, McKee *et al* distinguish between demand-side factors such as demographic change, changing patterns of disease and changing public expectations; supply-side changes such as improvements in diagnostics and clinical techniques, alongside workforce pressures; and wider societal changes, including financial pressures.[10]

As I have already described, in England the reconfiguration process is often contentious, with commissioners, clinicians, patients and the public all apparently prioritising different goals. To explore the drivers for change here, I will make use of the model proposed by the King's Fund because this helps to highlight directly some of the tensions and trade-offs that lie at the heart of reconfiguration decisions. The authors acknowledge that trade-offs must be made between four interlinked drivers of change: quality (including safety), workforce, cost and access (see Figure 1). The challenge for commissioners is to try to optimise all these elements.[13]

Figure 1: Drivers of hospital configuration[13]
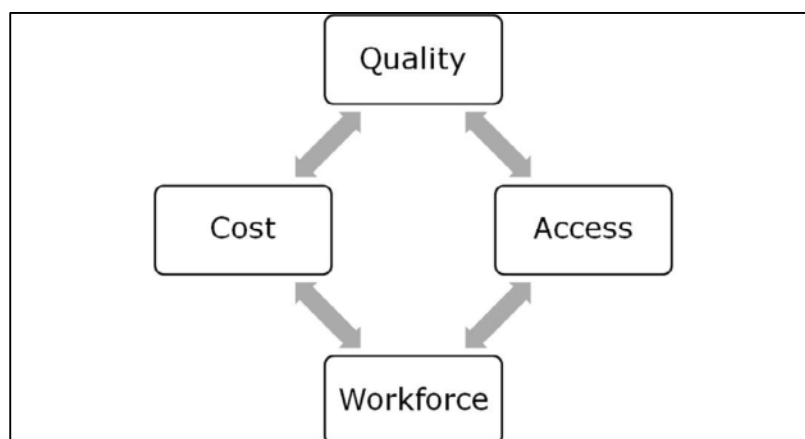
This thesis does not take a view on whether reconfiguration should or should not happen. Instead it focuses on the public consultation process that takes place once plans for change have been set out. However, below, I briefly consider the current pressures for change within each element of the model, as many of these will be relevant to the consultation process. In many cases, these represent high level factors which operate at a system level to influence how hospitals are organised across a geographical area. There is a separate literature describing the factors that are said to drive change in individual specialities such as paediatrics and obstetrics. This is beyond the scope of this thesis. However, I will briefly outline the evidence for change in emergency medicine, where it exists.

Quality and safety

For some, service reconfiguration offers an opportunity to address some of the variations that exist in the quality of care delivered by NHS hospitals.[13] There is a growing body of knowledge that addresses aspects of quality and safety assessment in health care. Perhaps the mostly widely accepted definition of health care quality is the one proposed by the Institute of Medicine (IOM). The IOM provides advice on issues relating to biomedical science, medicine, and health in the United States. It defines care quality as:

> The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[14]

Expanding this, a subsequent IOM report specified seven specific aims of a high quality medical care system:[14]

- Safe – avoiding injuries to patients from the care that is supposed to help them.

- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).

- Patient-centred – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

- Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care.

- Efficient – avoiding waste, in particular waste of equipment, supplies, ideas, and energy.

- Equitable – providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status.

However, within this framework, quality is defined very much from the perspective of the health care system: in other words, these are priorities or goals for providers. The two key concepts in the main overarching definition are professional knowledge and patient outcomes. The aims of a high quality system encourage providers to strive to deliver care that is 'patient-centred,' as well as seeking to reduce waiting times. Nevertheless, this gives little sense of patients' own priorities when it comes to the care they receive or what dimensions of quality are particularly important to them.

Donabedian set out one of the first frameworks for examining health services and evaluating care quality. According to the model, information about quality of care can be drawn from three categories: structure, process, and outcomes. Structure describes the context in which care is delivered, including the hospital buildings and equipment available to the staff. Process denotes the transactions between patients and providers throughout the delivery of health care. Finally, the outcomes dimension refers to the effects of health care on the health status of patients and populations. Processes can be further classified as technical processes, how care is delivered, or interpersonal processes, which all encompass the manner in which care is delivered. Technical quality of care describes the extent to which the services provided meet predefined clinical standards. Interpersonal quality

describes the characteristics of the interaction between health care professional and patient.[15] In turn, there are two principal aspects of interpersonal quality which are particularly important: expressive quality and information delivery. Expressive quality refers to the health care professional's mannerisms and perceived concern for the patient, for example their friendliness, courtesy, respectfulness, or compassion (i.e. their 'bedside manner'). Information delivery refers to the amount, quality, and understandability of information given to the patient during the A&E visit.

Donabedian's model was developed to enable the quality of care to be directly assessed in clinical practice. It does not have an implicit definition of quality care, precisely so that it can be applied to problems of broad or narrow scope.[15] Relevant to this study, Donabedian argues that the measurement of process is nearly equivalent to the measurement of quality of care because process contains all acts of health care delivery.[16] The model has, however, been criticised as too linear, with little regard to how the three domains influence and interact with each other. Some also take issue with the fact that it does not include antecedent characteristics such as patients' socio-demographic characteristics, which may be important to consider when evaluating the effectiveness of modifications to the care process. [17]

Nevertheless, despite its age, it still remains relevant to health service research. Also, because it does not have an implicit standpoint or definition of quality, it provides us with a useful framework for examining priorities for care quality from the perspective of both the provider and the patient. For this reason, I have chosen to use it in this thesis, rather than the more recent IOM definition, within its emphasis on the provider perspective.

The case for reconfiguring A&E services typically focuses on improving the technical quality of care. For example, one of the most widely used arguments in favour of change is that clinical outcomes would be better if care were centralised in larger regional units where greater numbers of physicians are concentrated, higher rates of interventions are performed and to which some patients inevitably have to travel further. This is due at least in part to emerging clinical evidence that some specialist services such as stroke, trauma and heart surgery may be better concentrated in fewer centres, supported by a critical mass of expert clinicians who manage such conditions on a regular basis. As an illustration, in 2010 stroke services in London were reorganised so that patients from across the capital are now taken directly to one of eight hyper-acute stroke units to receive specialist care, frequently bypassing their local hospital. A recent study has demonstrated that this change

has saved over 400 lives in three years and, if it were replicated across the country, over 2,100 lives could potentially be saved each year.[18]

Similar evidence suggests that patient outcomes may be improved when a range of other procedures— including surgery for colorectal cancer[19] and elective repair of aortic aneurysm[20]—are carried out in larger units serving bigger populations. However, whilst the evidence to support the centralisation of services such as stroke and trauma is relatively robust, for many other conditions there is no clear causal link between volume and outcome and where there is a link, the volume threshold for quality improvement can be quite low.[21] As Spurgeon *et al* observe, the evidence about the relationship between volume and outcome is rather more nuanced than some policy advocates or some of the professional bodies suggest. They note that there is evidence for an association between higher volumes and better outcomes, but researchers are often far from confident about just what should be inferred from the association. In particular they note:

> It has yet to be established both that the association is wholly causal rather than artefactual, and, to the extent that it is causal, that the mechanism is clearly understood.[5]

Equally, much of the research has been carried out in the US, where organisational differences may limit the generalisability of the findings to the NHS. In addition, many of the studies were poorly controlled for the effects of confounding variables. In summary, whilst the balance of evidence about volume-outcome relationships does seem to suggest 'a modest case for a connection that is probably at least in part causal' for some important procedures,[5] the evidence base is far from unambiguous.

In order to operate safely, emergency departments rely on the presence of a range of 'support' services within the hospital, for example acute physicians and surgeons, intensive care and 24 hour radiology and laboratory services. Ideally, other acute specialities such as paediatrics, general surgery and obstetrics should also be on site, so that patients do not have to be transferred to another hospital if the service they require is not available locally. Proposed changes to these specialities, for example consolidation of paediatric or obstetric services on fewer sites, may in turn impact the viability of an A&E department.[22]

Plans to reorganise emergency services are set against a backdrop of steadily increasing A&E attendances. Recent attempts at demand management, including establishing walk-in-centres and other initiatives, do not appear to have resulted in a decline in attendances

despite significant investment.[23] Plans to consolidate A&E services on fewer sites often include proposals to create an urgent care centre or equivalent on the hospital site that will lose its emergency department. The intention is that this would offer care for minor injuries and other less serious problems that do not require the full services of an A&E department. However, the College of Emergency Medicine has 'major reservations' about this approach. It argues that the development of walk-in and urgent care centres is largely unsupported by the evidence and has led to a fragmented system with duplication that patients find confusing.[24] There is often no clear definition of case mix, staffing or how such facilities relate to the local A&E.[25] At the same time, these facilities often aim to provide an alternative for people who need to see a general practitioner (GP) urgently during the evening or at a weekends, or those who are unable to wait to see their own doctor. However, there is very limited evidence to suggest that such models of care have an impact on A&E or GP attendance rates, processes, costs or outcome of care.[26]

Workforce and staffing

England is relatively unusual in its practice of training doctors in all its district general hospitals and relying on relatively inexperienced doctors to provide the front line of medical cover, particularly out of hours. This creates particular challenges for medical workforce planning and a range of workforce considerations have been offered as drivers of reconfiguration. Professional institutes have issued statements setting out their views about appropriate forms of service configuration and attempted to compile standards for consultant numbers; specialties that should be co-located on the same site; minimum population size required for a critical mass; and adequate volumes of work for hospital units to be capable of sustaining their skills and quality. Examples include reports produced by the Royal College of Physicians,[27] the Royal College of Paediatrics and Child Health,[28] and the Royal College of Obstetrics and Gynaecology.[29]

There are two particular challenges affecting junior and senior clinical staffing respectively, which particularly feature in discussions about how best to organise acute care. The first of these was the enactment of the European Working Time Directive (EWTD) which limited junior doctors' working hours and particularly impacted acute services with high emergency workloads.[30] The implementation of the EWTD in 2004 was predicted to drive reconfiguration proposals. This was on the grounds that a consolidation of acute services would be required to ensure that individual hospitals had both sufficient numbers of junior doctors to maintain adequate standards of patient care and sufficient numbers of patients for satisfactory clinical training.[28]

However, almost ten years on, concerns about its impact appear to have diminished: 'it did not turn out to be the insurmountable obstacle it was originally perceived to be.'[31] Solutions have been found to many of the challenges that were originally anticipated, although many workforce issues related to junior doctors remain. These relate to clinical competence now the length of clinical training has been reduced in many specialities; ensuring adequate supervision for trainees; and challenges in recruiting staff to work in particular locations and specialities.[31]

Whilst concerns about the implications of the EWTD appear to be waning, the challenges of ensuring sufficient levels of senior cover appear to be gaining prominence.[23, 32] Indeed, this is often one of the key reasons why proposals to consolidate A&E departments are put forward. Internationally, comparing A&E consultant staffing in England with similar models in Australasia and North America, current consultant numbers in England are less than half those that would be provided in similar departments in these regions. The model of care recommended by the College of Emergency Medicine (CEM) is to have a consultant present in the department 16 hours per day, seven days per week. This would require 10 Whole Time Equivalent (WTE) Consultants per A&E, compared to the current average of 4.5 WTEs.[33] In 2010 it was estimated that the total number of WTE consultants required to achieve such levels would be 2222; the number of consultants working in England at that time was 852 (WTE). According to recent data from the CEM, whilst 77% of A&Es currently have at least one consultant present over 12 hours on weekdays, only 17% have senior cover for at least 16 hours. At weekends the number of departments with 'shop-floor' consultant cover at least 12 hours a day, falls to 30%.[34] The College argues that improving these levels without service reorganisation would require a substantial increase in consultant numbers.[23]

The CEM describes current consultant numbers as 'woefully inadequate.' However, the problem is potentially compounded by poor recruitment of junior doctors to train in emergency medicine. In 2011 and 2012, the specialty achieved a lower than 50% fill rate into higher training. Fewer trainees are opting to choose this route for higher specialty training due to concerns over the intensity and nature of the work, unsociable hours, working conditions and the sustainability of such a career to retirement age.[33]

The call to increase the level of out of hours cover provided by consultants in A&E, as well as acute medical and surgical units, has been prompted by evidence that patients have higher mortality rates and are less likely to receive prompt treatment if they are admitted

to hospital at the weekend or during the evening, when currently fewer senior doctors are available.[35] Specifically in A&E, it is argued that greater consultant presence would not only deliver benefits in terms of patient outcomes but would result in a reduction in overall costs by: 1) decreasing inappropriate admissions to hospital beds, thereby creating additional capacity; 2) reducing unnecessary investigations, currently commissioned by staff with less experience; and 3) reducing potentially unsafe discharges. However, data about the relationship between time of admission and outcome are largely drawn from observational research. Although such studies have limited power to demonstrate causality, experimental designs of major service reorganisations are usually not feasible.[36] In these circumstances, the case for change often relies on a combination of observational research evidence and expert clinical consensus. Ultimately, however, the evidence base for optimal staffing ratios is slender. It rests instead on expert consensus and professional standards of acceptable clinical outcomes, as well as clinical judgments about the volumes of activity required to sustain skills, rather than on careful evaluations.[5]

Cost

As I have highlighted, reconfiguration of acute services has also been proposed as a means of improving productivity in a time when demand for care is rising, but financial resources are diminishing.[2] The need to find the equivalent of £20 billion of productivity savings over four years creates a major challenge for the NHS.[37] Some argue that there are also a number of NHS trusts that will struggle to achieve foundation trust status and a sustainable financial position without reconfiguring services.[13]

Indeed, some commentators reject the argument that there is a case for reconfiguring acute services on quality, safety and workforce grounds, and regard finances as the principal driver for reconfiguration. For Pollock, for example, 'government claims that [hospital] closures are necessary for centralisation and quality of care are poppycock.'[38] She does not expand further on this assertion, except to state that financial deficits, together with plans to replace the NHS with a competitive market of corporate providers, are the real drivers behind current proposals to reorganise NHS services.[39] Reynolds also supports this position and argues that safety arguments seldom hold water and merely serve as cover for explanations that commissioners would rather not express publicly, such as a desire to sell hospital land for development. She argues that this is being facilitated by a government quest to divert funds away from publicly-run services to private providers and help multinational providers establish themselves by in the UK market. Reynolds also explains that the NHS Act creates a new insolvency regime for hospital foundation trusts,

and would enable private equity companies to buy NHS facilities and asset strip them. At the same time, the Act contains new rules to allow easier extraction of NHS land, removing the prohibition on the sale of NHS assets.[40, 41] This may be relevant in some cases, but the recent publication of recommendations by the Royal College of Physicians,[42] the Academy of Medical Royal Colleges,[35] and the College of Emergency Medicine,[34] amongst others, all of which advocate service change, suggests that there is increasing clinical consensus about the safety arguments. Time will tell whether the predictions about asset stripping are accurate. However, it is notable that the view that reconfiguration is all about 'cuts' is often shared by the public, which is perhaps not surprising, given that austerity is currently part of mainstream political rhetoric about the NHS.[1]

In reality, there is little published evidence to demonstrate that significant cost savings can be achieved from reconfiguration in the short to medium term, and significant change frequently requires transitional and capital support.[43] The economic case for reconfiguration is seldom clear cut because it depends on the costs that are included (such as transaction costs and, where relevant, repayments on private finance initiatives). In addition, long time frames, uncertainty about the future, and changing conditions make it difficult to predict future costs. The Independent Reconfiguration Panel (IRP), which advises ministers about re-shaping hospital services, has noted that most of the reconfiguration proposals they have reviewed were not developed to save money and many in fact included plans for increased spending.[1]

Access

Again, according to the IRP, future access to services is the single biggest cause of concern about proposals for service change in the UK.[31] Most of the objections to hospital reconfiguration are framed in terms of claims that populations living near affected hospitals will suffer a loss of 'access.'[5] There are strong political and policy pressures to sustain, and where possible increase, the availability of services, particularly those needed in an emergency. There are also good social and quality reasons to provide good access to services. For example, many patients and their carers are elderly and many will rely on public transport to get them to hospital.

However, access is not a straightforward concept and there are several distinct definitions of access in the health care context. For example, 'having access' can simply mean a service is available for use if required, whereas 'gaining access' refers to use of a service.[44] The term may also be used to discuss the challenges, whether of time, distance, or journey

difficulty faced by patients in reaching hospitals; it is also used sometimes to discuss commissioning procedures that may determine, for example, which hospital might be able to admit someone in an emergency or the choice of hospitals available to patients requiring an elective procedure.[5] As this thesis considers emergency care from the patient's perspective, I will make use of Donabedian's definition of access as 'use of services.'[45]

For patients and the public, safety appears to be measured as a function of travel time to A&E and consequently concerns are often raised about the implications of having to travel further to access care in an emergency, if services are reconfigured.[7] There is a relevant body of literature on the impact of longer journey times to hospitals on clinical outcomes for patients. The most frequently cited study in this context is an analysis of retrospective data from ambulance call-outs for immediately life threatening symptoms in England, which found that increased journey distance to hospital was associated with increased mortality.[46] After case-mix was adjusted for, every additional 10 kilometres in straight line distance was associated with a 1% absolute increase in mortality.

These findings reflect the performance of emergency services between 1997 and 2001, and journey time may be less relevant now that paramedics commonly start definitive treatment. The results may also only apply to patients at high risk of immediate death. In addition, arrival at hospital is not a clinically relevant time; it is the commencement of the critical definitive treatment that affects outcome.[5] For example, the centralisation of specialist hyperacute stroke units across London has been associated with reduced mortality compared with national rates.[18] This is likely to be because patients receive rapid access to thrombolysis, even though most will travel further for care than previously. Access as a driver of reconfiguration is intrinsically linked with concerns about quality and safety. Arguments about the merits of particular reconfiguration proposals are often framed in terms of whether a balance can be found between clinical gains that may result from being treated in a specialist centre, and the potential delays that may be incurred in travelling to a specialist centre which is likely to be located further away. It is not known whether reconfiguration delays time to definitive care and there remain gaps in our understanding about the relationship between travel times and patient outcomes in an emergency.

Using the King's Fund model

The King's Fund model provides a useful way of classifying the key drivers in the reconfiguration process. Unlike other similar models, it allows us to begin to see how some

of the drivers inter-relate and even conflict. It also casts light on the trade-offs that have to be made, for example between the quality and financial gains that may be achievable through the concentration of services and the social and clinical costs to the patient of reduced access.

There is always a risk that such models are overly-simplistic, and the King's Fund model does not capture the fact that reconfiguration proposals are often initially driven by specific local forces. The IRP note, however, that the factors that drive service change in the NHS mostly fall within the compass of safety, sustainability and accessibility. The King's Fund model captures all of these to a greater or lesser extent, although it perhaps creates an artificial distinction between safety and workforce drivers. Many of the safety drivers relate to workforce concerns, and in this sense the two are not distinct. For example, in emergency care, the College of Emergency Medicine argues that increasing levels of consultant-delivered care 'is the most important factor in providing a consistent high-quality, timely, safe and clinically effective service to patients.'[24]

Public consultation and the reconfiguration process

At the time of writing, plans to reorganise acute services are being discussed in several areas of the England. For example, in North Yorkshire discussions are taking place about reducing hospital beds, expanding community services, limiting referrals, and rationalising hospital estate.[47] Similarly, in Worcestershire, proposals have been put forward to centralise A&E and emergency surgery, paediatrics and obstetrics services at one of the three hospital sites, with routine and elective surgery and treatments migrating to the other two sites.[48] There are also proposals to reorganise specific services, such as stroke services in the Midlands and East of England[49] and vascular services in the North West.[50] Such plans are not unique to England: similar proposals to consolidate services have been considered in Canada,[51] Australia,[52] Scandinavia,[53] and Ireland.[54]

As I have already noted, reconfiguration proposals are frequently contentious. The IRP was established in 2003. By mid-2012 it had undertaken 19 full reviews of contested plans for health service change in England and offered written advice on several others.[31] The panel provides independent advice on reconfiguration proposals when local agreement cannot be reached, and its members include clinicians, management representatives, and lay members with experience in delivering health service change.[1]

The previous government introduced several reforms aimed at increasing both public involvement in and local scrutiny of health care. The IRP was part of this; its terms of reference require it to assess whether the proposals will provide 'safe, sustainable and accessible services for the local population.'[55] Section 242 of the NHS Act 2006 also places a statutory requirement on NHS bodies to consult a range of stakeholders, including patients and the public, when plans to reorganise care are being considered.[56] This process of consultation is the focus of this thesis.

Current consultation practices

During the 2010 general election campaign, the Conservative party promised to stop 'centrally dictated' reorganisations of NHS services.[57] Writing in the *Daily Telegraph* on 21 May 2010, days after the coalition government came to power, the Secretary of State for Health, Andrew Lansley, declared a moratorium on such programmes.[58] All proposals now have to meet four tests, which include demonstrating strengthened public engagement. The other tests are support from GP commissioners, consistency with patient choice, and clear evidence for change. The Department of Health (DH) has not set specific thresholds for any of the four tests, instead recommending that 'the process should be locally-led and designed, and needs to allow flexibility given that schemes will be at different points in their lifecycle.'[59]

Consultation typically involves three stages. The initial phase involves exploring the need for change and the objectives before any specific options have been drawn up. An important part of this stage is first to inform stakeholders of the issues and help them understand the underlying principles behind the need for change. This is followed by an official consultation, where the views of different stakeholders on a range of options are usually sought more formally. The final decision is made by a committee of NHS organisations informed by the results of the consultation.[7]

At the end of the consultation process the local health overview and scrutiny committees (made up of elected representatives from the local authority) 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.[13] Referrals to the Secretary of State have most commonly been made on the grounds that proposals would not be in the interests of the local community. Some also include adverse comments about the wider

consultation process, most often that it did not reach enough people or that it was too difficult to understand. The most frequent reasons for referral are listed in Figure 2.[1]

Figure 2: Key reasons why reconfiguration proposals are referred to the Independent Reconfiguration Panel

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

The King's Fund observes that the current process often involves lengthy and sometimes hostile local debates, leading to delays which pose ' significant risks to the delivery of safe services.' [13] Because reconfiguration processes can be protracted and expensive, they and several others argue that improvements are needed to both the policy and the process of consultation about hospital change.[7, 13] For some, this would involve ensuring that proposals have credible and visible clinical leadership to give the public confidence in the plans, thereby potentially reducing the level of opposition.[1] At the same time, Imison argues that one of the key reasons the public and local politicians often find it hard to accept change to hospital services is because the case for change is not well articulated.[13] This is supported by the IRP, which argues that in many of the reconfigurations referred to them, the clinical case has not been convincingly described or promoted to the local community.[1] This may be because it is difficult to lay out a clear case for change when there are many interdependent factors, or because it is not possible to provide clear evidence of an existing quality differential between providers.[13] There may also be a reluctance amongst commissioners and providers to publicise the fact that existing services are not as safe or high quality as they could be.[31]

On the part of the public, the outgoing chair of the IRP called recently for a 'more reasoned debate about the pros and cons of centralisation,' challenging local communities to think

more deeply about what the NHS can realistically offer within the current financial circumstances. He was also sceptical about whether the public's assessment of the risks involved in a reconfiguration is realistic and whether people are truly prepared to weigh up the balance between risk and convenience. He concluded by calling for an open and honest dialogue about these issues and a debate that is couched in a 'healthy dose of reality.'[31]

In the UK policy context, the term 'reconfiguration' is typically used in a way which suggests a problem to be solved by calculations of optimal design. It is often presented as a technical matter, for example an optimisation of staff to population ratios, even though the evidence base for such ratios is slender.[5] Additionally, the mechanisms proscribed for engagement processes can render it a technocratic exercise.[13] The nature of the consultation process, and indeed the four Lansley tests, which present a series of tasks for commissioners to demonstrate that they have completed, arguably also emphasise the apparently technical, tick box nature of the process.

Framing reconfiguration as a technical issue belies the fact that such decisions are by nature political and involve a range of contestable values. The proposed changes will often have drawbacks as well as advantages and may require difficult judgements about trade-offs - for example, the potential benefits for patients of being treated by more specialised clinical teams versus greater travel times because these teams operate from fewer centres.[1] Different stakeholders will have conflicting interests, often aligned to one but not all of the key drivers for change. For example, an overview and scrutiny committee and other local politicians may focus on access and conclude that, in their view, the loss of a local A&E service is not in the best interest of the population. A commissioner may prioritise value for money and clinical outcomes, whilst clinical leaders and the professional bodies may prioritise the dimensions of quality and workforce issues. Spurgeon *et al* argue that it is these conflicts and trade-offs which make reconfiguration difficult, particularly where there no agreed or acceptable weighting system to determine which issues should take precedence.[5] Many of the professional organisations in fact seem to downplay the political character of the process, instead representing any politics involved as a reasonably straightforward conflict beetween enhanced outcomes and access.[5]

In addition, reconfiguration plans typically focus on the three major functions of the modern hospital: emergency treatments, elective surgery, and outpatient consultations.[60] This does not account for the role that hospitals play in the community above and beyond that of health care provider.[7, 8, 13] In most communities hospitals are important parts of the

local economy. They are often the biggest local employer of highly skilled, skilled and unskilled labour.[60] Hospitals also appear to have a particularly important symbolic role with the public in terms of representing a strong welfare state, as well as maintaining and improving trust in the NHS.[8]

Previous research

Earlier in the chapter I demonstrated that there is only a limited evidence base to underpin the drivers for reconfiguration; the case for change typically relies on a combination of observational research evidence and expert clinical consensus. At the same time, there is also a paucity of empirical studies examining the reconfiguration process. Academic debate about hospital configuration is dominated by technical research and analysis, whereas less attention has been paid to the actual dynamics of local decision-making.

There is a literature about the experience of closing long stay psychiatric hospitals and the rationalisation of acute hospitals in the 1980s. For example, McKee examined the closure process using detailed case study material from one hospital[12] whilst Pettigrew *et al* explored reasons for variability in the observed rate and pace of service change in eight District Health Authorities.[61] An additional literature examines hospital mergers, although these have not always resulted in service reconfigurations.[62]

There are also examples of studies based on particular local debates about reconfiguration proposals.[8] However, many of these focus on single case studies and a reconfiguration in one context will not necessarily offer a generalisable model elsewhere. Many papers examine the impact of a specific reconfiguration and the case that has attracted most attention is the reconfiguration in the Kidderminster area.[7] Raftery and Harris were commissioned to carry out an independent evaluation of the impact of the service changes by CHART, a charity linked to the Health Concern campaign which sought to restore the A&E department at Kidderminster Hospital. The study sought to review the impact of the reconfiguration in that area. Overall it had had relatively little impact on the level of use of the NHS acute hospital facilities by local populations: emergency admissions declined slightly in each of the two subsequent years before rising to above the previous level. The authors also commented on the decision-making process, concluding that the consultation process was 'universally considered to have been poor.'[63]

Other studies examine the decision-making process in more detail, and particularly the role the public plays in this. In another study of the Kidderminster reconfiguration, Brown noted the symbolic role health care facilities held for the local community. He observed that the

local community's strong sense of ownership of the hospital played an important role in their response to the proposals.[64] Oborn also examined the reconfiguration in Kidderminster and explored how legitimacy was constructed by stakeholder groups and how these strategies were used to support or resist change. Whilst the commissioners aligned their arguments with medical discourse about scientific progress, local protestors sought to challenge the legitimacy of the process by pointing out that the commissioners were out of touch with local sentiment and arguing that the contribution of local people had been marginalised. The stakeholder groups managed to talk past each other, failing to establish a dialogue, which led to significant conflict and political upheaval.[65] Parkinson similarly examined the reconfiguration of services in Leicester and found that decisions about and by the NHS suffer from being perceived as less than legitimate because administrators lack a local democratic mandate. Equally, the campaigners' claims to represent local feeling are questionable. For example, the campaign groups in Leicester had created legitimacy for their stand as the 'voice of the community' by going direct to the people with a petition and securing what was the largest number of signatures ever on a local issue in the area. The petition provided them with a powerful weapon in the ensuing debate. However, some members of the community expressed reservations about this approach on the grounds that the petition did not accurately represent their views because it was based on misunderstandings of the health authority's intent, for example it focused on the claim that hospital was being closed, which was not the case.[66]

In and amongst this, there are perhaps two studies which have the greatest relevance to this thesis. First, Fulop *et al* conducted a series of qualitative interviews with key stakeholders in three case study sites, to examine the process by which reconfiguration was negotiated and implemented. Building on the notion that reconfiguration typically involves political decisions that encompass a range of contestable values, they set out a typology of the claims and arguments presented by different groups. Arguments in terms of improved health outcomes were most likely to be put by clinicians; very few stakeholders made claims about the significance of NHS services to local communities. Almost all the managers and many of the clinicians interviewed made the claim that reconfiguration would result in a more efficient use of resources. Claims relating to access and the patient experience were most likely to be found among the diverse group of stakeholders 'external' to the hospital, including politicians and patient representatives. Interviewees putting forward this type of argument were likely to favour local services.

In addition, the researchers identified four inter-related factors which influenced the 'results' of reconfiguration programmes (i.e. what was implemented). These factors provided context for the consultation processes in all three cases:

1. The content of the reconfiguration (particularly the extent to which services were being withdrawn) and the related strength of local opposition were both influential in the outcome. Where reconfiguration was perceived as a 'downgrading' of services, there was more active stakeholder involvement.

2. Local party politics and their relationship to national party politics played an important role in strengthening the local opposition or creating a secure environment for the commissioners proposing the changes.

3. The financial context, both nationally and locally, was also important. For example, alterations to funding arrangements (e.g. payment by results) threatened the sustainability of all three trusts in the study and this was compounded by the financial legacy of buildings funded via the Private Finance Initiative (PFI), which drew on private capital to fund public infrastructure projects such as hospital redevelopment.

4. The role of the senior management team was also important in the process and outcome of reconfiguration.

The authors conclude that the differing emphases by stakeholder groups are largely irreconcilable, resulting in dissatisfaction in some part of the stakeholder set. There is a strong likelihood that conflict over hospital reconfiguration will persist and it is therefore 'unrealistic' to expect consensus.[8]

In the second relevant study, Farrington-Douglas and Brooks also examined the politics and process of hospital change at a local level using two anonymised case studies of recent hospital reconfigurations. They also interviewed local stakeholders including hospital managers and clinicians, local commissioners, patient representatives, hospital campaigners and local politicians. They adapted the typology used by Fulop *et al* and found that stakeholders broadly made similar claims. In addition, they noted a 'lack of public understanding of technical patient safety arguments' amongst the patient and public stakeholders. This group generally measured patient safety as a function of travel time to A&E, rather than trusting clinicians' definitions related to hospital configuration, staffing or numbers of patients treated. In addition, while patients, public and politicians often agreed with the need to change services, they opposed changes to their own local hospital. The

authors termed this position 'hospital in my back yard' – HIMBY, and hence HIMBYism – similar to the 'not in my back yard' (NIMBY) position held by local populations opposing the location of other public facilities, such as wind farms. The authors also observed what they called a 'paradox of consultation': local stakeholders expected to influence the outcome of consultations. Several options, including 'doing nothing', were presented for public feedback. Yet in practice change was unavoidable, even if it was unpopular with consultees. This led to a perception that the consultation was a 'sham.' In concluding, they recommended that the 'black box' of hospital safety needs to be opened in order to allow local stakeholders to judge the performance of existing hospitals.[7]

These two studies illustrate the different priorities of different stakeholder groups involved in the reconfiguration process. Crucially however, in both cases, only members of official patient involvement committees were interviewed. This is appropriate for a study of key stakeholders, but their views may not be representative of the wider patient population or indeed the public at large. As Parkinson demonstrated, patient representatives' close involvement with local health services may mean that they are more informed and engaged than the wider population. In addition, their views may not necessarily reflect those of the community.[66] Equally, whilst both studies mapped the views commonly expressed by stakeholders they did not go on to explore participants' willingness to accommodate the trade-offs that are often involved in reconfiguration decisions.

Conclusion

In this section, I first set out the key drivers that frequently lie behind reconfiguration proposals, and considered the evidence that underpins these. This thesis does not seek to take a view on whether reconfiguration proposals should go ahead or not; instead its focus is the process of public engagement which takes place, once plans have been drawn up. Nevertheless, I have demonstrated that the evidence base underpinning proposals to reorganise A&E services typically relies heavily on rules of thumb endorsed by professional clinical institutes.[8]

The empirical and policy literature I have outlined has a number of direct implications for the thesis. The first of these is the observation that there is currently a paucity of empirical studies about the reconfiguration process itself. In particular, limited attention has been paid to the actual dynamics of local decision-making.[7] We know very little about patient and public priorities in this context because most of the existing research has concentrated on the views of members of official patient involvement committees.

Second, consultation processes are often protracted and hostile. There are two distinct views about this in the literature. One the one hand, government documents and policies increasingly emphasise the role of 'evidence' and better consultation with the public as a potential way of reducing delays in implementation. This is apparently based on the assumption that if the public are involved 'enough' and are presented with the 'right evidence' they will be convinced of the need to change.[8] Organisations including the King's Fund and the IRP have called for changes to be made in both the policy and the process of consultation about hospital change. They argue that the public find it hard to change because the case is not well articulated. The NHS thus needs to work harder to make it clear why change is needed and articulate a persuasive and reasoned case to support proposals.[1, 13] Allied to this, there must also be 'open and honest dialogue'[31] about risk and a greater openness about safety data to allow local stakeholders to judge the performance of existing hospitals.[7]

On the other hand, some argue that this approach is – at best – optimistic.[5] For example, clinicians tend to focus on potential health gains and improved outcomes, whereas ease of access and loyalty to a local institution are more important to the public. Spurgeon *et al* conclude:

> Instead of thinking in terms of public education, it is necessary to think about hospital reconfiguration as a field of political conflict that requires conflict containment and conciliation rather than pedagogy.[5]

This thesis will explore the implications of both these positions. Before doing so, in the next section, I will set public consultation about reconfiguration decisions in the context of the wider literature about public participation in decision-making, including both the policy background to public involvement and the relevant theoretical literature.

Public involvement in health care decision-making

Over the last two decades, public involvement in local decision-making has emerged as a prerequisite of democracy.[67] Consultation with communities about plans to reconfigure health services in their area is set against this backdrop. The involvement of patients and the public is considered central to efforts to improve the quality of health care not just in England, but across Western Europe and North America.[68] Underlying this is a belief that involvement will lead not only to more accessible and acceptable services, but also improved health and quality of life for those who use them.[69] As several authors have

noted, the literature takes an implicit standpoint regarding the desirability of involvement:[70, 71] 'the idea of citizen participation is a little like eating spinach: no one is against it in principle because it is good for you.'[72]

My focus in this section is the purpose of public involvement in health-care decision-making; I will turn my attention to its content in the next chapter. Here, I will first chart the rise of public involvement, with particular reference to the English NHS. I will then go on to explore the reasons for this, as well as examining both the theoretical literature that underpins involvement initiatives, and the different conceptual models of involvement that have been proposed. Finally, I will explore the literature about the impact of public involvement on decision-making processes and the potential drawbacks of current initiatives.

Patient and public involvement in the English NHS

Formal arrangements for patient and public involvement in health care decision-making have existed in England since 1974[73] when statutory local 'watchdogs' – Community Health Councils (CHCs) – were set up to represent the interests of local people to health authorities.[68] The forerunners of current policies emerged during the 1990s when an internal market was introduced into the NHS.[74] This included the commissioning of services to meet local needs and a range of other initiatives aimed at increasing choice and competition.

In 1997, the incoming Labour Government announced its intention 'to rebuild public confidence in the NHS as a public service, accountable to patients, open to the public and shaped by their views.' [75] Since then, health authorities have been expected to involve the public in service planning and priority setting.[68] The case for greater patient and public involvement was further strengthened by evidence of serious service failures, fuelling demands for greater health service accountability.[68] For example, the Kennedy Inquiry into paediatric heart surgery in Bristol stated that 'the involvement of the public in the NHS must be embedded in its structures: the perspectives of patients and of the public must be heard and taken into account wherever decisions affecting the provision of health care are made.'[76] In the NHS Plan published in 2000, the then government announced that CHCs were to be replaced by patient forums and the Commission for Patient and Public Involvement in Health.[73] Later, in 2006, the Government announced that these would also be abolished and replaced by 152 local involvement networks (LINks). These groups would represent a single locality and focus on the commissioning of both health and social care.[73]

Governance of Foundation Trusts (FTs) in England, which were established under the Labour government, have been seen as one way to achieve more inclusive governance and citizen participation for local communities. FTs have a duty to consult and engage with an elected board of governors (now called Council of Governors under the Health and Social Care Act 2012), made up of patients, staff, members of the public and other key stakeholders.[77]

Although the duties of FTs remain similar, when the current coalition government was elected in 2010, they declared that the wider system of involvement was 'inaccessible and fragmented' and consequently failed to provide a strong and constructive voice. The NHS White Paper *Equity and excellence: Liberating the NHS* set a vision for a health service 'genuinely centred on patients and carers.'[78] A new consumer champion – Healthwatch – replaced LINks as a statutory body on April 2013. Local Healthwatch members now represent the views of patients and the public on local authority Health and Wellbeing boards, as well as playing a role in developing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.[79]

What does involvement involve?

Although patient and public involvement in decision-making is a key plank of health care policy,[56] the field is plagued by confusion about terminology.[68] This perhaps reflects the inherent confusion that exists about what exactly public involvement should encompass. First, there is little consensus about the meaning of the word 'involvement' itself. Terms such as 'involvement', 'engagement', and 'participation' are often used alongside each other, with little agreement about what they mean.[68] In one definition, public participation involves members of the public 'taking part in the process of formulation, passage, and implementation of public policies [to] influence decisions which are, in most cases, ultimately taken by public representatives and officials.'[80] Similarly, involvement may be considered as 'a local attempt to include organised groups of service users in the planning, and occasionally the management, of such services.'[81] In 'engagement' the public is involved in the practices of policy-making bodies 'in some limited manner.'[82] This is apparently further distinct from the notion of consultation which 'usually describes a situation in which the public can voice its opinion without any direct possibility of decision in the end.'[70, 71] For the purposes of this thesis, I will use the term 'involvement' in the same manner as Wait and Nolte, as a generic term that encompasses the notions of

participation, consultation, and engagement and the different degrees of involvement and influence that those terms imply.[71]

Second, the term 'public' is often used interchangeably with notions of 'citizen', 'consumer', or 'patient'; there have been several, conflicting attempts to define these concepts.[74, 83] As this thesis relates to decisions about the reconfiguration of acute services, I will use Florin and Dixon's definition of 'public involvement,' which is also used by Wait and Nolte. Together, they use this term to describe 'the involvement of members of the public in strategic decisions about health services and policy at local or national level—for instance, about the configuration of services or setting priorities.' This is distinct from 'patient involvement' which Florin and Dixon take to mean 'the involvement of individual patients, together with health professionals, in making decisions about their own health care.'[74] Although these distinctions are helpful, in reality the distinction between individuals as patients or members of the public is often less than clear cut, as I will go on to explore.

Why increase involvement?

The four Lansley tests for reconfiguration proposals require commissioners to demonstrate that they have 'strengthened' public involvement, reflecting wider calls for greater public involvement in decision-making about health care. Florin and Dixon identify two core arguments used in the literature to support this case. On the one hand, there are those who argue that public services are paid for by the people and therefore should be shaped by them. In the UK, the desire for local accountability stems largely from the fact that the NHS is a publicly funded service. Consequently managers and health professionals should be accountable to patients and the local community more broadly. Underpinning this is the assumption that greater public involvement will lead to more democratic decision-making and better accountability to taxpayers.[74]

The second argument is that increased involvement will make services more responsive to the communities that use them, and that more responsive services will, in turn, lead to improved health.[74] For Charles and DeMaio the drive for greater public involvement also reflects a general loss of faith in the superiority of medical knowledge as the key determinant of health care decision-making.[83] Allied to this is a belief that service users and local communities are best placed to identify what they need from their health care services. Ultimately it is their assessment of benefit that matters; professional definitions of benefit in health care are at best only partial.[74]

This distinction is simplistic, however, because there are numerous theoretical models for considering the involvement of patients and the public in decision-making. The two main conventional approaches are the democratic and consumerist perspectives, each of which has emerged from a distinct body of literature.[84] Butler and Greenhalgh draw on a review by Greener published in 2008, which introduced twin concepts of 'voice' and 'choice.'[85] This in turn was based on an article published by Hirschmann in 1970, which suggested that 'individuals wishing to improve the service they receive, have two main strategies: exit or voice.' By exit, Hirschmann meant choosing to move to another provider; by voice, he meant complaining or demanding an improved service.[86]

The consumerist perspective

The first perspective has its roots in the economic literature about marketing, quality control and quality assurance. The basis of this model is the 'economic man' – a rational decision-maker, who is willing and able to make and enact choices between services.[84]

Economists have long advocated public involvement as a necessary route to correcting the inherent 'failures' in health care markets. These include information asymmetry, where one party in a transaction has more information compared to the other. Consumer preferences and the exercise of choice are viewed as the lever to enhance competitiveness between providers and thus drive up quality.[71, 87] In a conventional market, consumers express their preferences by exchanging money for goods or services. However, in the context of a system like the NHS where a third-party pays for care, consumerism is considered to be a matter of patient choice. It is assumed that this approach will raise standards because providers risk the loss of 'business' (and income) if their consumers – patients – are dissatisfied with the service that they receive.[56]

The consumerist model – 'choice' – has become steadily more prominent in health care over the past 40 years. Butler and Greenhalgh note the growth of 'welfare consumerism' generally, which they link to a general rise in income and public expectations of a long, healthy life. The public is increasingly demanding that 'public services become as responsive and dynamic as the private services they consume.'[85] However, the consumerist model assumes that the public are able to choose between services and indeed want to make a choice. It also assumes that in relation to health care, everyone knows what is best for them, or at least has access to the information to find out. Clearly this may not always be the case.

Whilst some view choice as an important mechanism of change, others take issue with the fact that it conceptualises service users as 'consumers' and implies that a payment is made for services. In reality most consumers receive free services in the public sector. The strongest critics of choice, though, are those who take issue with its political basis.[84] For some, encouraging sick individuals to 'choose' merely shifts responsibility from the doctor to the patient, contributing to a smokescreen behind which the state can divest its responsibilities to safeguard its citizens.[88] Others regard choice as a rhetorical front for the marketisation or privatisation of public services.[89]

The democratic perspective

The second body of literature concerns democracy and citizenship, the former emerging from political science, the latter from sociology.[56] The democratic model aims to increase health care quality by enhancing public influence and control over the running of services.[84]

'Voice' assumes that greater public involvement will lead to more democratic decision-making and, in turn, enhance the accountability of services. It relates to the public in their capacity as citizens and taxpayers with rights to use public services and duties to contribute to society.[74] It is based on the principle that public participation should be encouraged, because it is beneficial to maintaining a strong democracy. It is hoped that by participating in policy decisions, citizens will develop a more realistic understanding of what health care systems can and cannot provide, which will then empower them to use the system more effectively.[71]

Historically, the concept of citizenship has carried a complex cluster of meanings. It may imply a defined legal or social status, or provide a means of signifying political identity or loyalty. Equally, it may carry a requirement to perform duties, or come with the expectation of rights. Different elements of this cluster have received prominence at particular times. For much of the 20th century, the rights inherent in citizenship have been predominant. However, over the last two decades, the emphasis has shifted to incorporate a more active perspective in which citizenship entails a moral duty to 'take part in constructing and maintaining [the] community.'[56]

In the context of health care, the push for public involvement policies assumes that citizens want to engage in 'active citizenship' and participate in decision-making. This may be presumptuous, however, as it depends on how politically engaged they wish to be and how empowered they feel to actually have an impact on results.[71] Equally, this argument also depends on how responsible members of the public feel for the health care system. Many

individuals will come in to contact with health services only intermittently, and only a few will have longstanding contact with a particular service.

Choice versus voice

In reality, the distinction between 'voice' and 'choice' has become increasingly blurred. Greater choice and improved 'customer service' are both considered to be compatible with, and complementary to, a stronger voice in public services.[68] As a consequence, many involvement initiatives and policies contain an element of both. The four Lansley tests for reconfiguration proposals, for example, require commissioners to demonstrate on the one hand that they have 'strengthened public and patient engagement' (i.e. voice). On the other they must also prove that their plans are 'consistent with current and prospective patient choice'.[90]

This seems to ignore the obvious tension that exists between a perspective that encourages citizens to stay and work together to improve a local service and one that encourages them to vote with their feet and seek care elsewhere if they are unsatisfied. In terms of the balance between the two, Fredriksson argues that reforms aimed at increasing patient choice will ultimately undermine established 'voice' mechanisms: 'choice' mechanisms empower patients at the individual level by increasing the opportunity of seeking care elsewhere, but they simultaneously reduce the collective voice of citizens channelled through mechanisms of 'voice.'[91] The Department of Health has not set specific thresholds for any of the four tests and crucially they have also not provided guidance on which should take precedence. [90] However, the tests could result in a range of conflicting outcomes. For example, the evidence may suggest clinical benefits from reconfiguring services on fewer sites, but this could reduce patient choice of provider. In the past concerns have been raised about the quality of public engagement around reconfiguration decisions. However, there have also recently been instances of proposals for change being blocked because they would lead to a lessening of competition and a consequent reduction in choice for patients.[92]

In the UK, the focus of the health service is being redefined as markets and consumerism are promoted in health care.[93] At the same time, the role of the state as the guarantor of health and wellbeing is being redrawn.[94] As a consequence, Baggott argues that 'choice' rather than 'voice' is currently prioritized in the NHS.[68] Tritter endorses this, noting that in Britain, choice and individualism have been elevated to the status of moral imperatives.[94] Time will tell whether the role of choice will gain further prominence in decisions about

reconfiguration as the reforms enshrined in the NHS Health and Social Care Act 2012 unfold.

The lack of guidance provided to commissioners about how to conduct involvement initiatives may further weaken the value of 'voice' mechanisms.[95] There is typically confusion about the aim of many current policies and what objectives they should seek to fulfil, [74] as well as a lack of direction about how to handle the information gathered. For example, the DH guidance to commissioners about meeting the four Lansley tests makes multiple references to both 'engagement' and 'consultation.' However, it provides little information about what 'strengthening' should involve or achieve, beyond seeking the views of local stakeholders and incorporating the outcome into their submission to the Strategic Health Authority.[90] Perhaps because current public involvement policies are piecemeal and disparate, different health care organisations employ different methods to engage the public, which results in further confusion and differing perceptions of the value of such initiatives.

Models of patient and public involvement

Wait and Nolte's definition of involvement, used here, encompasses the notions of participation, consultation, and engagement.[71] These activities cover many levels of involvement and each implies a slightly different power relationship. The key document that continues to inform patient and public involvement initiatives is Arnstein's 'Ladder of Citizen Participation' published in 1969.[72, 93] In this article, she sought to categorize the levels of power available to citizens involved in decision-making. This ranged from professionals merely providing information to the public, to a genuine hand over of decision-making power.[74] Arnstein's ladder is often linked with the democratic model of public involvement, or Greener's 'voice'.[84]

Arnstein's ladder

Arnstein proposed a model of participation consisting of a ladder with eight rungs representing different degrees of involvement in decision-making (see Figure 3). Her principal metric is citizen power, specifically 'redistribution of power that enables the have-not citizens, presently excluded from the political and economic processes, to be deliberately included in the future.'

The different rungs on Arnstein's ladder relate to the degree to which citizens have attained decision-making power, with complete citizen control as the highest point.[74] The first two rungs are seen as non-participatory, with the bottom rung - 'manipulation' -

representing the persuasion of citizens to support existing plans. The rungs towards the middle consist of modest degrees of involvement, but without obligation to take notice of or act on the public's views. The higher rungs identify forms of participatory activity in which the public has increasing power. These range from partnership or shared responsibility for decision-making, through to citizen control, whereby citizens are given control of a programme or project.[96]

Figure 3: Arnstein's ladder[72]
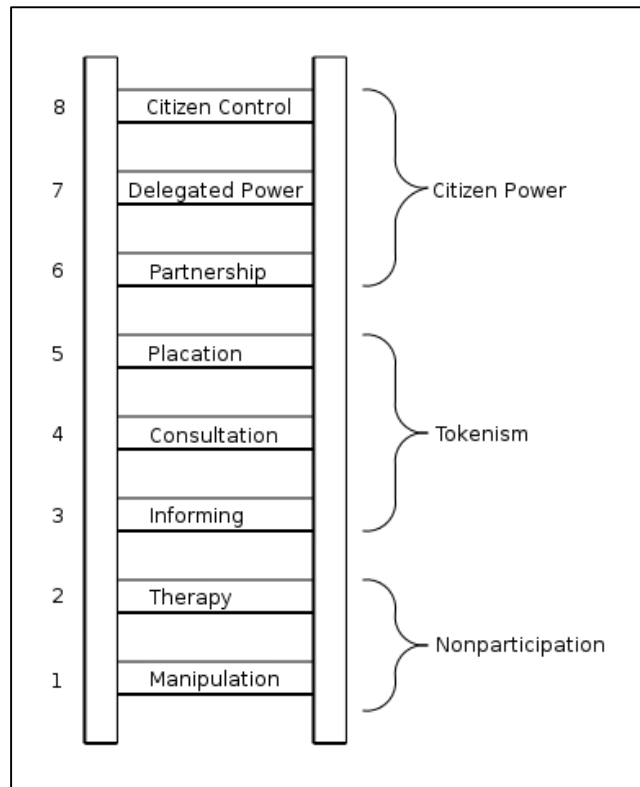
Some argue that the ladder fails to engage with the complexity and nuances of public involvement[94] and does not consider the different types of involvement or the varied contexts in which it might take place.[84, 93] Nevertheless, it is still a touchstone for policy makers and activists over 40 years on and continues to play an important role in shaping thinking about public involvement.[93]

However, Arnstein was an urban redevelopment specialist in the United States, working in the 1960s, and her article very clearly sets public involvement in the context of the hierarchical structures that were evident in that country at that time. The content also largely focuses on planning issues, but she argues that her model is broadly relevant to other settings in which 'the underlying issues are essentially the same – "nobodies" in several arenas are trying to become "somebodies" with enough power to make the target institutions responsive to their views, aspirations, and needs.'[72] If the goal is citizen control,

as she advocates, genuine involvement in health care planning would seem to require a complete transfer of power from commissioners and clinicians. The model promotes the agenda of 'the have nots' in society, which may be appropriate in some settings. However, it doesn't seem to acknowledge that there may equally be situations where partnership may be preferable to citizen control. Returning to reconfiguration decisions, for example, it is not clear whether patients and the public are actually 'demanding that degree of power (or control) which guarantees that participants or residents can govern a programme or an institution, be in full charge of policy and managerial aspects, and be able to negotiate the conditions under which "outsiders" may change them.'[72] Equally, in health care, this may not be desirable. Whilst there may be potential downsides to information asymmetries in this context, such as supplier-induced demand, patients consult doctors because they require clinicians' specialist knowledge.

Other models

A number of authors have sought to redesign and reinterpret Arnstein's ladder. One of the most widely cited was published by Charles and DeMaio in 1993.[83] They collapsed Arnstein's categories into three levels of participation: consultation, partnership, and lay domination. They also argued that involvement could also take place in different 'decision making domains' which encompass 'voice' and 'choice': (1) macro level policy issues; (2) decisions about service design and resources; and (3) matters relating to individual treatment. In addition, they acknowledged that the perspectives of citizens would depend on the role they were playing (patient, member of the public, and so on).[68, 96] Within this framework it is possible to have partnership for patients in the realm of individual treatment, consultation for the public on policy and planning, and lay control of service design and resources. This approach apparently ignores the differing theoretical bases of 'voice' and 'choice' and considers them to be complementary. However, it is useful because it not only acknowledges the multidimensional nature of public involvement but also recognises that complete citizen control may not be the holy grail of involvement.

Others have also attempted to reduce the complexity of Arnstein's model, with Feingold suggesting five degrees of participation (informing, consultation, partnership, delegated power, and citizen control).[96, 97] Wilcox's ladder also has five rungs that reflect various aspects of user involvement including deciding together, acting together, and supported independence,[93, 98] whilst Burns' ladder of citizen empowerment attempts to incorporate the degree of participation and the quality of the engagement process.[11] In attempting to

reduce the complexity of Arnstein's ladder, these models seem to have gone to the other extreme and fail to capture the complexity of involvement as a consequence.

All these models retain the hierarchical approach of Arnstein's ladder and still uncritically embrace citizen control as the pinnacle of involvement.[93] An alternative model, recently proposed by Ives *et al*,[99] calls this in to question. Its focus is public involvement in applied health research, but as I will demonstrate, I think it also has relevance to health care more broadly. It usefully demonstrates some of the unspoken tensions that are inherent in the practice of public involvement, which I have already highlighted. Their core proposition is that there has been relatively little reflection about whether the concept of public involvement is internally coherent. To illustrate their point, they draw on Plato's classic argument against democratic government:

> Imagine you are on a ship. The captain is in charge. He is bigger and stronger than anyone else, and can impose his orders by sheer force of will. However, he is a little deaf and has little knowledge of navigation. The crew are all individually expert in the mechanics of sailing, though ambitious to dominate the captain. Their legitimate presence on this ship, however, is justified solely insofar as they act to carry out the orders of the captain. Last, there is an expert pilot-navigator, who is a skilled seaman, and who knows how to navigate by the stars.
>
> In Plato's analogy to a democratic state, the captain represents the public, which is able to impose its will by force of numbers, despite having no expertise in statesmanship. The crew represents the politicians, who are expert statesmen, but are obliged to execute the will of the public. The pilot-navigator represents the philosopher who, according to Plato, has the knowledge, moral expertise and wisdom to steer the 'ship of state' along the right course.
>
> Plato's challenge to the democratic ideal is to ask who we would really want sailing the ship: the unskilled but forceful captain, the ambitious crew, or the skilled and experienced pilot-navigator? The assumption is that we should favour the pilot-navigator. The challenge to [public involvement] is similar: why would we want to put unskilled lay people in a position where they can direct a process about which they know and understand little?[99]

In the context of applied health research, Ives *et al* suggest we should not allow untrained people to play a significant role in carrying out research, in a way that gives them some

power and control over the process. Rather, the public (the captain) should have a say in where the ship is going, but the expert (the pilot-navigator) is then given the rudder. Given the information asymmetry that exists within health care planning, a similar argument can perhaps be made. The balance between the views of the public and those of the experts is a key issue in the context of reconfiguration, but there is at present no agreed or acceptable weighting system to determine whose views should take precedence.[5]

Clearly, Ives *et al*'s argument may sit uncomfortably alongside one of the ideological motivations for public involvement – to redress power imbalances between patients, the public and an exclusionary and elitist medical community. Arnstein's ladder remains the touchstone in UK health policy, but it is applied uncritically, with little thought given to exactly what it involves or whether its goal of citizen control is appropriate in this setting.[93] Ives *et al* acknowledge that their model is likely to be controversial, but they suggest that it is unlikely that any alternative could incorporate the inclusiveness that would be necessary to ensure that whole communities feel engaged and valued.

However, this consultative model also does not offer any guidance on the way in which the pilot-navigator should incorporate the views of the captain which does limit its utility. Again, the extent to which the public actually want citizen control in health care planning (or applied research) is unclear. Continuing the ship analogy, in the context of hospital reconfiguration, the public may well want to take the ship in a completely different direction to that proposed by the pilot-navigator. How should these differences of opinion be addressed? Nevertheless, Ives *et al*'s model does provide a challenge to the assumption that is implicit in much current health care policy, that we should be striving for greater citizen control in decision-making, and usefully illuminates some of the issues inherent in this.

The role of citizens

A number of other authors have sought to categorise the role of citizens in decision-making processes. In the context of health care, Tuohy and Evans note that citizens assume two major roles. They are on the one hand collective taxpayers, and on the other, individual consumers of services.[100] The public may also assume different roles at different times, depending on their interaction with the health care system. Thus, Lomas *et al* define the roles of citizens in three distinct areas of decision making. First, there is the citizen-taxpayer concerned by how health care services are financed and what services will be offered. Secondly, there is the citizen-collective decision maker, concerned by the range of services

that will be offered within his or her community setting. Finally, there is the citizen-patient, whose concerns will be the appropriate provision of services to meet his or her individual needs.[71, 101]

In reality, the distinction between individuals as patients and members of the public is more opaque than these models suggest: most of us have been patients at some point and this experience inevitably frames our views about the health system.[71] The interests of these two groups – patients and the public – are not necessarily the same, however.[71, 91] Tritter suggests that individuals will be involved in different ways if the decision relates to their own consumption of health care, rather than the provision and prioritisation of services for the wider community.[94] Similarly, Harrison argues that if an individual suffers from a particular condition, their *a priori* interest is in better specific service provision for themselves and others in the same situation. In contrast, if an individual's health is generally good, their interest is in the provision of a broad range of services, balanced against a desire to pay a reasonable level of taxation.[56] Again, however, these models assume that the wider public, many of whom will not access health care on a regular basis, wish to be involved in improving services they may or may not need. They also assume a certain homogeneity on the part of the public, when in fact an individual's perspective on health services is likely to be shaped by their current needs. For example, the expectations of young parents may differ from those of other people. In particular, the models may be less relevant to emergency services. Most people will rarely access care in A&E and then their contact will usually be brief.

In summary, there is no common framework for describing the key dimensions of public involvement.[83] This is partly because there is little consensus about what the term means, or indeed what the concept of public involvement actually encompasses. Arnstein's ladder of participation, with citizen power as the ultimate goal, remains the touchstone for policymakers. This goal and indeed the relevance of the model to health care settings, seem to be accepted uncritically, as Tritter observes.[93] Additionally, the models largely fail to take into account the differing theoretical literatures that underpin various involvement policies and the potential this creates for conflict between initiatives.

The impact of public involvement

Many of the assumptions that underpin drives to increase public involvement cannot be tested empirically because they are based on values or ideology. This includes, for example, the belief that more public involvement is an intrinsic good in itself. However, it would in

theory be possible to test some of the other assumptions, such as the belief that greater public involvement will lead to more democratic decision-making and, in turn, better accountability of services.[74] Evaluation is important for all parties to inform practice, to ensure that public money is being properly spent, to learn from past mistakes, and to ensure all groups are being represented fairly.[102]

There is, however, a dearth of research about user involvement in health care decision-making.[103] A review by Rowe and Frewer identified only a small number of rigorously conducted evaluations.[82] Similarly, in a systematic review reported by Crawford *et al*, only 42 of the 337 eligible studies (12%) published during the study period (1966–2000), actually described the impact of involvement. These generally showed that user involvement did contribute to changes in the provision of a range of services, including the provision of improved information sources and the commissioning of new services. However, they were unable to ascertain from any of the reports whether involvement strategies had any effect on the quality of services.[71, 74]

A more recent systematic review by Mockford and colleagues also examined the evidence base for the impact of patient and public involvement on decision-making. The authors identified 42 papers published in the UK during the study period (1997-2009), including 20 case studies or reports. Most of the studies provided very little information about the lay participants, and they reported that there was a lack of consistency in defining public and patient involvement. Conceptual or theoretical underpinning of the studies was also scarce; just two reports included a theoretical argument for their work. Most studies were driven by current policy initiatives as their primary framework.[103]

One reason for the paucity of high quality research may be that there are a range of practical and political barriers to carrying out rigorous evaluations.[74, 102] Additionally, many policies are short lived or very recent.[71] The focus on measurement that exists in other areas of health care, such as patient reported outcomes, has not yet emerged in this area. Although there is extensive experience of patient and public involvement in the NHS, the research evidence base underpinning this activity is underdeveloped[104] and the impact of involvement on the quality and effectiveness of health services consequently remains undetermined.[69, 94]

Rather than the impact of involvement, most published work focuses on the experience of being involved as an outcome, perhaps reflecting the perception of involvement as a good

in itself.[94] Additionally, much of the published evidence relates to involvement activities in mental health and cancer services.[94] This leaves those planning involvement work reliant on 'previous examples, intuition and an array of approaches that have not always been evaluated for a particular setting.'[104]

Limitations of public involvement

The sparse evidence base underpinning involvement initiatives potentially jeopardises the important contribution that the public could make to health care improvement. It is also limited by various other constraints. Referrals of reconfiguration proposals to the IRP, for example, frequently include some adverse comment about the consultation process, most often that it did not reach enough people or that it was too difficult to understand.[1]

Tritter notes a 'continued unwillingness by public sector managers to make involvement more than a "tick-box" activity.'[94] Others describe an apparent reluctance on the part of health professionals and managers to engage with the public and put into practice the outputs of public involvement processes.[69, 105] This perception could play a role in fuelling dissatisfaction with consultations about reconfiguration proposals. Martin also cites a range of ways that professionals may seek to undermine the legitimacy of those involved and retain control over decision-making processes, including controlling the course of meetings and selectively implementing the suggestions of public-participation processes.[106] On the other hand several authors observe that it may be used to bolster professional and managerial power or as a means of co-opting citizens into a political agenda, for example by commissioners seeking to legitimise potentially unpopular service change proposals.[68, 107, 108] The role that the consultation process plays in influencing the public response to reconfiguration proposals is a further focus for this thesis.

There is also a concern that whilst government policies may increase public involvement in the NHS, they may not necessarily do so in a way that is representative of the population.[74] Church *et al* observe that public involvement initiatives often rely on self-selection or the selection of 'appropriate' individuals by health professionals. This can result in exclusion and elitism, and a reliance on 'the same traditional middle-class cross-section of citizenry.'[107] Involvement mechanisms may well exclude the population groups that are most likely to require health services. Klein describes this as the 'inverse law of participation' where those with the greatest need to further their own interests often have the least capability to do so.[109] For example, vulnerable groups such as the elderly, those with mental health problems, refugees, and those who are most deprived in terms of

health care are least likely to participate in involvement activities.[71] Additionally, involvement processes often require individual buy-in over long periods of time, as well as skills of discussion and analysis, and thus tend to privilege the middle-class and the educated. [67]

As I have noted, many of the models of involvement assume that, because the public have greater expectations about the health care they receive, they are naturally also concerned about the quality of services generally. In contrast, it may be that the wider public actually has limited incentive to participate in decisions because an individual's contact with the health care system is usually involuntary, sporadic, and unplanned.[71] Klein cautions against the assumption that 'there is a dammed-up demand for greater participation, only waiting for the institutional changes needed to open the floodgates of public involvement.'[109] Concerns that reconfiguration consultation processes are not genuine and that the public do not have an opportunity to influence the outcome[7] suggest that there is some demand for involvement, at least in certain sectors of the community. However, the role that these groups would want to play in the process is unclear, as is the extent to which this feeling is shared across the community.

Conclusion

Public involvement in strategic decisions about NHS services is a core plank of health policy in England and in this chapter I have sought to set decisions about reconfiguration within this wider context. I have focused on the literature about public involvement in strategic decision-making about health services, paying particular attention to the purpose of involvement initiatives. There is also an extensive literature about patient participation in treatment decisions, as well as the roles patients and the public can play in the research cycle, but this is less relevant to this thesis.

Both the previous and current governments have taken steps to increase the level of public involvement in the English NHS. This has been informed partly by the belief that public services are paid for by the people and therefore should be shaped by them. It is also hoped that increased involvement will make services more responsive to the needs of local communities and in turn improve health. There are, however, two very distinct theoretical literatures that underpin involvement initiatives, as I have outlined. The consumerist perspective, 'choice,' is based on economic principles and seeks to improve care quality by encouraging users to make choices between services. Providers thus risk the loss of 'business' if patients are dissatisfied with the service that they currently receive. In

contrast, the democratic perspective, 'voice,' seeks to improve care quality by increasing opportunities for patients and the public to impact how services are run. From my review of this literature, I have identified four areas of concern that have implications for this thesis, with its focus on public involvement in the context of reconfiguration debates.

First, Arnstein's ladder of participation continues to dominate thinking about public involvement,[72] with its aspiration of citizen control over the decision-making process. In many settings this may be entirely appropriate, but this goal seems to have been taken on unquestioningly by the health care community.[93] Indeed, few authors seem willing to explore the potential implications of transferring complete power to the public in the health care context. The emphasis on public involvement in health policy partly reflects the wider shift towards patient-centred care and a general rejection of medical knowledge as the key determinant of health care decision-making. In the clinic, one way this manifests is in the doctor seeking a patient's informed consent to undergo a procedure. In this setting, we would not expect patients to make choices about their care without first giving them relevant medical information. In the context of health care planning, we similarly cannot escape the fact that there is an asymmetry of information between health professionals and patients. Extrapolating from Ives *et al*'s model,[99] would it really be feasible to have decisions about the organisation of care, for example about the configuration of services, driven solely by patient preferences? Concerns about past consultation processes demonstrate clearly that at least some sectors of the public do want a say in decisions about how services are organised and may have helpful contributions to make. Whether or not they are really seeking a full transfer of decision-making powers is unclear. However, the nature of medical decision-making calls in to question the relevance of existing models of public involvement in this context as most consider citizen control over the process as the ultimate goal.

Second, the literature seldom acknowledges that the views of the public may be in direct tension with another central plank of policy, evidence-based health care. This tension is perhaps nowhere better illustrated than in debates about reconfiguration. Citing the Kidderminster general election result in 2001, Harrison *et al* note that 'to put it bluntly, giving people what they want may not be compatible with what the evidence says they should have.'[56] What should we do in this situation? Policy offers little guidance about which concerns should take precedence.

Third, policy currently considers approaches based on 'voice' and 'choice' respectively to be compatible and even complementary. In reality they conflict and potentially undermine each other, as I have demonstrated; one encourages dissatisfied patients to seek care elsewhere, the other seeks to persuade them to stay and contribute to efforts to improve care. The statutory requirement for commissioners to consult local stakeholders about reconfiguration proposals suggests that 'voice' mechanisms have a key role in this process at least, but the four Lansley tests also emphasise 'choice.' The relative importance of these two in this context is not clear, but some commentators argue that the increasing importance placed on market mechanisms means that 'choice' is being prioritised within the NHS.[68]

Finally, there is widespread confusion about the aims of many involvement initiatives and the meaning of terms such as 'involvement' and 'engagement.' This is perhaps the consequence of failing to engage with the theoretical underpinnings of public involvement and recognise that the two main conventional approaches ('voice' and 'choice') emerge from distinct bodies of literature. As a consequence, policies are piecemeal and disparate and there is little clarity about what involvement initiatives hope to achieve or the impact that the public can hope to have on decision-making. This undoubtedly contributes to the 'paradox of consultation' as Farrington-Douglas *et al* describe it,[7] and it is compounded by a limited evidence base to guide practice. It is perhaps because of the lack of clarity about the goals of public involvement that there seems to be an implicit assumption regarding the desirability of involvement.[70-72] In the context of reconfiguration, it appears that public involvement is regarded as an end in itself, rather than a means of achieving more democratic decision-making or more responsive services: if only the public are involved 'enough' and are presented with the 'right evidence' they will be convinced of the need to change.[8]

Chapter 2: Risk communication and reconfiguration

Having considered the theoretical underpinnings of public involvement, I now turn my attention to the specific approaches used to engage the public in decisions about the organisation of hospital emergency services. As I demonstrated in the previous chapter, the current focus of reconfiguration policy is on technical processes, such as optimising pathways of care and clinical procedures. The process however is marked by conflict, and some argue that this occurs because the case for change has not been articulated clearly enough to local residents.[9, 13] Improved public involvement and consultation are consequently seen as a solution. The apparent assumption behind this is that the involvement will be educative in such a way as to lead to smooth acceptance of the proposals.[5]

However, because the process involves a range of contestable values, with various stakeholder groups typically holding to differing priorities, rather than a technical process, reconfiguration may be better framed as a social process that involves participants who each bring their own specific knowledge to the issue and seek to negotiate their differences. Indeed, Spurgeon and colleagues argue that, because the differing emphases of stakeholder groups are largely irreconcilable, there is a 'strong likelihood that conflict over hospital reconfiguration will persist.' Those who oppose change are not irrational or lacking education, but have a distinct view of which kind of public interest claim ought to be pre-eminent. They conclude:

> It would therefore be unrealistic to expect consensus. Instead of thinking in terms of public education, it is necessary to think about hospital reconfiguration as a field of political conflict that requires conflict containment and conciliation rather than pedagogy.[5]

In their analysis, Spurgeon *et al* point to parallels between the reconfiguration process and the literature about technological or environmental risks. In this chapter, I will explore these links in more detail. Crucially, they note that - although some advocates of centralisation talk of 'educating the public' about the importance of reconfiguration - risk communication research has repeatedly shown that this approach typically fails.[5] This is relevant because much of the public anxiety about proposals to reconfigure emergency services relates to concerns about the safety of centralised services and the potential risks

involved in having to travel further for care.[7] One of the most common objections to reconfiguration proposals is that emergency services will be too far away if the changes are implemented. Communities argue that very sick people will be put at risk by the longer journey and may die as a result.[1]

As is also often the case with environmental hazards, the public perception about the risk involved in a reconfiguration is frequently at odds with the view put forward by commissioners. This may be because proponents and opponents of change operate within different paradigms of understanding about risk.[5] This chapter conceptualises the public consultation process as a process of risk communication. Risk communication is defined by the World Health Organisation as 'an interactive process of exchange of information and opinion on risk among risk assessors, risk managers, and other interested parties.'[110] In this case, commissioners and the public are all arguably 'risk assessors' with the onus being on the former to manage the risk. This approach of course sits within the democratic model of public involvement ('voice'), which encourages a community to engage in a process aimed at improving their existing services, rather than the consumerist perspective ('choice').

The previous chapter addressed the theoretical literature about the purpose of public involvement in decision-making. Here, I turn my attention to the content of the involvement process in the context of reconfiguration decisions and outline the conceptual framework for the thesis. I will first compare and contrast the two dominant models of risk communication in the scientific literature. The first of these is the psychological model of risk. The biomedical literature typically draws on this approach, which places a heavy emphasis on probabilities. I will explore the extent to which this currently influences reconfiguration policy. I will also look to sociological theories, and specifically to the contextual model of risk, which seeks to move away from probabilities to explore 'the ways in which people conceptualise and experience risk as part of their everyday lives.'[111] Anthropologist Mary Douglas's theories about the cultural role and importance of risk in contemporary western societies will be used as the first theoretical focus for my research.

Alongside concerns about whether or not the process itself is genuine,[7] there is often also scepticism amongst the public about the case for change put forward by clinicians during a consultation about reconfiguration proposals. This relates partly to concerns about risk as well as the potential benefits of centralising care, and the practicalities of accessing services after a reorganisation.[1] To address this, I will draw on Brian Wynne and Mike

Michael's research about the intersection of lay and expert knowledge as an additional theoretical focus.[112, 113]

Risk perception

The literature demonstrates how public reactions to environmental or technical risks frequently appear to be at odds with scientific opinions and estimates, as appears to be the case in debates about reconfiguration.[114] A key early paper examining public responses to risk was written in 1969 by Chauncey Starr, an electrical engineer in the United States. He used a revealed preference approach to demonstrate that people will accept risks 1,000 times greater if they are voluntary (e.g. driving a car), compared with involuntary risks (e.g. a nuclear disaster).[115]

This work has subsequently been built up on by Paul Slovic and other psychologists who have sought to demonstrate that responses to risk are predictable. Slovic and colleagues identified a broad domain of characteristics that influence risk perception. These may be condensed into three high order factors: 1) the degree to which a risk is <u>understood</u> or known to science, 2) the degree to which it evokes a <u>feeling of dread</u>, terror, or inequality, and 3) the <u>number of people exposed</u> to the risk. The more a person dreads an outcome, the higher its perceived risk and the more that person is likely to want the risk reduced.[116, 117]

Psychological research, such as the work carried out by Slovic, initially defined the study of risk perception. The 'psychometric approach' examines cognitive processes to explore how different attributes of risks affect individual responses.[118] It has highlighted a range of dimensions which are said to be reliable predictors of responses to risk (see Figure 4). Debate remains as to which of these are most important, but risks scoring highly against these 'fright factors' are said to provoke a strong public response. It is important to note that the 'fright factors' relate to perceptions of risk: what matters is not whether exposure to a risk is really involuntary, for example, but whether it is seen in that way.[114]

Figure 4: Factors likely to provoke a strong public response to a potential risk[114]

Risks are generally more worrying (and less acceptable) if perceived:

1. To be *involuntary* (e.g. exposure to pollution) rather than voluntary (e.g. dangerous sports or smoking)
2. As *inequitably distributed* (some benefit whilst others suffer the consequences)
3. As *inescapable* by taking personal precautions
4. To arise from an *unfamiliar or novel* source
5. To result from *manmade*, rather than natural sources
6. To cause *hidden and irreversible* damage, e.g. through onset of illness many years after exposure
7. To pose some particular danger to *small children or pregnant women* or more generally to future generations
8. To threaten a form of death (or illness/injury) arousing *particular dread*
9. To damage *identifiable* rather than anonymous victims
10. To be *poorly understood by science*
11. As subject to *contradictory statements* from responsible sources (or, even worse, from the same source)

For Paul Slovic, effective risk communication involves overcoming 'a number of obstacles that have their roots in the limitations of scientific risk assessment and the idiosyncrasies of the human mind.' This involves 'finding comprehensible ways of presenting complex technical material that is clouded by uncertainty, and is inherently difficult to understand.'[119]

Risk communication

The ultimate goal of the psychometric approach is to improve public understanding of risk by assessing how people form judgements about potential risk, in order to decrease the gap between lay and expert perspectives.[120] This seems to be reflected in current reconfiguration policy which seeks to better articulate the case for change on the assumption that involvement will be 'educative.' In contrast to the WHO definition of risk communication, which considers the process to involve an 'exchange of opinions'[110] this would appear to be more about providing information, rather than exchanging views. Drawing again on Arnstein's ladder, this would sit very low down in terms of the amount of influence the public have over the process.[72]

There is also perhaps a difference between the 'opinions' exchanged in the WHO definition, which perhaps share a similar validity, and 'educative' information in the psychometric approach, which assumes that the recipient is somehow in need of correction. The

psychometric approach has traditionally assumed that individuals behave in a rational manner, weighing information before making a decision. Individuals thus have exaggerated fears simply due to inadequate or incorrect information. Consequently, giving people additional information will help them better understand risk, and hence lessen their worries.[121] Again, calls to better articulate the case for change in a bid to assuage public concerns, reflect this type of approach with its emphasis on giving information, rather than exchanging it.

The field of risk communication has emerged over the past thirty years, partly to explore how to address practically the gap between lay and expert understandings. The goals of risk communication include information and education, eliciting behaviour change, and providing emergency information. According to Cohrssen and Covello, difficulties in communicating about risk fall into three categories: 'source' problems such as a lack of trust in responsible authorities, disagreement among scientific experts and the use of technical language; 'channel' problems such as selective and biased media reporting, and oversimplifications or inaccuracies in interpretation; and 'receiver' problems such as inaccurate perceptions of risk and a reluctance to make trade-offs between different types of risk.[122]

This model of risk communication has been termed the 'deficit model' because it seeks to decrease the gap between lay and expert perspectives by addressing 'inaccurate perceptions' amongst the public.[123] However, it has received widespread criticism. For many, the pattern of experts telling unqualified and ignorant non-experts what constitutes a proper concern is no longer sufficient.[124] For Scherer there are three flawed assumptions underlying the deficit model: that science alone can provide objective truths; that scientific and technical experts are the only sources of valid and rational information; and finally, that the public is a passive receiver of risk information.[125]

Socio-cultural perspectives of risk

As misgivings about the deficit model have grown in other fields, there has been a gradual shift away from 'correcting misperceptions' to an approach that views risk communication as a two way process.[114] The contextual model of risk communication acknowledges that individuals do not simply respond as empty containers for information; the way we process information is shaped by our previous experiences and personal circumstances. In the deficit model, science is sufficient and the public is deficient; communication is one way and assumes the public are passive recipients of information. In the contextual model,

there is a two way interaction between science and the public.[126] As I noted in the previous chapter, it would be naïve not to acknowledge that there is an asymmetry of information between health care professionals and the public. However, the contextual model recognises that the public have concerns and priorities which are just as valid as the 'expert' perspective. This acknowledgement of course underpins the practice of shared decision-making, which is gaining increasing prominence in clinical practice.[127] However, lessons from the literature about the contextual approach to understanding how the public assess risk have not been applied to the debates about reconfiguration and can potentially provide new and important insights into the public response to proposals for change.

The sociologist Deborah Lupton argues that the psychometric literature on risk evaluation focuses on probabilities, 'contempt towards lay perspectives', the notion of rational behaviour and 'perceptual pathology.'[111] This research typically relies on survey methods which limits participants' ability to state what is really important to them.[118] It also treats respondents as atomised individuals, rather than members of a social group.[120] In contrast, the shift towards a contextual model of risk communication has occurred partly because of a growing body of research that emphasises the importance of the social context in which a risk is understood.[111] An individual's social context is the immediate physical surroundings, social relationships, and the cultural milieu within which they function and interact.[128] If we understand that the identification of risks takes place within this framework, some suggest that no amount of information on probability will change opinion, unless context is also taken into account.[129]

Lupton goes on:

> The difference commonly observed between 'expert' and 'lay' judgements of risk is founded not in the fact that lay people cannot think in terms of probabilities, as some psychometric risk analysts have contended, but rather that other concerns are brought to bear in the ways they judge risk.[111]

This research will seek to explore how other concerns are brought to bear on how the public assess the potential risks involved in a reconfiguration. Mary Douglas and Ulrich Beck are the two authors principally credited with establishing risk in the lexicon of sociological theory,[120] which Lupton draws on. Douglas was a British anthropologist; Beck is a German sociologist. Both explore the historical development of the cultural meaning of risk. However, Beck identifies a disjunction between today's 'risk society' and earlier periods of

human history, whilst Mary Douglas emphasises a continuity between the contemporary significance of risk and that of any other period.[120] Beck argues that the novel technological hazards of the industrial age have created for the first time a risk of self-annihilation, and ushered in a new and unprecedented culture of risk.[130] In contrast, for Douglas, our technologies may be new but humanity has always conceived itself to be courting catastrophe in the face of an uncertain future.[131]

The cultural role of risk

Mary Douglas's work sought to analyse the concepts of ritual purity and impurity, pollution and cleanliness in different societies and times.[132] Much of her early research was carried out in what was then the Belgian Congo, now the Democratic Republic of the Congo. In *Purity and Danger,* published in 1966, she took on the task of 'vindicating the so-called primitives from the charge of having a different logic or method of thinking'.[133] Her theorising about the cultural role and importance of risk in contemporary society builds on this anthropological research.[111] As I will go on to explain, it is used as a theoretical focus for this thesis, because it has more direct relevance to the question of reconfiguration, than Beck's work on the risk of self-annihilation inherent in modern technologies.

In her book *Risk and Blame*, Douglas makes the case that beliefs about hazards are shaped by social context, rather than by modes of cognition and personality types, as favoured in the psychometric model.[120] She notes that risk research has found that the public simply does not see risks in the same way as experts, as the debate about reconfiguration well illustrates. The gap between lay and expert views about risk has given rise to a whole new branch of psychology, she says, and yet 'the baffling behaviour of the public continues as before.'[133]

Douglas writes:[133]

> Consensus does not depend on the facts being recognised. And consensus amongst a group of scientists does not guarantee consensus amongst the public. The profession of psychologists which has grown up to study risk perception takes the culturally innocent approach by treating political dissension as intellectual disagreement. Aiming to disregard the contests over power which give rise to differences of opinion about risks, the profession neglects the central issue. It seeks to bring to the assessment of public perceptions the same degree of objectivity aimed at in risk analysis itself, and by similar methods. Unfortunately, the effort is

skewed by the culturally innocent assumption that cultural bias is irrelevant. Using the innocent model of risk perception generally leads to the conclusion that there should be more education of the misguided public. But in a democracy education is not expected to change political commitments. It would obviously be helpful for policy in risk if the public were better educated in many subjects. But it is most unlikely that better communication and more education would reconcile differences of opinion on risks.

For Douglas, a risk is not only the probability of an event, but also the probable magnitude of the outcome - and everything depends on the value set on the outcome.[134] In other words, people select a risk as being important partly because they especially value what is under threat. For example, crime damages one's personal sense of security but it also threatens the stability and organisation of one's community; terrorism attacks a way of life; the use of genetic modification threatens the 'naturalness' of food.[135]

Different individuals and different communities might judge a risk more or less seriously because they value the consequences differently— for example, they value differentially what is being harmed and by whom. In this way, Douglas argues, the identification of a threat or danger and the appraisal of its possible consequences are political, aesthetic and moral matters, rather than technical ones.[134]

She does not deny that in many areas, it would be helpful if the public were better informed about individual risks. However, citing the very low probabilities of a particular risk makes little difference to the public. This is not because the public does not understand the maths, but because many other important factors have been left out of the risk calculation, for example interactions between individuals and their advice to one another.[133] She is in fact critical of the idea inherent in the psychometric model that the ordinary lay person is weak on probabilistic thinking. She argues that humans have to be able to size up probabilities informally. For example, anyone whose livelihood has depended on understanding the weather or tides, any sailor or fisherman, is used to taking a huge number of factors into account, she suggests.[133]

Douglas traces how the meaning of the word 'risk' has changed with time. The concept emerged in the seventeenth century in the context of gambling. Risk meant the probability of an event occurring, combined with the magnitude of the losses or gains that would be entailed. Since the seventeenth century, the analysis of probabilities and the calculation of

risk has been the basis of scientific thinking, transforming the nature of evidence, knowledge and logic. In the eighteenth century, the analysis of risk had important uses in maritime insurance. The chances of a ship coming safely home and making the fortune of its owner were set against the chances of it being lost at sea, bringing ruin. The idea of risk itself was neutral; it simply took account of the probability of losses and gains. In the nineteenth century, the theory of risk-taking became important in economics. Human beings were thought to be risk averse, so the owner of a firm needed a special profit incentive for risk-taking, or he would not invest.[134]

Today, however, the meaning of the word has changed again and, Douglas suggests, it has weakened its connection with technical calculations of probability and now refers only to negative outcomes.[133] The language of risk is reserved for political talk about undesirable outcomes. Risk today means danger; high risk means a lot of danger.

Douglas goes on to propose that in western societies, risk has become a forensic resource for holding others accountable and apportioning blame - 'a stick for beating authority.' She argues that in contemporary cultures, where every misfortune is chargeable to someone's account, every accident is caused by someone's criminal negligence, 'to be at risk is the equivalent of being sinned against.' [133] The modern concept of 'risk, parsed as danger', is invoked to protect individuals against the encroachment of others.[134] To be 'at risk' is to be vulnerable to events caused by others.[133]

Risk carries connotations of accountability and blame.[133] For this reason particular risks may gather special salience and resonance, and become battles over competing values and definitions of social order. For example, companies, scientists and regulators may be seen as imposing a particular view of nature through the development of technologies such as genetic modification. These technologies have the potential to generate new dangers but equally, they impose a conflicting set of values on others who have little power to resist or make their voice heard.[135] A group that perceives it has little power may select a risk as worthy of attention and dramatise its dangers to make their point. As Tansey suggests 'groups with marginal political or economic power can only exert their influence by appealing to the populace through accusations that those in power are responsible for exposing them to danger.' He continues:

> Risk becomes politicized not simply because it is a threat to life but because it is a threat to ways of life. Rather than ask how a risk comes to be magnified or how risk

perceptions are influenced by heuristics, irrationality or pure emotion, this approach asks indirect questions: At whom is the finger of blame being pointed? Who is being held accountable? What is being rejected and what is being defended in a particular collective social action? This implies that for issues such as genetically modified organisms, research that seeks to demonstrate the safety of the technology will not dissipate political opposition since protest is in defence of a moral boundary.[136]

Critiques and limitations

Theories such as Douglas's work on risk provide a useful means for describing and predicting behaviour, but necessarily oversimplify reality.[137] This body of work is useful for understanding the cultural reality of risk perception, but is obviously not sufficient in itself to account for all the ways that people perceive and respond to risk. The process of risk perception is undoubtedly more complex.[120] Some have been sceptical about the universalist claims of her theories.[120, 138, 139] However, researchers have found her work to be useful for exploring perceptions of risk in a range of different contexts.[140, 141]

Douglas has also been accused of being a 'cultural relativist' and assuming that risk is 'merely a social construct.'[142] However, she is quite clear that she is not taking issue with the reality of the dangers, they are all too real.[134] Equally, she has been criticised for taking issue with other positions such as the psychometric model of risk perception without proposing an alternative and viable risk evaluation technique of her own.[143] Additionally, Wilkinson argues that Douglas did not 'make much effort' to consider the validity of her theories in relation to the body of psychometric research conducted into social perceptions of risk. He regards the core theoretical principles of her theory as untested and effectively polemical, rather than being confirmed by existing anthropological data.[120] However, Douglas's theories about the social function of risk arose from her early anthropological work, studying ritual purity and impurity and the book in which she set out her theory of risk explored responses to air pollution and nuclear power in the United States.[131] A variety of authors, including Wildavsky, have subsequently produced further empirical evidence in favour of the theory.[140]

Douglas's work potentially provides an important insight into how views about the risk involved in a reconfiguration are influenced by the context in which those judgements are made. Nevertheless, her theory comes from an interpretive tradition, rather than the positivistic tradition which still dominates the biomedical sciences. For some, this

theoretical outlook may limit its relevance to health care settings.[144] However, several groups have argued that improvements are needed to both the policy and the process of consultation about hospital change, as outlined in the previous chapter.[7, 13] The current approach to consultation appears to be based on the psychometric approach to risk communication. This approach has been rejected in other fields, but current recommendations about how to improve the reconfiguration process call for more of the same. The increasing emphasis placed on the contextual model of risk in other scientific fields suggests that it may be equally useful here and offer fresh insights into how the process might be improved.

The public relationship to 'experts'

During a consultation about a proposed reconfiguration, considerable weight is often given to an 'expert' presenting the case for change. In line again with the psychometric model of risk communication, this is typically a senior clinician, whose view - it is thought - will carry weight with the community and convince them that the proposals must happen. However, the public often remain sceptical and simply do not believe the claims put forward by commissioners.

Doctors are considered to be the most trustworthy profession in the UK, with 88% of adults stating that they would trust clinicians to tell the truth.[145] Expert opinion has a special status in scientific debate more broadly, and is often idealised as objective and disinterested.[129] At the same time, however, others have described a 'crisis of trust' in scientific decision-marking.[146] Expert pronouncements are more likely than ever to be scrutinized and questioned. This distrust may be attributed to broad social changes, which heighten our appreciation of risk, such as those described by Mary Douglas. Recent events that have defaced the public image of the scientific experts perhaps also play a part. An example includes the bovine spongiform encephalopathy (BSE) crisis in the UK in the late 1990s. An expert advisory committee was established at the time to advise the government. However, it was later claimed that the purpose of the group was in fact to provide political support to officials who wanted to persuade ministers to sanction the slaughter of clinically infected animals.[147] Either way, the literature on environmental risks strongly suggests that relying solely on experts is not sufficient for the provision of credible scientific advice.[148]

Sociologist Brian Wynne was responsible for many of the key early critiques of the deficit model of science communication, which I described above. He has subsequently sought to

challenge the assumptions traditionally embedded in approaches aimed at improving the public understanding of science. These include the apparent assumption of 'public ignorance' in matters of science and technology, and the belief that science offers a uniquely privileged view of the world.[149] Within the psychometric approach to risk communication, there is little scope for the views of the public. At least in health care, this perspective may also go some way to explaining Tritter's observation that public sector managers appear to be unwilling to engage in public involvement.[94]

Research on environmental risk management suggests that opponents of new technologies are inclined to emphasise a 'worst case' scenario about what can go wrong, whilst 'expert' proponents seek to emphasise a 'best case' scenario, highlighting how well a new technology could operate in ideal conditions. Each group employs a different model of how technological systems work.[123] This is perhaps also the case in hospital reconfiguration, with proponents focussing on the potential patient benefits, whilst opponents seek to highlight what might go wrong.

Wynne describes a 'naïve' view that every part of a system can be expected to unfailingly follow carefully defined rules. He notes that this perspective has frequently been fostered as part of a process aimed at legitimising new, potentially controversial technologies.[150] However, this view carries two principal assumptions: that a facility will routinely achieve the performance it was designed to achieve; there will rarely be any significant deviation from routine operation and accidents will seldom occur. However, opponents of new technologies often seek to uncover potential uncertainties and throw into question the naïve view of technological systems. This contrasting view portrays complex systems as unpredictable, invoking a version of Murphy 's Law: watch out because everything that can go wrong is likely to go wrong.

Wynne has also examined the intersection of expert and public/local knowledge. He explored the perspectives of hill sheep-farmers in the English Lake District who experienced radioactive fall-out from the 1986 Chernobyl accident, contaminating both their flocks and their land. As a consequence, they were restricted from selling their sheep, with serious implications for their livelihoods. The scientists persisted in their belief that the initially high caesium levels would fall, but it later emerged that these predictions were based upon a false scientific model of the behaviour of caesium in an upland environment. Their exaggerated sense of certainty was a major factor in undermining their credibility with the

farmers. At the same time the scientists ignored famers' own knowledge of their local environments, hill-sheep characteristics and hill-farming realities. [151]

Trust and credibility were major factors in influencing the uptake and understanding of scientific messages in Cumbria. Whereas the farmers were quite reserved in their scepticism about scientific matters, they were abrupt and outspoken when they saw the extent of the scientists' ignorance of hill-farming practices.[151] Wynne argues that the public are likely to be sceptical, critical or hostile to scientific statements when such statements seem to emerge from an idealised and inappropriate model of real world conditions.[149] Equally, because people use 'local' framings to make sense of risk, discontent with expert knowledge is likely to arise when 'expert' accounts of physical reality conflict with local people's knowledge and understanding.[152] As I have already noted, in the case of reconfiguration we often see scepticism about the case for change, for example the potential risks and benefits of central services.

The public relationship to science

This research will explore the foundations for this scepticism in more detail. The work of Wynne and his colleague, Mike Michael, is proposed as a further theoretical focus, to explore in more detail the ways in which the public respond to consultation process about reconfiguration proposals. There is a large literature exploring the public relationship to science from a range of perspectives; this particular body of work has been chosen because of its relationship particularly to how the public relate to risk communication initiatives. Wynne's work with the sheep farmers showed that traditional approaches to risk communication have fallen short because they have failed to connect with local concerns, resulting in a loss of trust, conflict and dissonance.[114] This has relevance for reconfiguration, if it is again framed as a social process involving interaction and negotiation between participants with differing knowledge and concerns.

Michael, also a sociologist, builds on Brian Wynne's work to examine how people negotiate the term 'science' in discourses about risk. He observes that, whilst people are often highly critical of particular scientists or scientific views in this context, they can simultaneously retain confidence in the pronouncements of other scientists and science more generally. From interviews with laypersons about various aspects of ionizing radiation, including Wynne's study of sheep farmers, Michael identifies a distinction in how the public relate to science, between science as an abstract entity or principle (which he terms 'science-in-

general') and as an activity directed at specific phenomena or problems (termed 'science-in-particular').

Science-in-general

In discourses about 'science-in-general', Michael notes that science is talked about as a coherent entity. Emphasis is placed upon the form of its activities and its knowledge domain of technological and natural phenomena.[112] Bickerstaff and colleagues identify two key themes in Michael's work that recur when people discuss science-in-general: the uniqueness of science and the inaccessibility of science.[118]

1. The uniqueness of science

Michael identifies science-in-general as an impenetrable entity that the individual perceives themselves to be at some distance from. That is, scientists are in possession of a particular type of specialist knowledge, from which the individual is permanently barred from entering. [112] He describes how, in some cases his research participants saw themselves as having a sort of 'global scientific ignorance.' The criteria of what counts as scientific knowledge are so strict that they could never hope to realise them. By describing their knowledge of science as 'zero', participants were bracketing scientific knowledge as 'other':[112]

> Speakers who use this terminology are not merely differentiating themselves from science-in-general; they are also saying that they are constitutionally not mentally equipped to comprehend science. Science-in-general comes to be negatively constituted as an 'other' from which one is permanently banned from entering.

Michael quotes one of his participants who identified physics as 'a science because I know nothing about it.' The less insight she had into a subject, the more science-like it is. This is not due to any fault on her part; it is rather a comment about the nature of science itself.

2. Science as inaccessible

In a study of public perceptions of the risks of radon, Michael also observed a discourse of ignorance about science, centring on mental constitution. In other words people presented themselves as being mentally incapable of grasping the science or making decisions about risk as they did not have a 'scientific mind.'[112] For Michael, the process of reflecting upon one's unscientific mind (or lack of scientific skills) is interpreted as a tacit relation to science – the individual is placing themself as subordinate to and dependent upon the experts, at least in relation to the relevant scientific matter.[113]

Bickerstaff and colleagues also observe that non-scientific or lay knowledge is often assigned inferior status relative to 'science,' prefaced in conversation by phrases such as 'I don't know, I'm not a scientist', or 'I'm just a layperson.' They argue that discourses of ignorance display more than a deficit of knowledge and dependency on science. They also serve as resources by which individuals fashion other relationships to science. These include co-operation or a division of labour: science in this abstract sense is considered to be best placed to make decisions about risk problems.[118]

Science-in-particular

The second discourse Michael identifies addresses science-in-particular, that is, specific examples of science that involve particular knowledge and often identifiable practical goals. Public judgements about science-in-particular frequently raise questions about the competence of science in a specific context. As Michael notes, 'if science-in-general is used as a means of distancing self from science, science-in-particular can be used to downplay the status of science – to shift the emphasis from the mystique of science to its mundane character.'[112]

Here there is also a discourse about the division of labour between science and non-science, but it often takes a conflictual form when directed at science-in-particular. For example, his interviews demonstrated that the hill farmers affected by the nuclear fall-out from Chernobyl no longer saw scientists as credible. They reached this view for a number of reasons. The solutions offered by scientists took very little account of the constraints on farmers' practices, revealing great ignorance of basic farming knowledge. Their pronouncements were also often phrased in terms of certainties which ran contrary to the farmers' own experience of their work as entailing uncertainty and adaptive flexibility. Although the scientists' expertise was ostensibly deployed in the farmers' interests, it actually encroached upon and often denied, rather than complemented, the farmers' own knowledge.[150] It became apparent that scientists were imposing a particular view that was inappropriate for the farmers. Scientific knowledge was consequently downgraded both because it conflicted with local knowledge and because the way it was framed effectively dismissed the farmers' own expertise.

Bickerstaff and colleagues also observed people repeatedly making reference to a sense of disenchantment with science. In their work, doubts about the competence of science were particularly to the fore where technological risks involved considerable temporal uncertainties and experience had demonstrated that scientists often got it wrong. For

some, the apparent inconsistency of messages from the scientific community serves to raise doubts about the competence and skills of the 'so-called' experts. People do not know who (if at all) to believe.

In summary, Michael offers a view of how lay people construct a view of science in relation to themselves, as well as society more generally. He observes a distinction in public discourse between what he refers to as 'science-in-general' and 'science-in-particular.' For most people science-in-general was viewed as a specialised and exclusive epistemological system from which the individual is barred access. By contrast, the discourses about science-in-particular were concerned with the competence (skills, abilities, methodological limits) and motivations (interests and subjectivities) of science within specific contexts. He argues that science-in-particular can be used by the public to downplay the privileged status of science.

Critique and limitations

Michael's distinction between science-in-general and science-in-particular provides us with a generalised image of scientific knowledge. This type of image is said to play an important role in determining the relationship between knowledge and prevailing norms, values and ideologies.[153] However, others have noted that such representations are inevitably abstract generalisations, and are more responsive 'to the rhetorical requirements of political discourse than to social science standards of empirical adequacy.'[154] Citing Michael's work, Kallerud and Ramberg reject such images of scientific knowledge on the grounds that they are developed to justify and promote public expenditure on science and technology, rather than serving the interests of society. Citing Michael's work, Kallerud and Ramberg dismiss generalised images of science, such as this, on the grounds that they are developed to justify and promote public expenditure on science and technology, rather than serving the interests of society. Instead they perpetuate the message that: 'science needs to be well-provided for, and accorded a high degree of autonomy and authority.' For them, science-in-general endorses the position of science as an 'icon of modern society, and an exclusive and remote source of knowledge.[154]

At the same time, the boundary between science-in-general and science-in-particular is not clear-cut. For example, in their study of how people frame and balance different risks, Bickerstaff *et al* found that, in some cases, participants' expressions of scepticism about science-in-particular were building to a more general critique of science, or at least recognition of its limits and contingencies. Nevertheless, the theory was useful in their

analysis[118] and, as I have demonstrated, there are apparent parallels between Wynne and Michael's work and the reconfiguration process, which the theory may help to illuminate further.

Conclusion

The previous chapter demonstrated that much of the public concern about the reconfiguration of hospital services relates to the perceived risk involved in travelling further to access care in an emergency. In terms of addressing this, on one hand, it is argued that the case for change is just not articulated clearly enough to local residents.[9, 13] On the other, it is suggested that consensus about reconfiguration decisions may be impossible because proponents and opponents of change operate within different paradigms of understanding about risk.[5]

This chapter has drawn together a range of debates, each of which has consequences for understanding, first, how individuals assess the risk involved in reorganising health services and, second, how this influences their response to risk communication efforts during the consultation process. The literature on risk is interdisciplinary and fragmented, and few attempts have been made to create an overarching theory about how people form judgements about risk.[114] The biomedical literature largely draws on a psychological model of risk perception which focuses on probabilities and aims to reduce the gap or 'deficit' between lay and expert perspectives. In contrast, the socio-cultural model of risk understanding emphasises the importance of the social context in which a risk is understood: no amount of information about probability will change opinion, unless this context is also taken into account.

The approach to public involvement in reconfiguration decisions advocated in the policy literature appears to be very much based on the psychological model, with its emphasis on providing more information and engaging the public more, in the hope that the process will somehow be educative.[1, 13] In Chapter 1, I noted Farrington-Douglas *et al*'s observation of a 'paradox of consultation' in terms of reconfiguration decisions: local stakeholders expect to influence the outcome of consultations, yet end up concluding that the process is a 'sham' when their views ultimately appear not to have counted.[7] Once again we return to the question about the purpose of public engagement in health care decision-making. Policy creates the expectation that the public will have a say in decisions. However, the approach to engagement in this context seems to regard the purpose as educative, the process as one way, and medical knowledge as uniquely privileged. This may be partly because of the

lack of clarity about the aims of public involvement that exists in health care, which in turn results partly from an ongoing failure to engage with its theoretical underpinnings.

In this chapter, I proposed that Mary Douglas's theory about the cultural role of risk offers a framework for analysing how the public evaluate the risk involved in a reconfiguration. If, as Douglas proposes, the concept of risk has more to do with 'unacceptable danger' than probabilities, this adds further weight to the argument that providing more information about the case for change will not work, which has important implications for debates about reconfiguration. At the same time, despite increasingly innovative attempts to present the case for change more clearly, the public frequently remains sceptical about the information put forward to support reconfiguration proposals. The final section of this chapter explored the work of Brian Wynne and Mike Michael, examining how people negotiate the concept of 'science' in the context of risk communication.

Douglas sets out a theory about the cultural role and importance of risk in today's society; Michael's work similarly examines discourse about risk, but also the wider relationship between citizens, science and scientific experts. It may well be, for example, that estimates about travel times do not fit with the experience of local residents, as the expert advice seemed 'wrongheaded' to the Cumbrian sheep farmers. Douglas suggests risk does not signify an all-round assessment of probable outcomes. Instead it not only signifies 'unacceptable danger' but also represents a 'stick with which to beat authority.' If this is the case, I would suggest that Douglas and Michael's perspectives are complementary, and together strengthen the conceptual basis of this thesis.

Conceptual framework for the thesis

This thesis conceptualises the process of public engagement about reconfiguration decisions as a process of risk communication. The literature demonstrates that safety and access are particular concerns for local communities, but this has not been explored before in detail. In order to understand more about the way in which the public respond to reconfiguration proposals, the thesis draws on the theories I have just outlined, which relate to the way in which the public a) perceive risk and b) respond to risk communication efforts. The latter includes both the way in which local communities respond to the case for change, and then the way this and other factors inform their response to the consultation process.

The conceptual framework below (Figure 5) was used to guide both the data collection and the analysis of the findings. The three rectangular boxes depict the processes under investigation; the oval boxes, the body of work used to inform the analysis of each process and the way the three inter-relate.

Figure 5: Conceptual framework for the thesis
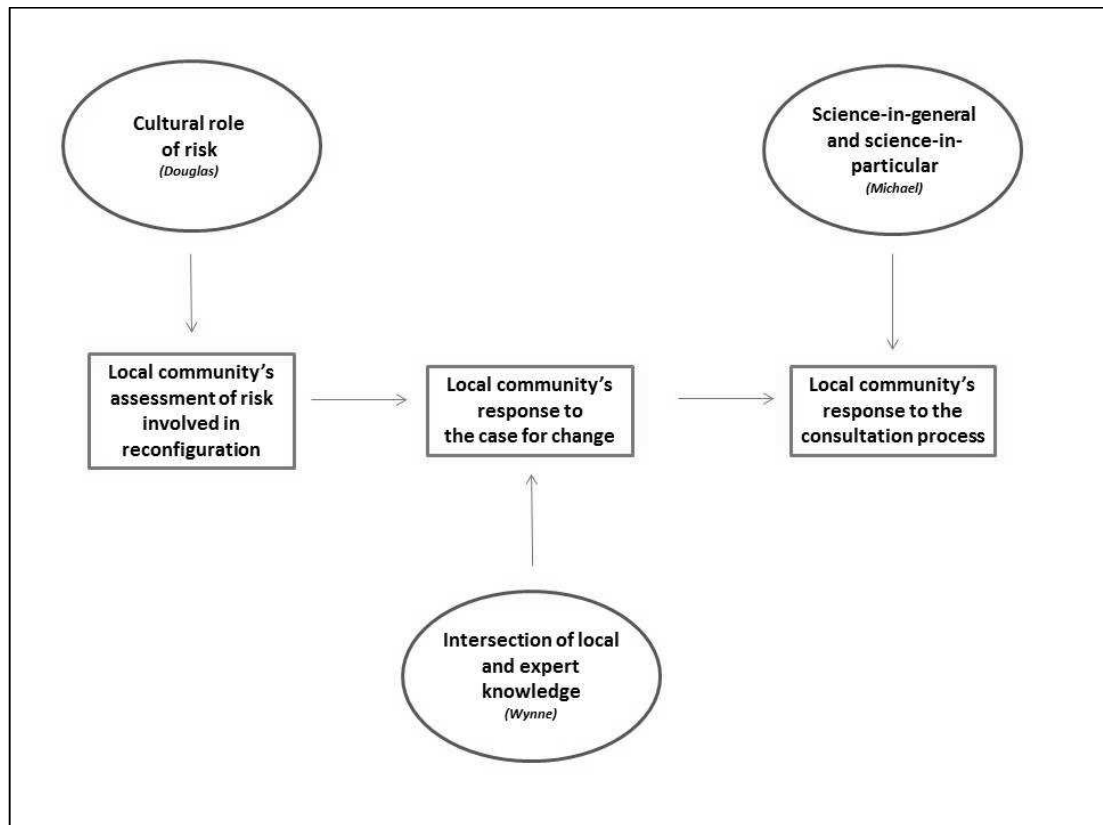
Research questions

This thesis has two overarching aims:

1. To explore the determinants of patient and public priorities regarding the organisation of hospital emergency services

2. To examine the ways in which these priorities impact the local community's response to proposals aimed at reconfiguring hospital emergency services

To fulfil these aims and address the gaps identified in the empirical and theoretical literature, I set out to answer the following research questions.

1. What concerns are raised by local communities when proposals to reorganise A&E services are put forward?

2. How do the public evaluate the safety of hospital emergency services?

3. What is the impact of current practices used to consult local communities about reconfiguration decisions?

4. What other factors influence the way in which the public respond when proposals aimed at reconfiguring hospital emergency services are put out to consultation?

Drawing on the conceptual framework, research questions 1 and 2 relate to the public's priorities in the context of a reconfiguration, including the way in which they assess the risks inherent in the proposals (i.e. they address Aim 1). Research questions 3 and 4 relate to the public response when a reconfiguration is proposed, including their response to both the case for change and the consultation process (i.e. they address Aim 2).

Previous empirical research about the reorganisation of hospital services has largely concentrated on policy issues. Little attention has been paid to the dynamics of local decision-making and no studies have formally examined the views of patients and members of the public, including the extent to which they are prepared to accept the trade-offs inherent in reconfiguration decisions. In addition, we do not know whether priorities for emergency care vary within different population group**s**, or indeed whether they vary in an area where reconfiguration is being considered, compared with areas where it is not.

By addressing these four research questions, this thesis will contribute knowledge about patient and public priorities for the organisation of emergency care. It will also detail for the first time the factors that play a key role in public opposition to reconfiguration plans. Its unique contribution lies not just in its detailed analysis of the determinants of public opinion, but in the broader perspective gained by comparing responses across population groups and geographical areas.

Finally, it is likely that reconfigurations of hospital emergency services will become increasingly common and there have been several calls to improve the quality of public engagement processes when proposals are being considered.[1, 13, 31] The conceptual framework I have outlined above frames the engagement process in a novel way and consequently offers the potential to contribute significant lessons in terms of how the process might be improved.

Research overview

In order to address these questions, two studies were carried out. The diagram in Figure 6 provides an overview of the research described in this thesis, including how the two studies fit together.

Figure 6: Research overview
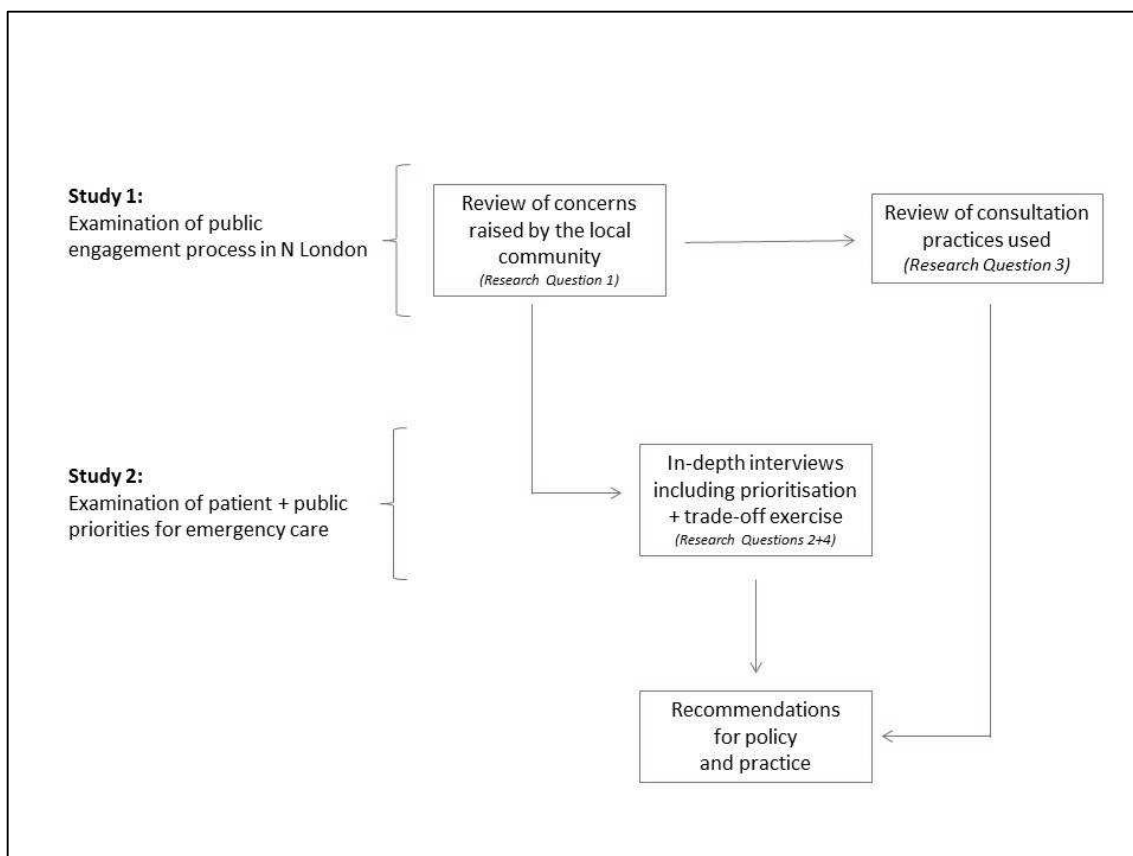
Study 1 is described in **Part II**. It examined the process used in 2010 to strengthen public engagement with high profile reconfiguration proposals in North London. The methods, including the rationale for the methodological approach, are set out in **Chapter 3**, the results in **Chapter 4** and the discussion in **Chapter 5**. Study 1 addresses research questions 1 and 3. This study is described first, because its findings played a critical role in informing the design of Study 2.

Study 2 examined patient and public priorities for emergency care via a series of in-depth interviews and is described in **Part III**. The methods, including the rationale for the methodological approach, are set out in **Chapter 6**. **Chapter 7** is the first of three results chapters relating to this study, each of which relates to one of the three processes encompassed by the conceptual framework. It addresses research question 2 and explores

how the public evaluate the risk involved in a reconfiguration. **Chapter 8 and Chapter 9** both address research question 4, examining the public's response to the content of reconfiguration proposals and the process of public engagement respectively. The findings of Study 2 are reviewed in the light of the existing literature in **Chapter 10,** before **Chapter 11** (Part IV) sets out the implications of both studies for policy, practice and future research.

PART II: STUDY 2 - EXAMINATION OF A RECONFIGURATION PROCESS IN NORTH LONDON

Chapter 3: Study 1 design and methods

Chapter 4: Study 1 findings

Chapter 5: Study 1 discussion

Chapter 3: Study 1 design and methods

Part II of the thesis outlines the findings of Study 1 and, in doing so, will seek to answer two of the four research questions:

1. What concerns are raised by local communities when proposals to reorganise A&E services are put forward?

3. What is the impact of current practices used to consult local communities about reconfiguration decisions?

The research questions build on the literature review and the conceptual framework described in Chapter 1 and Chapter 2. There I highlighted how consultation processes are often protracted and hostile, perhaps as a consequence of differing stakeholder priorities. Government documents and policies increasingly emphasise the role of 'evidence' and better consultation with the public as a potential way of addressing this – an approach which draws on the 'deficit model' of risk communication, which has been widely criticised elsewhere in the literature.[114]

Study 1 addressed these research questions by reviewing the process used to strengthen public engagement with the Barnet, Enfield and Haringey Clinical Strategy (the BEH Clinical Strategy), which proposed changes to acute hospital services in North London. Its purpose was twofold: to map the concerns of the local community in order to describe the key issues and inform the design of Study 2; and to review the impact of current practices used to consult the public about reconfiguration decisions in the light of the empirical and theoretical literature about risk communication.

This chapter outlines the rationale for the methodological approach, the background to the BEH Clinical Strategy, and the methods used in the review. In light of the theoretical framework, it considers first the way in which the public responded to the reconfiguration proposals, and the key concerns they raised, and then the way in which they responded to the engagement process. I will first describe the local community's key concerns in North London in Chapter 4, and then go on to review the findings about the engagement process in the light of the literature about risk communication in Chapter 5.

Rationale for the methodological approach

Study 1 makes use of a case study design – an approach that 'facilitates exploration of a phenomenon within its context.' This design has become a commonly used strategy when 'how' or 'why' questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within a real-life context.[155]

This approach was chosen acknowledging the fact that, although many of the drivers of reconfiguration are common to health care systems across the world,[10] individual reconfigurations cannot be separated from their particular history and unique blend of local circumstances.[12] The study involved a single case study: the proposed reconfiguration of acute hospital services in North London.

Case studies are concerned with gathering in-depth information from fewer cases, compared to surveys, which collect less in-depth information from a large sample. It is possible to use either a single case study, or multiple case studies. The exemplar single-site case study is Goffman's participant observation within a psychiatric hospital, which resulted in theories of institutional behaviour.[156]

Yin classifies case study research as exploratory, descriptive or explanatory.[155] This study is a descriptive and exploratory single-case study, in that it seeks to map the concerns raised by the public when a reconfiguration is being considered and to explore the impact of current public engagement practices.

A range of data sources can be used in case study research, including documentation, archival records, interviews, physical artefacts, direct observations, and participant-observation. Each data source is one piece of the 'puzzle,' with each piece contributing to the researcher's understanding of the whole phenomenon.[157]

Study 1 sought first to capture the range of concerns raised by local communities when reconfiguration processes are being considered (research question 1) and, second, to critically review the techniques currently used in public consultation exercises (research question 3). To address these questions I carried out a content analysis of a range of documentary sources relating to a recent reconfiguration. This drew on work I carried out in 2010, providing independent academic input into a review of the Barnet, Enfield and Haringey (BEH) Clinical Strategy, which set out plans to reconfigure acute hospital services in North London. My input is described in more detail in Appendix 2. As part of the review, I was commissioned to produce a report describing the process used to strengthen public

engagement and documenting its key findings. The documentation I used to do this provided a rich source of data for a secondary analysis, outlining the views of a range of stakeholders.

Study context

At the time of the review in 2010, the Clinical Strategy had been debated for many years and it was described as a 'test case for the NHS.'[158] Proposals to downgrade services at Chase Farm Hospital in north London were first raised more than 15 years ago. They included replacement of the emergency department with an urgent care centre and consolidation of women's and children's services at Barnet and North Middlesex Hospitals, which are each six to seven miles away to the west and east of Chase Farm respectively.

In July 2009, work had begun to implement the proposals, including building work on the North Middlesex site to accommodate increased patient flows. However, implementation was put on hold in May 2010, days after the coalition government came to power, when the then Secretary of State for Health, Andrew Lansley, declared a moratorium on reconfiguration programmes. He delivered his speech outlining the four tests reconfiguration programmes must now meet in a speech delivered from the steps of Chase Farm, and pledged to put an end to 'top down' bureaucratic processes.[90]

The local Primary Care Trusts (PCTs) began work to review the BEH Clinical Strategy against the four tests in the summer of 2010. The relevant key components of the process are briefly outlined here to provide context. In September 2010, a panel of clinicians, known as the Clinical Review Panel, was convened to review the clinical evidence underpinning the plans. The Panel consisted principally of local GPs, as well as clinician representatives from outside North Central London. They were asked to review each of the speciality strands affected by the proposals, in order to ascertain whether the case for change had altered in the three years since the original consultation.

Because local clinical commissioning groups (CCGs) had not yet been established in the affected areas, all local GPs were invited to comment on the panel's conclusions in order to gauge the level of support for the proposals. The commissioners were not required to carry out a full consultation, as this had previously been carried out in 2007. Instead efforts were made to strengthen patient and public engagement via a series of public meetings and a supplement in local newspapers explaining the rationale for the proposals. Local

involvement network (LINks) representatives were involved in assessing the strategy against the patient choice test.

The focus of Study 1 is the process used to strengthen public engagement with the proposals. In this section, I will first outline the Clinical Review Panel's recommendations, as these were central to the public engagement process.

Clarity on the clinical evidence base

The Panel heard oral evidence from local clinicians working within the relevant specialties. They also considered a portfolio of published evidence underpinning the service changes that were envisaged in the Clinical Strategy, which I had compiled, to ascertain whether any significant changes in wider circumstance or evidence had taken place since the consultation in 2007.

The Panel was asked to make a recommendation about the optimal configuration of services for each speciality strand on the basis of the evidence it received. Their recommendations are summarized below in Table 1.

Overall, the Panel concluded that the clinical case for change had increased since the original consultation. They noted that 'no change' would not be a realistic option because the clinical situation at that time was both unstable and unsustainable in terms of patient safety, clinical staffing and modern clinical practice. The subsequent engagement process focused on communicating the rationale for these ten recommendations.

Strengthening public and patient engagement

The Department of Health guidance about the 'strengthened public engagement' test was limited in its scope. It simply advised that local commissioners should engage the LINks and local authority Health Overview and Scrutiny Committees (HOSCs) to seek their views, as well as making public the outcome of any local review. [90]

A proportion of this work was coordinated centrally by NHS Enfield, the PCT in the area most affected by the proposals. However, in each of the other affected areas (Barnet and Haringey) the process was supported locally by the relevant PCT. Patients in Hertfordshire were considered to be affected to a lesser extent, although there were efforts to engage patient groups in that region.

Table 1: The Clinical Review Panel's recommendations about the BEH Clinical Strategy

Recommendation 1	The plan to consolidate inpatient services for children at Barnet and North Middlesex is supported. Running two inpatient services at both Barnet and Chase Farm is unsustainable in the medium to long term, particularly in terms of staffing.
Recommendation 2	The plan to concentrate neonatal care at Barnet and North Middlesex is supported.
Recommendation 3	The Panel supports the plan for the development of a consultant-led paediatric assessment unit on the Chase Farm site. However, the nature of this will depend on the configuration of other facilities at the hospital, including those for urgent care.
Recommendation 4	Separate neonatal and general paediatric rotas must be established at the Barnet and North Middlesex sites to ensure adequate cover is available out of hours, thus improving clinical safety.
Recommendation 5	The plan for obstetrician-led maternity services to be based at Barnet and North Middlesex is supported. The clinical argument for consolidating obstetrics and neonatal care on two sites is considered compelling.
Recommendation 6	To provide choice to as many women as possible, both units should develop new co-located midwife-led units. Routine antenatal and postnatal care can continue to be offered at a range of sites, including potentially new ones based in the community.
Recommendation 7	The plan for Barnet and North Middlesex Hospitals to provide major emergency services is supported.
Recommendation 8	The Panel agreed that a 24/7 full Emergency Department should no longer be provided at Chase Farm. A local urgent care service should be introduced to strengthen the services available to the community, along with the co-located GP out of hours service.
Recommendation 9	The plan for appropriate planned inpatient surgery to move to Chase Farm from Barnet and North Middlesex is supported.
Recommendation10	Day surgery can appropriately continue on all three sites.

Wider public engagement

As part of the process of wider engagement, a four page supplement which outlined the Clinical Review Panel's conclusions and included an article written by the senior clinician who chaired the Clinical Review Panel outlining the need for change, was distributed with local newspapers. Local residents were also given the opportunity to hear the Clinical Review Panel's findings and debate their recommendations at three public meetings in Enfield. The meetings were held at different times during the day and during the evening, over the course of six days, in a variety of locations. Each meeting was facilitated by an independent consultancy firm with experience of leading deliberative processes. At each session, the Clinical Review Panel's recommendations and the evidence underpinning them were both presented by members of the Panel. Participants then had the opportunity to express their views in round-table small group discussions. They were asked for their views about the evidence underpinning the plans and how they felt the proposals might affect them. They were also asked whether they had any concerns about the proposals and what information or evidence they had to support these reservations. Meetings were not held in Barnet, Haringey or Hertfordshire; residents were instead directed to the meetings in Enfield.

Borough level engagement

Each of the PCTs sought to strengthen further the level of patient and public engagement locally, leading a process to engage a range of other relevant stakeholders in the review, including Local Authorities, local MPs, and voluntary and community groups. The views expressed by the public during the consultation process are described in more detail later in this chapter. However, the responses received from the public in each borough are briefly reviewed here.

In Barnet, documents were distributed to over 100 voluntary and community groups in the borough. One group responded, expressing a number of reservations about the proposals, including the 'lack of evidence behind them', the national problem of staffing, and the impact of the proposed planned care changes on the elderly. Similarly, in Enfield, an outline of the Clinical Review Panel's findings was also cascaded to local voluntary and community groups as well as patient and public involvement mailing lists.

In Haringey, information was also sent to a number of voluntary and community groups in the area. A response from a local Pensioners Action Group queried why no public meetings

had been held in Haringey and raised concerns about both the possibility of services at North Middlesex becoming 'overloaded' as a result of changes to services at Chase Farm.

Methods

In order to map the concerns raised by local residents in North London, including their perceptions of the engagement exercise, I carried out a secondary analysis of a range of documents that I had previously used to compile the report reviewing the engagement process against the Lansley tests. The process to strengthen public engagement with the BEH Clinical Strategy took place between 20 September 2010 and 15 November 2010. At the end of that period, the BEH Clinical Strategy Implementation Team – the commissioners leading the review – provided me with documentation relating to the review from each of the PCTs. This included a short report documenting the engagement activities undertaken in each area, copies of stakeholder communications received during the engagement period, and copies of the raw data documenting the discussions that took place at the public meetings held in Enfield.

In Study 1, I specifically focused on correspondence and concerns raised by members of the public, rather than local politicians, because the thesis focuses on the response of the public. The following documents were used in my analysis:

- Reports from each PCT describing their engagement activities and summarising the feedback obtained (n=3)
- Report of the formal consultation process carried out across the region in 2007 (n=1)
- Report prepared by the London Communications Agency containing copes of media coverage relating to the on BEH Clinical Strategy published between 21 May and 10 November 2010 (n=1)
- Copy of pull out supplement included in the Times series newspapers distributed across the region on 20 October 2010 (n=1)
- Log of activity on the BEH Future website, which contained information relating to the review, between 20 September and 15 November 2010 (n=1)
- Log of phone calls and emails received by BEH Clinical Strategy team from members of the public, including copies of all electronic correspondence (n=84)
- Copies of correspondence from relevant Local Involvement Networks documenting their response to the review (n=4)
- Copies from other community groups responding to the review (n=4)

- Copies of both handwritten and typed notes taken by PCT staff tasked with taking notes from table discussions at the public meetings held in Enfield on 2 November (n=4 table discussions), 4 November (n=6 table discussions) and 8 November 2010 (n=6 table discussions)
- Copies of presentations (n=3) and handouts (n=3) used at the public meetings
- Public meeting attendance statistics (n=3)

Having reviewed all the documentation to identify feedback from members of the public, I then carried out a thematic content analysis. This involved documenting points relating to concerns raised by the public about a) the content of the proposals and b) the engagement methods used. I then examined each of these categories separately to identify the key themes.

Chapter 4: Study 1 findings

This chapter outlines the findings of Study 1 and highlights the key areas of public concern about the implications of the BEH Clinical Strategy.

This analysis drew largely on the notes of issues discussed at the public meetings held in Enfield, as well as the points raised in correspondence by local community groups. The PCT team provided information about attendees at each of the three public meetings, which is summarised in Table 2. Nine members of the public attended more than one of these events, including 4 who attended all three.

Table 2: Attendance data from North Central London public meetings

	Public	Local politicians	GPs/ Other clinicians	Presenters	Support team	Total
2 Nov 2010	19	4	8	4	10	45
4 Nov 2010	35	7	9	4	12	67
8 Nov 2010	36	2	7	4	13	62

Key areas of concern

Five areas of concern were evident in the public feedback. Four of these related to different aspects of the content of the proposals; the fifth to the public's response to the engagement process itself.

1. Travel

The first area of concern was the potential implications of having to travel further for care in an emergency. Concerns were raised at all three public meetings that, if the BEH Clinical Strategy were implemented, patients would have to travel further to access care. Several table groups commented on the additional distance critically ill patients would be required to travel and were concerned whether this would result in less favourable outcomes. One table felt 'patients will die as a result.' At a third table there was a 'general feeling of hostility' towards the changes; it was felt that many people were 'frightened' at the

prospect of urgent care facilities moving further away. Others noted that it would be 'too far' to travel to Barnet, particularly when some conditions need treatment as soon as possible. In order to assess the implications of the proposals, one group wanted more information about the relationship between travel times and patient outcomes, and wondered what happens in other cities with comparable levels of population and traffic density.

Some groups did comment that there was evidence that in some cases it may be more beneficial to travel further to a specialist unit, than to arrive more quickly at a non-specialist unit. However, others queried why all local hospitals couldn't provide specialist services, as this would negate the concerns about travel times. Equally, one group was concerned about the implications of ambulances travelling out of the area to deliver patients to specialist centres and queried what would happen if the crew was needed again locally. They also felt that, again, whilst it might be better to travel further to a specialist centre for some conditions, for other conditions time could be critical and patients still need to go to a local Emergency Department. Several emphasised the importance of 'local care for local people.'

Several groups commented on the challenges of travelling to the alternative hospitals by public transport, partly because east-west links across the region are poor. Attendees sought information on how these were being addressed. For example, participants on one table questioned whether there would be any consultation with Transport for London to 'enable better access to hospitals.'

Attendees' views about transport were influenced by their knowledge of the local area, for example about bus routes. Others raised concerns that there was already limited parking at Barnet Hospital, before the changes were implemented, whilst another group were concerned about patients travelling into the area from Hertfordshire experiencing travel delays crossing the M25 orbital motorway around London.

2. Future urgent care facilities

A second area of concern related to the availability of urgent care in the future, if the proposals are implemented. There was also extensive discussion about the proposals for urgent care and planned care services. Some felt that the proposals were 'defective' and that there was limited evidence to support them. Indeed, because of travel issues in the area, attendees in another group felt that A&E departments should be 'available at more locations rather than less.'

Several meeting attendees sought information about how the proposed urgent care system would work. They also noted that it is difficult for people to know how sick they really are and many felt that the public are currently unclear on where to seek help in an emergency. Knowing whether to attend an Emergency Department or an urgent care centre was identified as a particular challenge. Attendees also called for clear information about opening hours, if the proposed urgent care centre at Chase Farm was not to be open 24 hours a day.

Some table groups recognised that a key driver behind the BEH Clinical Strategy was the need to invest and improve local primary care facilities. However, they felt that the changes must be in place before the reconfiguration went ahead. This was because they considered poor access to primary care to be a particular issue in the area, such that the local Emergency Departments have to act as an 'overflow' and are hence 'too busy with unnecessary cases.' If GPs extended their opening hours, this may reduce A&E attendances.

3. Future services and staffing

Alongside uncertainty about urgent care provision in the future, a number of other concerns were raised about the organisation of services in the future. Some were concerned that the services would be closed before alternative facilities were up and running. For example, one group sought assurance that new facilities would be in place before the proposed reduction of services began at Chase Farm

Another source of significant concern was the ability of Barnet and North Middlesex Hospitals to accommodate increased patient flows. One group queried what additional capacity would be required to absorb the capacity being displaced from Chase Farm, whilst another noted that existing facilities would need to be extended and improved. They also questioned whether there would be an increase in staff numbers at Barnet and North Middlesex.

There was a very real sense that local hospitals are 'already over-subscribed' and two groups noted that services at Barnet currently close on occasions when they are working at capacity. Others expressed concerns that there are 'not enough staff in the area' any way. On top of this, several groups felt that the population in the area was set to increase: hospitals should be upgraded, rather than downgraded because of the 'increasing number of people who are using Enfield's services' and the 'influx of immigration.'

The longer term implications of the proposals were also questioned. Several attendees noted that when hospitals lose their Emergency Department, 'all the expertise and technology goes with it.' Consequently, some were concerned that their local services would ultimately be 'run down.' One particular concern was that the proposals masked a plan to sell off land at Chase Farm. The review was described as 'a stitch up', with Barnet and North Middlesex being favoured, at the expense of Chase Farm.

Some groups acknowledged that another key driver behind the BEH Clinical Strategy was a lack of middle grade and senior clinical staff, particularly on the Chase Farm site. They acknowledged that not only did shortages of staff impact on the provision of services and need to be addressed, but also that in many cases this is a national problem. At the same time, however, others recognised that the proposals were predicated on not having enough staff, so 'all we need to do is to add more staff.' Others questioned whether expanding the number of clinicians on all three sites, wouldn't be a more cost-effective solution, rather than amalgamating services on fewer sites.

4. Funding

As I have mentioned, some groups concluded that Barnet and North Middlesex Hospitals had been given preference over Chase Farm and the aim of the exercise was to 'get rid of Chase Farm.' Several felt that the proposals were driven by financial, rather than clinical concerns, and the overall aim was to fund improvements at Barnet Hospital whilst running down Chase Farm. Even though a large sum of money had recently been 'found' to refurbish a local community hospital in Barnet, patient safety in Enfield was being 'sacrificed' for financial reasons.

At the same time, several questioned 'where the money is coming from' to fund both the planned investment in primary care and improvements to hospital services at Barnet and North Middlesex. Another table queried whether, given current financial pressures, budgets and resources would really be transferred to the other remaining sites following the reduction of services at Chase Farm. Participants at one table questioned whether the proposals were 'just a pipe dream' given the current financial situation of the local PCTs. Others questioned whether 'a proper financial assessment' was carried out and whether or not this could be made available.

5. Public engagement process

Finally the fifth area of significant concern related to the engagement exercise itself. For some it was 'not a thorough process,' whilst others felt that communication with the general public had not been effective, and the public needed to have a clearer understanding of the evidence. Similarly, another group felt that there is 'not enough clinical evidence to show this as the right course of action.' Another group felt that the information they were given was 'very skewed.' They suspected that the public were being misinformed about the proposals and sought clarity and further information about the proposed changes, the details of the investment and local population figures.

One table group felt that there had been a 'failure to consult' because only clinical evidence was being used to inform the decision, and not the views and experiences of residents. Other groups were concerned 'the public are not in a position to properly challenge the views of clinical professionals' and therefore could not argue with the clinical case for change.

Allied to this there was a perception that the public view was not being taken into account. Some queried 'what weight' would be given to the public voice and how much the evidence from the engagement process would be 'spun.' Another group noted that there were previously 'tens of thousands of signatures on petitions to keep A&E and maternity' at the Chase Farm but the PCTs 'are not listening to us.' One group acknowledged that there was real anxiety amongst people in Enfield area and they wanted to know how the PCT was going to address these concerns and fears. They argued that this was more important than repeatedly referring to the clinical case for change.

Others were concerned that they had not sufficient opportunity to express their views at the public meeting, with one group noting that 'out of two hours, one was spent explaining.' One group also felt that more could have been done to promote the meetings and that the use of jargon had made things difficult to understand. Another attendee questioned whether residents in other affected areas had been adequately engaged and consulted, because public meetings had only been held in Enfield.

Several commented on the 'lack of public trust in the decisions being made' and in some cases this related back to dissatisfaction with the way the original 2007 public consultation was carried out. Some felt that this was 'just a post-analysis exercise' and wondered whether the decisions were in fact already 'pre-determined.'

Chapter 5: Study 1 discussion

Study 1 sought to describe the concerns raised by local communities when proposals to reorganise A&E services are put forward (research question 1). In the previous chapter, I described the five main areas of concern that were put forward by members of the public during the exercise to strengthen public engagement with the BEH Clinical Strategy. There were very real concerns about the implications of the proposals, with individuals described as 'frightened' or 'anxious' about having to travel further for care. Equally, there was also concern about how the local urgent care system would work in future, for example, which service patients should access in which circumstance. There was a perception that services are currently operating at capacity and thus would not be able to accommodate increased patient flows. In many cases, it also seems it was not clear to the public why the proposals had been put forward, and why seemingly more straightforward options, such as recruiting more staff, could not be pursued. Perhaps as a consequence the proposals were seen to be more about cuts than improving care. At the same time, some felt that, whilst the clinical case for change formed the focus of the exercise, there was limited scope in the debate for their views.

Strengths and limitations of the study design

This was not a formal consultation process, and this review draws largely on the views of those who attended the three public meetings, because this was the most detailed information source. The fact that only a relatively small number of members of the public attended these meetings (and several people attended more than one) raises questions about the generalisability of the findings. We also cannot know if the strength of feeling amongst these individuals was representative of that amongst the community at large, or indeed representative of all attendees at the public meetings. There are also inherent methodological limitations associated with using a single case study research design. This is only one case; each reconfiguration programme is unique. However, the methods used here permitted me to draw on a wider range of documentary data sources, which could then be triangulated. Equally, the concerns I have described here do reflect the three issues that the IRP acknowledge are 'most likely to excite local opinion' – money, transport and emergency care.[1]

The accuracy of the information used for this analysis obviously depends on the accuracy with which the PCT staff recorded the concerns raised during the round-table discussions. However, many of the concerns were raised by more than one group, and at more than one meeting. A key strength of this study was that participants were asked to describe their concerns, rather than completing a tick box survey. I was also able to return to the original meeting records. As a consequence, the engagement data provide a rich source of 'real life' information about public concerns raised at a time when a reconfiguration decision was being actively discussed.

The public engagement process

In the earlier chapters of the thesis, I set the process of consultation about reconfiguration plans in the context of the literature about public involvement in health care decision-making, as well as the literature about risk communication. In this chapter, I reflect on the public's perception of the practices used to strengthen engagement in Barnet, Enfield and Haringey in the light of these bodies of work. Drawing on the findings set out in Chapter 4, there were three overlapping reasons why the public in North London had concerns about the engagement process carried out there.

The first of these reasons was that attendees at the public meetings felt that inadequate attention was being given to the views of the public. This was compounded by an existing sense of disillusionment with the formal consultation carried out in 2007, when 'tens of thousands of signatures on petitions' had apparently been disregarded by the PCTs. I discussed the relevance of Arnstein's ladder of citizen participation[72] to reconfiguration debates in Chapter 1. However, it is worth considering how much decision-making 'power' the community in Barnet, Enfield and Haringey had. The comments suggest that, at least in the eyes of the public, the process sat somewhere towards the middle of the ladder, where the rungs represent modest degrees of involvement, and certainly some way from the top with its aspiration of citizen control. It is not clear that the community in North London did want full control over the decision-making process. However, their comments indicate that they clearly expected their views to carry some weight and the fact that they apparently didn't, fuelled their frustration with the process. Meeting attendees not only expressed dissatisfaction that their concerns, for example about parking and transport, were apparently not being heard. They also took issue with the logistics of the exercise. The fact that the commissioners determined the structure of the meetings and only held a small number of events seemed to further limit the opportunity for public input.

The second reason was the way in which the exercise was framed. The structure of the public meetings seems to suggest that the aim of the engagement process was to give the public an opportunity to hear and respond to the recommendations of the Clinical Review Panel, rather than form their own view. Local stakeholders expected to influence the outcome of a consultation, yet the commissioners believed that change was unavoidable, which then led further to the perception amongst the public that consultation was a 'sham.' The presence of public engagement in the four Lansley tests presumably reflects its central role in current health policy, yet the guidance about the tests does not require commissioners to actually do anything with the information they gain from the exercise, other than 'make public the outcome of any local review.'[90] It says nothing about the way in which the views of the community should inform decision-making.

The final area of concern related to the role of clinical knowledge in the process. Meeting attendees argued that only clinical evidence was being used to inform the decision. They were not in a position to challenge this and the use of jargon had made things difficult to understand. Equally, they had not sufficient opportunity to express their views at the meetings because time had been spent 'explaining'. As I have said, the engagement exercise took the Clinical Review Panel's recommendations and sought to use these as a tool to bolster the case for change with the local community, again perhaps assuming that if the public were presented with the 'right evidence,' they would finally be convinced of the need for change after years of opposition.[8] In turn, this is apparently underpinned by the psychometric approach to risk communication with assumes that individuals have exaggerated fears simply due to inadequate information and therefore giving them more information will lessen their worries.[159] Indeed, in Barnet, Enfield and Haringey the engagement process focused largely on explaining why the changes needed to happen.

Alongside this, a senior clinician was appointed to chair the Clinical Review Panel in the belief that visible clinical leadership would give the public confidence in the plans. Individuals were also recruited to the Panel from outside the sector to provide an impartial assessment of the plans and thereby boost the credibility of the Panel's recommendations. It is not clear whether or not the public were aware of this strategy, but – if they were – it appears not to have convinced them to accept the proposals. Attendees at the public meeting still worried that they were being given 'skewed' information, and felt that the emphasis on medical knowledge further excluded them from the process.

Conclusion

As I have highlighted, the commissioners in North London were not required to carry out a full consultation in 2010 to meet the Lansley tests, because this had already been done in 2007. However, it is useful to review the practices that were used and in many ways the concerns raised by the public echo those of local communities around the country. The IRP describe several reasons why reconfiguration proposals are typically referred to them (see Figure 2) and many of these were in evidence here.[1]

What was the impact of the engagement methods used in North London? As in Farrington-Douglas and Brooks' study, in the eyes of the public, a 'paradox of consultation' seems to have been evident: local stakeholders expected to influence the outcome of the consultation, yet they perceived that inadequate attention was actually being given to their views, which in turn led them to conclude that the process was a 'sham.'[7]

On the other hand, if the commissioner's aim was actually to somehow 'educate' the public such that they would accept the proposals,[8] from the comments raised at the public meetings this appears to have failed. Many attendees were clearly not convinced by the clinical case for change, despite the visible clinical leadership and the time and effort the commissioners had put in to explaining it. The benefits of the proposals and the plans for future services also remained opaque, which only fuelled concerns, particularly when there was a perception that existing services were already stretched.

Scherer observed three 'flawed assumptions' underlying the psychometric model of risk communication. According to the concerns raised about the engagement process at the public meetings, from the perspective of the local community there seemed to be evidence of each of these: that medical science alone can provide objective truths; that scientific and technical experts are the only sources of valid and rational information; and finally, that the public is a passive receiver of risk information.[125] I have noted both the lack of evidence to guide best practice in public involvement work[103] and the lack of clarity with regard to what involvement initiatives should be aiming to achieve.[7] However, if we consider public engagement in this context as a process of risk communication, the psychometric approach has been widely criticised,[114] and yet we see it here, still underpinning practice the practice of commissioners in this case.

I will go on to explore the impact of this approach in more detail in Study 2. I will describe how the findings of Study 1 informed the design of Study 2 in Chapter 6.

Part III: Study 2 – EXAMINATION OF PATIENT & PUBLIC PRIORITIES FOR EMERGENCY CARE

Chapter 6: Study 2 design and methods

Chapter 7: Study 2 findings – risk evaluation

Chapter 8: Study 2 findings – response to the case for change

Chapter 9: Study 2 findings – response to the engagement process

Chapter 10: Study 2 discussion

Chapter 6: Study 2 design and methods

Part III of the thesis outlines the findings of Study 2, which addressed the other two of the four research questions:

2. How do the public evaluate the safety of hospital emergency services?

4. What other factors influence the way in which the public respond when proposals aimed at reconfiguring hospital emergency services are put out to consultation?

The literature review described in Chapters 1 and 2 demonstrated that previous research has paid limited attention to the dynamics of local decision-making when a reconfiguration is being considered. Little is known about patient and public priorities in this context, or indeed whether priorities vary in areas where a reconfiguration is being considered compared with those where it is not.

To address these questions, and the gaps in the empirical literature, Study 2 examined patient and public priorities for the organisation of hospital emergency care via a series of semi-structured interviews. This chapter outlines the rationale for the methodological approach, and the methods used in the data collection and analysis, including how the findings of Study 1 influenced Study 2. Once again, the three findings chapters are structured around the processes that are captured by the theoretical framework for the thesis. Chapter 7 explores the way in which participants assessed risk in the context of hospital emergency services, and in doing so seeks to answer research question 2. Chapter 8 and Chapter 9 address research question 4. Together they examine the public response when proposals aimed at reconfiguring hospital emergency services are put out to consultation, considering the response to the content of the proposals and the engagement process itself respectively.

Rationale for the methodological approach

In a similar way to Study 1, Study 2 also makes use of a case study design. As I outlined in Chapter 3, this approach permits the development and testing of theories about how phenomena interact with the real-life context in which they take place; a multiple case study approach allows the development and testing of theories in several contexts.[155] In this case, the approach was used to explore whether patient and public priorities for

hospital emergency care vary in an area where a reconfiguration is being considered, compared with one where it is not.

Each case study sought to explore whether and how these priorities were influenced by the local context. The two sites were chosen purposively. This approach chooses its participants with a 'purpose' after considering the questions driving the research and does not necessarily look for representativeness. Instead, some diversity is usually included, so that the impact of the characteristic concerned can be explored.[160]

The first case study examined priorities in an area I have called Greenville, which is an urban area in England. Greenville was chosen as the setting for this case because a process of public consultation about proposed changes to acute services at the local hospital was ongoing at the time of the study. Greenville is in the most deprived 20% of local authorities in the country. The main hospital in the area is Greenville Hospital, a district general which serves a population of around 300,000. Black and minority ethnic (BME) communities make up around half of the population with significant variation between wards: the proportion of the population classified as White British varies between 10% in one ward to 66% in another.

When the study took place, Greenville Hospital had a 24 hour A&E department, which saw around 50,000 attendances each year.[161] At that time, a public consultation was taking place about proposals to reorganise emergency services across an area that included Greenville. This area encompassed several hospitals, most of which provided a 24 hour A&E service. In the consultation document, the commissioners set out a range of reasons why they believed this system 'needed to change in order to improve quality.' They recommended that all the acute sites should continue to provide a range of basic services, including a 24 hour urgent care centre and outpatient facilities. However, they argued that emergency services in the area should be consolidated. As a consequence, in the future, only some of the hospitals would provide a full A&E service, emergency surgery, maternity and inpatient paediatric services. Their preferred option for Greenville was to downgrade services on that site, so that the hospital would be left with an urgent care centre, rather than a full A&E service. If the proposals went ahead, most local residents would be expected to go to A&E at one of the two remaining hospitals closest to Greenville, which I refer to here as Redbury Hospital and Yellowtown Hospital.

The consultation document explained that the area currently had one of the highest numbers of A&E departments per person in the country. It was argued that instead the region needed a 'system that allows all of our hospitals to benefit from having senior, expert consultants on-site at all times.' The authors of the consultation document cited evidence that patients treated at weekends and evenings– when fewer senior doctors are currently available – stand a higher chance of dying than if they were admitted during the week. Alongside workforce concerns, the document also noted that, unless the changes happen, work could not be undertaken to upgrade the current poor state of many hospital buildings. The consultation document concluded:

> Though services are mostly providing good standards of care at the moment, they cannot do so for much longer and it will be patients, and the clinicians who treat them and care for them, who will be the first to feel the consequences.

In the second case study, the participants were all NHS patients who received care for a chronic condition at Hilltown Hospital. This group was chosen because their condition is relatively common and may require emergency admission to hospital. The area was chosen because, at the time of the study, no public discussions were taking place about potentially reorganising local hospital services. Hilltown is a teaching hospital with a 24 hour A&E department, as well as a co-located GP-led urgent care centre. In 2011-12, there were approximately 90,000 A&E attendances at Hilltown.[161] At the time of the interviews, there were no discussions taking place about reorganising emergency services in the Hilltown area.

The hospital's catchment area includes a diverse urban population of over a million people, resident in several local authority areas. There are significant differences in terms of life expectancy between the most and least deprived areas and BME communities make up approximately 30% of the population. Much of its acute work is driven by population who live in the immediate vicinity of the hospital. However, patients from across the region travel to Hilltown to access specialist services.

The characteristics of Greenville and Hilltown hospitals, including the communities they serve, are compared below in Table 3.

Table 3: Greenville and Hilltown Hospitals – key characteristics

	Hospital type	A&E attendances/ year 2011-12	Size of population served	% Population from BME communities
Greenville Hospital	District general hospital	50,000	300,000	50%
Hilltown Hospital	Teaching hospital	90,000	1,000,000+*	30%

* This figure, provided by the hospital, includes specialist services; the population accessing the hospital for acute care is likely to be smaller

As well as comparing the views of individuals resident in different areas with respect to reconfiguration, this study also sought to compare the views of four different population groups. Alongside the views of the NHS patients at Hilltown Hospital, participants from three other population groups were chosen. These were older people and parents of young children, all of whom may have cause to access emergency services, as well as local 'activists' including those involved with official patient involvement committees, and members of groups campaigning against the downgrade of services. The views of this latter group have been explored in previous studies, but in much less detail. This group is included here to facilitate comparison between the public at large and those individuals who are already engaged with their local services.

To develop worthwhile lessons for future reconfigurations, it is important to establish why the public respond to proposals aimed at downgrading services in the way that they do. Study 2 sought to explore the way in which the public evaluate the safety of hospital emergency services (research question 2) and the factors that influence the public response to both the content of reconfiguration proposals and the mechanism used to engage them in decision-making (research question 4). Detailed, individual data were therefore required and this was gathered through one to one interviews. This type of enquiry is appropriate to exploring the beliefs and attitudes held by participants. Unlike other methods such as focus groups or quantitative surveys, interviews allowed me to explore the preferences, motivations and decisions of each participant in depth.[160]

I noted in Chapter 1 that reconfiguration proposals will often have drawbacks as well as advantages for patients and the public and may require difficult judgements about trade-offs, for example between the quality and financial gains that may be achievable through the concentration of services on fewer sites and the potential costs of reduced access. However, we know very little about the determinants of public opinion or, crucially, the

extent to which local communities are prepared to accommodate the trade-offs that are often involved in reconfiguration decisions.[5]

Requiring the public to make trade-offs between, for example, the potential benefits of being treated by more specialised clinical teams versus greater travel times, assumes first of all that individuals have all the necessary information to make the choice, which may not be the case in health care. It also assumes that patients and the public are 'rational' decision-makers, who are willing and able to make and enact choices between services. The rationality assumption consists of two components: first, individuals are assumed to form, on average, correct beliefs about events in their environment and about other people's behaviour; second, given their beliefs, individuals choose those actions that best satisfy their preferences.[162] This forms the basis of rational choice theory, which has its roots in economics and assumes that all action is fundamentally 'rational' in character and that people calculate the likely costs and benefits of any action before deciding what to do.

Rational choice theory begins with the premise that individuals will choose the course of action that is likely to give them the greatest satisfaction, or utility in economic terms. Another important element of the choice process is the presence of constraints. The presence of constraints requires the individual to make an explicit choice or trade-off between alternative options. An illustrative constraint would be a budget constraint, within which the consumer cannot spend more than their income.[163] Reconfiguration decisions require stakeholders to make a choice between, for example, timely access and the clinical case for change, which involve patients travelling further to access care.[5] The constraints within this equation would include limited availability of funds, availability of specialist staff, and legislation, such as the European Working Time Directive.

What distinguishes rational choice theory from other similar forms of theory is that it denies the existence of any kinds of action other than the purely rational and calculative. All social action is regarded as rationally motivated, however much it may appear to be 'irrational' or 'non-rational' to the outsider. However, a large body of evidence accumulated over the last three decades shows that many people violate the rationality and preference assumptions that are routinely made in economics.[164] Among other things, people frequently do not form rational beliefs, objectively irrelevant contextual details affect their behaviour in systematic ways, they prefer to be treated fairly and resist unfair outcomes, and they do not always choose what seems to be in their best interests.[162]

In order to understand preferences for particular goods or services and explore the extent to which individuals are willing to trade one attribute for another, economists make use of discrete choice experiments (DCEs). DCEs are a quantitative survey technique in which participants are simply asked to state their preferred option from a list of hypothetical scenarios. This approach is underpinned by rational choice theory and consequently assumes that the public are willing and able to make rational choices. Although it provides information about the relative importance of the selected options, it provides limited scope for the researcher to explore why one option is considered more desirable than another.[165] Consequently, Study 2 drew on the principles of DCEs, but used qualitative methods to explore in detail the extent to which members of the public are willing to accommodate the trade-offs involved in reconfiguration decisions. A set of flash cards detailing different aspects of emergency care was used as the basis of interview discussion.

Research design and methods

Prior to the commencement of Study 2 a topic guide was developed for use during each interview, (see Appendix 3). This covered three areas: a) the participant's views about their local services; b) an exercise in which the participant was asked to select, rank and discuss their priorities for emergency care ('the prioritisation exercise'); and c) a second exercise exploring the extent to which the participant was prepared to accommodate trade-offs between different aspects of emergency care ('the trade-off exercise'). A single set of flash cards detailing different aspects of emergency care was used in both exercises.

Development of the flash cards and topic guide

This section describes how the interview topic guide and flash cards were developed. The development of the topic guide, which covered the three areas outlined above, drew on the published empirical literature regarding the reconfiguration process and the conceptual literature about public perceptions of risk, which I described in Chapter 1 and Chapter 2.

The development of the flash cards used in both the prioritisation and trade-off exercises also drew on the findings of Study 1 and involved three discrete steps, which are described in more detail below.

Step 1: Identification of key concerns raised in the Chase Farm consultation

In terms of developing the flash cards, the first step involved drawing up a list which encapsulated the specific issues raised by the public during the Chase Farm engagement process (Study 1). These related to both the implications of the plans and the clinical

rationale used to justify the reconfiguration proposals in North London. Examples included good bus travel and parking provision.

Each of the issues was summarised to produce a draft flash card. At each stage of development, the text was literacy checked using the Flesch readability test in Microsoft Word, aiming for a Flesch Reading Ease Score of >90 (text easily understood by an average 11 year old).[166]

Step 2: Development and validation of flash cards
In order to assess both the content and face validity of the flash cards, I then contacted three patient representatives and three commissioners with experience of implementing reconfiguration programmes in other parts of England to seek their views on the contents of the list. They provided feedback confirming that these issues did have relevance outside of North London, as well as insights into why they thought these issues mattered to the public.

Step 3: Pilot interviews
Taking into account the feedback on the flash cards from Step 2, I then carried out a series of pilot interviews. The aim of this was to refine the draft interview topic guide, including testing the feasibility of the prioritisation and trade-off exercises.

Six pilot interviews were carried out with members of the public who reflected the characteristics of the four groups who would be interviewed in the main study. None of the pilot interviewees lived in Greenville or Hilltown, where the main study was to be carried out, or indeed in an area where a reconfiguration was being discussed at the time.

In terms of the trade-off exercise, asking pilot participants to rank their priorities for A&E generated a lot of useful discussion. However, with three of the six pilot participants the trade-off exercise did not work – these individuals were not willing to consider trading-off any of the priorities. This was not because the idea of trade-offs did not resonate with them. Instead they did not perceive having more senior staffing, for example, as a 'gain' worth having, compared for example with getting to A&E as quickly as possible. The other pilot participants were willing to consider possible trade-offs to varying degrees, but this yielded a range of results with two being reluctant to trade-off access for a higher standard of care, because of the relative importance they placed on timely access in an emergency. It quickly became apparent in the pilot study that the two most relevant trade-offs were 'sick patients taken to A&E as fast as possible' versus 'patients' care meets nationally

agreed standards of quality' and 'sick patients taken to A&E as fast as possible' versus 'consultants on duty in A&E 24 hours a day'; pilot participants dismissed other trade-off pairs as either irrelevant or unrealistic.

Several amendments were made to the final topic guide in light of the findings of the pilot interviews. These included:

- Some pilot participants were not clear about the content of some of the flash cards, particularly around care quality and consultant-led care. The text was further refined in conjunction with a patient representative and a scientific communications specialist

- Alongside questions about alternative urgent care facilities, I added in additional questions about access to primary care, as interviewees identified this as a core issue

- Pilot participants were clear that their priorities for the care of life-threatening emergencies would be different to those for the care of minor injuries. In the main interviews I therefore specifically asked participants to complete the prioritisation exercise for both scenarios, rather than for a generic 'emergency,' as I had originally planned.

The final working of the eight flash cards ultimately used in the main interviews for Study 2 is listed in Figure 7.

Figure 7: Content of interview flash cards

- A local hospital to serve the local community
- Good bus or tube links
- Easy to park
- Patients can choose which A&E to go to
- Sick patients taken to A&E as fast as possible
- Consultants on duty in A&E 24 hours a day
- Patients' care meets nationally agreed standards of quality
- A&E convenient to get to for patients and their families

Study sampling approach

Once the development phase was complete, and the topic guide and flash cards had been finalised, Study 2 commenced. I used a purposive sampling approach to identify potential

interviewees from the four subgroups described above. Whilst there may be a degree of homogeneity within each of the subgroups, the goal of this approach was to make comparisons across the subgroups and the two cases,[167] and explore any major variations.

This process of identifying eligible individuals and raising awareness about the study continued until, for each of the study groups, I had sufficiently oversampled a number of individuals who indicated an interest in the study. Oversampling was required as I anticipated that some of the individuals who show an initial interest may subsequently change their minds.

Recruitment

This section describes the methods used to identify potential study participants in the two study areas, referred to as Greenville and Hilltown.

Greenville

As I described at the beginning of this chapter, participants in three of the four groups (the parents, the activists and the older people) were all resident in Greenville, an urban area in England. Recruitment in Greenville was carried out via relevant community groups which were asked to help with the identification of potential interviewees. These included two parent and toddler groups, one group providing educational activities for older people, a charity providing support services for older people, a local patient involvement committee, and the groups involved in campaigning against the closure of the local A&E department.

Groups that agreed to support the research were given details of the study and asked to help identify members who would potentially be willing to participate. When individuals showed an interest in participating, they either received my contact details or agreed to provide their own contact information on the understanding that I would then contact them directly.

At the first contact, I provided them with further information about the study, including explaining what participation would involve and emphasising that I was independent of the local NHS structures. Where participants commented about the closure plans, I sought to make clear that the study was not related to the ongoing consultation and would have no bearing on the outcome. I also established whether or not the potential participant met the study eligibility criteria, and provided them with a participant information sheet either by post or email. I obtained written consent from participants prior to their interview, having

checked that they had read the participant information sheet and understood the implications of participation.

Hilltown

A research nurse at Hilltown Hospital helped to identify eligible potential participants who would be attending the outpatients' clinic during the study period. She contacted them to provide information about the study and to invite them to take part. Individuals who were potentially interested in participating were provided with the participant information sheet and consent form. I then attended the clinic on the day of their appointment to further explain the details of the study. Those who wished to take part were offered an interview slot either on hospital premises or at their home. Those who wished to spend further time thinking about whether to participate were provided with my contact details so they could get in touch at a later date.

At the time of the interview I confirmed their eligibility to take part and provided additional information about the study. This included explaining what participation would involve, providing further reassurance about anonymity and emphasising that their future health care would not be affected by their decision to participate (or not) in the research. Recruitment and consent procedures then continued in the same manner as I have described above for the Greenville participants.

Study inclusion and exclusion criteria

Inclusion criteria

Across all four groups, English language speaking NHS patients and members of the wider public, aged over 18, who were able to give informed consent and are resident in the UK, were eligible to participate. Additional resources were not available to permit interviews to be conducted via an interpreter. Participants had to be able to read the cards for the trade-off exercise during the interview; large print versions were available, but none of the interviewees required these.

Exclusion criteria

The purpose of the study was to explore the views of patients and the public, with the hypothesis that these groups have different preferences and priorities for the organisation of emergency hospital services compared to health care professionals. Individuals who worked in health care at the time of the interview (or who had done previously), and those whose partners work in health care, were therefore excluded from the study.

Individuals unable to fully understand the consent procedure or the implications of taking part in the research were also excluded. In addition, because of the limited relevance of the study to these groups, young people under 18 years and those in correctional facilities were excluded because:

- Young people under 18: individuals in this group were considered likely to be more dependent on their families for support and less in a position to make a decision about where to access care in an emergency.

- Prisoners: it was considered that individuals who are incarcerated would be likely to have very limited engagement with their local area and health services.

Interviews

In this section I describe first the participants' demographics, and the the details of the interviews.

Participants

Table 4 shows participants' demographics. Considering first the parent participants, all participants in this category were female. They had between one and three children, ranging in age from nine months to six years. Income data for participants was not sought, but information about participants' current or former occupation was gathered. Specific information about participants' occupations is not reported, as in some cases this could lead to participants being identifiable. However, participants' current or previous occupation was gathered and this information was summarised using the National Statistics Socio-Economic Classifications (NS-SEC).[168] Although some of the parents were currently not working, most in this group had a background in a managerial or professional occupation. The older participants were a more diverse group; all were retired, but had backgrounds in occupations across the employment spectrum, from professional to routine occupations, as defined by the NS-SEC.

The activists and patient representatives were perhaps the most diverse group in terms of gender, ethnicity and occupational background. Within this group, four were members of local patient and public involvement groups, the remainder were involved in campaigning against the proposals in Greenville. These individuals were affiliated to a range of organisations, including local community groups, trade unions, and the local council.

There were eight interviewees in the Hilltown group, three of whom were female. Five in this group described themselves as retired. However, prior to this, Hilltown participants

had largely worked in technical or routine occupations, or been long-term unemployed. Seven interviewees in this group lived within the broad Hilltown Hospital catchment area; the eighth travelled from another area to access outpatient care at Hilltown.

Table 4: Study 2 participant demographics

	No. of participants	No. Female	No. BME	Age range
Greenville Parents (GP)	5	5	1	28-40
Greenville Older People (GO)	6	2	0	65-85
Greenville Activists/ Patient Reps (GA)	9	4	2	60-76
Hilltown NHS Patients (H)	8	3	0	52-81
Total	28	14	3	28-81

The sampling strategy aimed to include individuals with a range of experiences and backgrounds. However, it proved difficult to recruit from certain population groups. For example, two community groups representing local BME residents in Greenville did not respond to communications seeking their assistance with recruitment.

Once each interview had taken place, the participant was allocated a study number and this was subsequently used to identify them, thereby maintaining their anonymity. In terms of nomenclature, the Greenville participants are identified first by a letter G; then a letter which indicates the group they were recruited to (P= parent; O=older people; A= activists and patient representatives); and finally a number. Participant GP.2 was therefore the second parent participant to be recruited in Greenville. Hilltown participants are identified by a letter H and then a number. Participant H.3, therefore, was the third patient to be recruited to the study at Hilltown Hospital.

Interview locations
Home-based interviews were proposed for the Greenville participants, in order to limit the potential time and travel burden of taking part. Asking individuals to attend an alternative setting could potentially have introduced practical difficulties, particularly for those with caring commitments. This approach also allowed participants to relax in their own environment, to dictate the time of day they preferred and to moderate the intrusion into

their personal or private lives. The majority of interviewees in Greenville did opt for home-based interviews. Where this was not acceptable, alternative arrangements were made and several opted to come to the university for their interview.

Although participants in the Hilltown group were also offered home-based interviews, all opted to be interviewed in the clinic at the hospital, as they and I were already there. This created some logistical difficulties as space was limited in the outpatient clinic, resulting in interruptions to one or two of the interviews. Additionally, speaking to me about health care, in the hospital where they receive care, may have influenced their responses to some of the questions. However, to minimise this, I was careful to emphasise clearly my independence from the clinical team and assure them of their anonymity.

Interview structure

At the beginning of this chapter, I described how the interview topic guide and the flash cards used in the prioritisation and trade-off exercises were developed. Figure 8 outlines the structure of the interviews in more detail. The interviews began with an introduction to the study and the interview process. Participants were then asked a series of open questions about their local hospitals, including which hospital they would normally go to in an emergency and why.

Following on from this, participants were shown the eight flash cards, each detailing an aspect of emergency hospital services previously highlighted as important by patients and the public. At this stage, I verbally confirmed participants' understanding of the concepts on the cards prior to the prioritisation exercise.

Participants were then invited to complete the prioritisation exercise. Each person was asked to select and then rank their top three priorities from the eight cards, selecting first their priorities in the event of a minor injury, and then for a more serious situation where they or a relative were critically ill. In both cases, this then led on to a discussion about why they had selected the three aspects of care and ranked them in that particular order, as well as why they had discarded other aspects of care as less important.

Figure 8: Interview structure
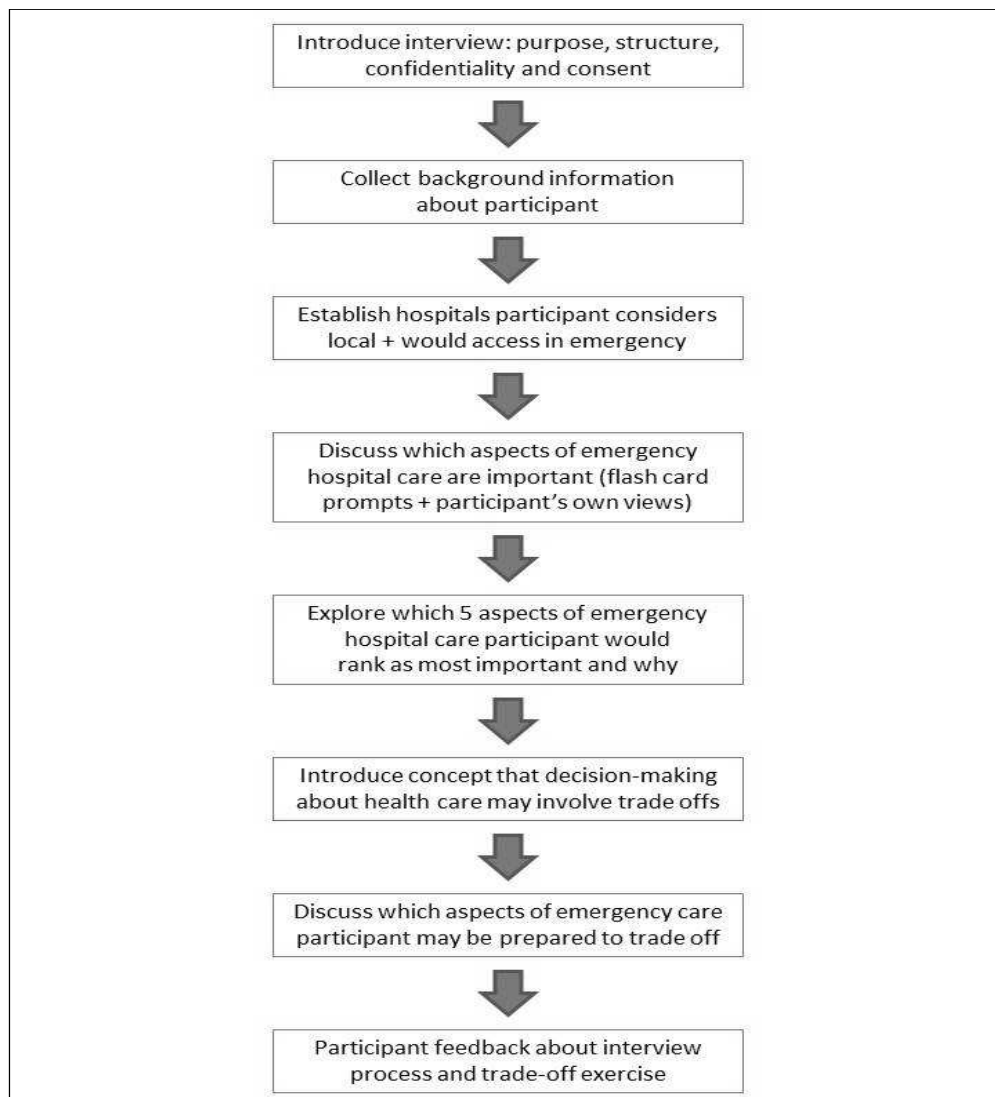
After the prioritisation exercise, the concept of trade-offs was introduced. I explained verbally that, just as in real life, sometimes decisions that involve trading-off different factors have to be made when planning health care. This then led into the trade-off exercise: I asked participants whether there were any aspects of emergency care that that they would be prepared to have 'less' of, if it meant having more of another. For example, would they be prepared to have to travel a greater distance in an emergency, if they were going to get more specialist care.

Interviews typically lasted between 45 minutes and one hour. All were audio recorded and then transcribed verbatim by a transcription company familiar with qualitative research and health terminology.

Analysis

My overall approach to the data analysis was to make use of the preliminary theoretical framework I set out in Chapter 2, rather than taking a grounded theory approach, as advocated by Glaser and Strauss.[169] Consequently, the analysis combined induction (data-driven generalisation) and deduction (theory-driven exploration of hypotheses).[170] This approach complemented the research questions by allowing the concepts at the core of the theoretical framework to be integral to the process of analysis, whilst at the same time allowing themes to emerge direct from the data.

The first stage of the analysis involved familiarising myself with the data in order to identify the key emergent issues. This included reading the interview texts and listening back to the recordings as well. I also revisited the field notes, which I had written after each of the interviews.

The next step involved applying thematic content analysis to the interview data. Patton describes this process as bringing order to the data, stating that 'simplifying the complexity of reality into some more manageable classification system is the first step of analysis.'[167] The transcripts for each group were analysed separately to allow for an exploration of the data within and between the study groups.

An initial coding framework was developed, drawing on both the literature review and the theoretical framework. Pre-defined themes included risk and safety, hospital reconfiguration proposals and public engagement processes. These themes were expanded and refined inductively and new themes were also added to the initial framework. Each group of transcripts was first 'open coded' using the initial framework to identify and compare recurring themes and ideas.[160] Open coding is the initial process in the analysis which involves breaking down, analysing, comparing, and categorising the data. The codes were then organised into overarching categories and I reviewed a sample of the transcripts in conjunction with my supervisory panel to identify and agree key themes. The analysis was an iterative process, so the data were then re-analysed to ascertain that they still fitted the codes that had been collapsed into categories.

In order to help manage the analysis, all transcribed interviews and field notes were imported into the software programme N-Vivo (version 10). This helped to manage and handle the large dataset and facilitated organised storage and easy retrieval.

Microsoft Excel 2010 was used to manage the data from the prioritisation and trade-off exercises. Following the interviews, I reviewed each transcript to identify the three aspects of emergency care that they had prioritised and recorded these, along with their key reasons for selecting these cards. I also summarised their response to the trade-off exercise in Excel to facilitate comparison between participants.

As part of the analysis, I explored both participants' preferences with respect to accessing local hospitals and the extent to which Greenville participants were involved in the public engagement process. In both cases, there were a range of different perspectives, each associated with a specific point of view. An iterative constant comparison technique, involving repeated checking comparison across categories and cases, was used to refine the definition of each of the perspectives and then decide which perspective individual participants held.[160]

Reflections on the role of the researcher

In order to explore my role as the researcher in this study and take stock of how my biases, feelings, and thoughts may have influenced the research, I kept a diary with field-notes throughout the process. As Watt puts it, by engaging in ongoing dialogue with themselves through journal writing, researchers may be able to 'better determine what they know and how they think they came to know it.'[171]

First, it is relevant to record my own personal experiences of emergency care. As a junior doctor I worked in A&E departments where, less than two years out of medical school, I was sometimes one of the most 'experienced' doctors present, for example at night. These experiences undoubtedly inform my own views about safety and the type of emergency care I would want for myself and my family. Nevertheless, collecting the data for this study via semi-structured interviews allowed me to engage with research participants and discuss issues with them in a way that would not have been possible through more quantitative designs. It was been illuminating to explore how they conceptualised the safety of A&E departments and interpreted their previous experiences of emergency care.

I introduced myself to participants as a researcher and did not tell them I was a doctor. This was partly to avoid creating the expectation that I could provide advice, but also because feedback from the pilot interviews suggested that the pilot participants who knew my professional background felt it inhibited them from giving honest answers about how they believed the health system works, in case their interpretation was somehow 'wrong.'

There were clear advantages to carrying out the interviews in Greenville during the period of consultation about the reconfiguration proposals. However, I became aware that some participants appeared to think that by taking part they were in some way registering their protest against the changes. I had made it clear in all the communications before the interview that my work was not related to the local NHS and would not influence the consultation process or the subsequent decisions in any way. However, I became increasingly careful to re-emphasise my independence again before, during and after the interviews. I suspect the realisation that taking part could not influence the process ultimately put some potential participants off. Most were still happy to be interviewed and, for some, simply voicing their concerns seemed to be in some way therapeutic, particularly where they felt they had not been able to communicate their protest via other means.

Again on the theme of my independence as a researcher, from the comments that they made, I suspect that some participants at Hilltown Hospital felt I was associated with the hospital. This was not unreasonable given their interviews took place in the outpatient clinic. It is difficult to know whether conducting the interviews elsewhere would have made a difference to this, when I was relying on the clinical team to assist with recruitment. Whether it significantly impacted their responses, I will never know.

Ethics and data protection

Ethical approval

In early 2012, I approached several community groups in Greenville to explore whether or not they would, in principle, be willing to participate in the study and assist with recruitment. I also visited the consultant responsible for the relevant clinic at Hilltown Hospital to seek her approval. At this point, approval was obtained from the East Midlands – Nottingham 2 Research Ethics Committee (REC reference number 12/EM/0258), along with separate research governance approval from Hilltown Hospital NHS Trust.

The application for ethical review addressed a range of issues raised by the study. Key amongst these were the potential time-burden of participating in a qualitative interview study and the possibility of invoking emotional distress during the course of interviews. This might not necessarily arise from the study questions, but could occur if participants chose to discuss past experiences of hospital emergency care. The application described plans to balance the burden upon participants by ensuring as far as possible that interviews would be held at times and venues most convenient to participants, and their willingness to take part was checked at several stages. I also sought to ensure that the content of the topic

guide would not cause excessive amounts of anxiety to interviewees anticipating changes to local health care services. In practice, none of the participants stopped the interviews or became emotionally distressed.

Data protection

As I have noted, each participant was allocated a unique identifier, which was used to label the transcript and recording of their interview. In this way, all quotations are anonymised, reducing the risk that comments can be traced back to specific individuals. The names of specific health care services and information about medical conditions is also redacted. Personal information was only used to facilitate contact with potential participants. The data protection procedures were approved by the UCL Data Protection Manager (reference Z6364106/2012/05/28).

Chapter 7: Study 2 findings – risk evaluation

This is the first of three findings chapters. Together, these consider in turn each of the three processes encompassed by the theoretical framework: first the way in which the public evaluate the safety of hospital emergency services; then the way in which this informs their response to reconfiguration proposals; and finally the response of local communities to consultation processes designed to engage them in decision-making.

This chapter focuses on the first process – risk evaluation – and in doing so addresses research question 2: how do the public evaluate the safety of hospital emergency services? It considers the way in which the public assess risk in the context of hospital emergency services, and then goes on to explore how this influences preferences for care in an emergency.

Study 2 compares and contrasts the views not only of different population groups, but also individuals living in different areas with respect to reconfiguration. To facilitate this comparison, the views of Greenville residents and Hilltown patients are reported alongside each other. Participants' study numbers are used to set quotes in context. As I outlined in the previous chapter, the Greenville participants are identified first by a letter G; then a letter which indicates the group they were recruited to (P= parent; O=older people; A= activists and patient representatives); and finally a number. Hilltown participants are identified by a letter H and then a number.

During the interviews, participants were invited to complete both the prioritisation and trade-off exercises, using the flash cards. The results from the trade-off exercise are reported in Chapter 8. The quantitative findings of the prioritisation exercise are referenced, where relevant, alongside the qualitative data in the following chapters. The data tables depicting the complete results of the prioritisation exercise are included in Appendix 4.

The importance of access

One of the most common objections to reconfiguration proposals is that emergency services will be too far away if the changes are implemented. Communities argue that very sick people will be put at risk by the longer journey and may die as a result.[1] In the prioritisation exercise, almost all study participants selected 'sick patients taken to A&E as fast as possible' (see Appendix 4) as one of their their three priorities for emergency care in

the event of major incident. Individuals varied in the extent to which they prioritised this relative to other concerns, but across all the study groups participants stressed the importance of timely access to emergency care. This chapter begins by unpacking this emphasis on timely access.

For many participants, getting to hospital quickly in an emergency was paramount. This was partly because 'everything else goes out of the window' aside from getting to hospital, as one put it. Here, I draw on a range of quotes from across the study sample, to demonstrate just how common this belief was. The desire to get there quickly is 'at the forefront of your mind' (H7) and takes precedence over other concerns. GP.3, one of the parent participants, explained this as follows:

> In all probability, if I was in an emergency situation, the only thing I'd want is to get to a hospital as fast as possible. That is the only thing that would be important to me. I'd want to know that people were there looking after me and that I was getting help. (GP.3)

This sentiment was often expressed in terms of necessity. H5, one of the Hilltown patients, put it very simply:

> If it's serious, you need to be quick, don't you?... You have to get there as fast as possible (H5)

The perceived need to get to hospital as fast as possible was not just 'very important' (H4), it was '*obviously* very important.' (GA.9, emphasis mine) One participant commented that being taken to hospital as fast as possible in an emergency 'is, obviously, important.' (GO.1) Another noted that, 'obviously, you need to get to hospital ASAP.' (GP.2) In other words, it was simply self-evident to the majority of participants.

But why is it 'all about speed,' as one participant put it? (GO.11) As another interviewee observed, 'it's hugely important, getting into the A & E environment quickly.' (GO.1) Another commented that, in an emergency, she would 'just want to get there.' (GA.9) However, this was not sufficient for many interviewees:

> It's getting to the A&E and getting seen, you know, getting seen quickly. (H7)

There was a strong sense, again across all four groups of interviewees, that if you were sick or injured, you would want 'to get dealt with in A&E.' (GA.6) Others echoed the same concern in almost identical terms:

Well if someone is sick, then they should be seen to as soon as is practically possible. (H6)

If a person is taken ill, they want to get there as quickly as possible, to get seen to as quickly as possible. (GO.4)

Participants explained further that getting to hospital as quickly as possible is about getting 'the patient to experts.' (GA.1) GA.7, one of the campaigners, described why he felt this was important:

Health care is quite simple, I don't feel very well, actually my wife doesn't feel very well, I want to get myself and my wife or my child or my mother to somewhere quickly where someone competent can do a triage and say you're dying, its indigestion or we're putting you in for surgery. (GA.7)

Interviewees felt that it would be important to get to 'those who know what's happening' (GP.4) and 'be looked at straight away.' (GA.2) Great emphasis was placed on the importance of the initial response in an emergency: that 'instant response is colossally important… it's so important to alleviate that initial problem. ' (GO.1) GA.1, one of the campaigners explained why this is so important in her view :

If the emergency happened, someone collapsed… Say it was street or at home, for the most part it's not known what the problem is… But I think getting them somewhere where you think you can at least start to work out what the problem is and therefore what treatment would be appropriate seems to me to be the first priority.

Participants gave several reasons why it was so important for serious ill or injured patients to 'be taken to a hospital to be treated as soon as possible.' (GP.1) Again, these views were broadly similar across the study, including participants from both Greenville and Hilltown.

First of all, interviewees commented that either they had been 'frightened' when going to hospital in the past (H8) or that they anticipated that they would 'be worrying [so] if you ring an ambulance, you want them to get there immediately.' (GP.1) At home they would neither know 'what the ramifications are,' (GO.1) nor know what to do if a relative was acutely unwell. H6, one of the Hilltown patients, described why this was important to him:

I just feel that if we're at home, we wouldn't know what to do for each other. We would desperately need to be taken to the hospital as quickly as possible, find out

what's wrong, and they sort it out. I think as you get older, you get things going wrong… I know it's not the right way of looking at it, but if you've got a [health problem], chances are that they're going to know exactly what's going on in you. But when you're elderly, you get all these horrible things… I think you've just got things unexpectedly that you know could happen and you want someone at the hospital that knows what they're talking about and what they're looking at. (H6)

However, the overwhelming reason why participants felt it was so important for patients to get to hospital and be seen by A&E staff, was the importance of receiving care as quickly as possible. Three participants observed that time (or speed) 'is of the essence' (H6, GO.1, GA.2) in an emergency. In other words, it is critical that something is done immediately: the problem requiring attention might get worse with time. H2, another Hilltown patient described why she felt it was so important to 'get to grips' with the problem.

I think it's important, because the longer you leave it, the worse whatever your problem is… It's getting grips. The sooner you get into A&E or wherever it is you're going, to a ward or whatever, you get seen to and they see to you straight away with the bloods and everything you know. They know what they're doing. Every hospital knows what they're doing. (H2)

Interviewees across the four participant groups were absolutely clear why this was relevant in an emergency. As one put it: 'It's dead simple, [the patient] could be dead otherwise.' (H3) Acknowledging how widespread the perception is, GA.9, one of the campaigners, said:

Well I suppose I'm of the opinion, like a lot of people… that the quicker I get to an accident and emergency with a serious problem, the better my chances. (GA.9)

To sum up, for the majority of participants, across the study, there was an implicit assumption that there is a direct association between timely access to medical care and better outcomes. Consequently, in an emergency every minute counts. One parent described a recent experience taking their child to hospital. Commenting on the need to have the shortest journey possible to hospital, she said:

In extreme circumstances that could be the matter of between life and death, couldn't it? You know, in an extreme situation taking your child to hospital, minutes could be critical. (GP.2)

These discussions focused on the care participants would want for themselves or a relative in a hypothetical situation, where one of them was *in extremis*. As I outlined in Chapter 1, the evidence about the association between timely access and patient outcomes is equivocal. There is some evidence that increased journey distance to hospital may be associated with increased mortality, but these findings reflect the performance of emergency services between 1997 and 2001 and probably only apply to a small sub-set of patients at high risk of immediate death.[46] Most A&E departments treat hundreds of patients every day, but only a small proportion will be seriously unwell and require a time-critical intervention. Similarly, the probability of an individual requiring such care is small, yet this is obviously a very real concern for many.

Douglas highlights the apparent gap between lay and expert views about risk, concluding that the public simply do not perceive risks in the same way. She suggests that this is because an assessment of risk for the public not only involves the probability of an event, but also the probable magnitude of its outcome. However, everything depends on the value set on the outcome.[133] In other words, one explanation for why people select a risk as worthy of their attention is that they particularly value what is being threatened.[135]

She also argues that the public can assess probabilities, but risk has weakened its connection with probability to such an extent that the term now refers only to negative outcomes.[133] Here it was clear that participants did recognise that 'the really big stuff happens thankfully less often and might not even happen at all.' (GP.3) H1, one of the Hilltown patients described why, in his view, timely access may be less critical for some conditions:

> It's not [important] in most circumstances, but it is to you. You're in pain and you
> want to get it over with quick. I mean in most cases it's something that they can
> keep you there for half hour and find out what it is. Unless it's an emergency like a
> cut artery or something like that, when you want to get there quick. (H1)

In other words, participants acknowledge that the chance of them or a relative requiring time-critical, life-saving treatment is remote. However, if there is an association between timely access and better outcomes, as participants strongly believed, then the magnitude of the outcome is potentially huge. Douglas suggests that members of the public select a risk as being important partly because they especially value what is under threat. Here, because of the implicit belief about the association between access and outcomes,

participants perceive that travelling further for care potentially threatens their life and the lives of their loved ones. Drawing on Douglas, Jackson *et al* theorise that, for the public, risk does not exist in a vacuum. People do not view the possible risk separate from its context; rather, this context 'soaks the risk with meaning' and people 'populate a risk with "flesh and blood."'[172] Here the risk was very much 'populated with "flesh and blood"' – their own. Indeed, GP.4, one of the parent participants seemed quite baffled when I asked her why she felt it was important to get to hospital quickly in an emergency. She exclaimed, with some surprise:

> It's my life! I mean it could be my life, maybe it's not even... It could probably prevent something bad happening. I may not die, but maybe they could help prevent something worse happening. Prevent catastrophe, maybe. (GP.4)

If the proposals go ahead, the potential outcome of having to travel further for care in an emergency could be death – death of self, or perhaps worse, death of loved one. The response of GP.4 described above illustrates why, perhaps regardless of whether it is likely to happen, this risk is considered to be an 'unacceptable danger,' as Douglas describes it. The point is not that such a situation *might* occur, but that it *could* occur, potentially with devastating consequences. This finding also appears to support Douglas's theory that, for the public, the concept of risk has weakened its connection with technical calculations of probability and now refers only to negative outcomes.[133]

Douglas goes further to suggest that different individuals and different communities might judge a risk more or less seriously because they value the consequences differently— for example, they value differently what is being harmed. It is interesting that here, with one or two exceptions (which I will go on to explore), most participants – in both the Greenville and the Hilltown groups – similarly judged the risk of travelling further for care as being an 'unacceptable danger.' This is perhaps because they perceived the possible consequence – death – similarly. Nevertheless, individuals did vary in the extent perhaps to which they assessed the magnitude of this risk and hence the extent to which they were prepared to accept it and prioritise it relative to other concerns.

Summary and conclusions

The public concern that a reorganisation will put patients' lives at risk is widely recognised. Using Mary Douglas's work to inform the analysis in this section produced substantive findings about how the public evaluate risk in this context (research question 2) and why proposals to downgrade local A&E departments cause significant concern amongst local

communities. In particular, I have explored the consequences of the assumption that there is a direct relationship between timely access to medical care and better outcomes in an emergency.

Proponents of the psychometric model of risk analysis would argue that lay people cannot think in terms of probabilities. However, for most interviewees there seemed to be a binary distinction between life-threatening conditions that require immediate medical intervention and other conditions that require emergency care, but for which time is less critical. Participants fully recognised that the likelihood of them requiring hospital care *in extremis* was remote. However, the fact that access could be delayed, with potentially devastating consequences, was much more important than the likelihood of it being delayed. As Douglas suggests, the possibility of undesirable negative outcomes and unacceptable danger played a more significant role than probabilities in the way that participants in assessed risk.

The findings therefore provide support for Spurgeon *et al*'s observation that proponents and opponents of reconfiguration operate within different paradigms of understanding about risk[5] and help to explain why this is the case. The commissioners in Greenville argue that the changes to local services are needed to ensure safer services for patients in the future. Yet we begin to see here that, in the minds of the public, the changes actually represent a decline in safety, because of the risk so many believe is inherent in delayed access.

Douglas also proposes that in western societies, risk has become a 'forensic resource' for holding others accountable and apportioning blame. I will return to this in Chapter 9, when I examine participants' responses to the consultation process in Greenville. In the next section I will explore the extent to which participants' perceptions of risk influenced their preferences in terms of accessing hospital care in an emergency.

Hospital preference in an emergency

During the interviews, I explored participant's perspectives on their local health care services. This included where they would chose to access care in an emergency and the factors that influenced this decision. There were three distinct types of view.

'Localists'

The first, and by far largest, group I have termed the 'localists.' These were patients who would choose to go to the hospital closest to their home in an emergency, mainly 'because

it's the nearest.' (H7) As one of the Hilltown participants put it, 'the closer the better.' (H8) GP.3, one of the parent participants, is a good example of an interviewee with this perspective. She described why she felt a sense of attachment to Greenville Hospital:

[It's] primarily because of its proximity to us. I don't know people that work there particularly, I don't have any particularly sort of… I don't have any sort of personal relationships with people there, but I would certainly be very sad if it closed because the security blanket of knowing there is a hospital that I could probably walk to if I was really stuck, is very comforting. (GP.3)

She went on to explain why she felt being able to get to hospital quickly was so important:

I think because in a genuine emergency situation, where you could die if you are not treated, I think every minute counts. I think the faster you can get to the right people, to the people that know how to treat you, the better. So I think getting to A&E as fast as possible has to always be the priority when you are in a proper life and death emergency type situation. (GP.3)

Most other participants in this category similarly emphasised the importance of getting to hospital and commencing treatment quickly because you 'could be dead otherwise.' (H3) For these individuals, the belief that travelling further for care could impact your outcome, as I described in the previous section, took precedence.

Allied to this, many were simply unwilling to travel further than their local hospital for care, or felt that they would not be able to. H6, one of the Hilltown patient interviewees, spoke about why she felt it was important to have a hospital nearby:

You need a hospital that's close to you. I do feel for people whose hospitals get shut down. I think it must be absolutely appalling and they say 'oh well get on the bus and go five miles' you know. You can't always can you? You need local stuff. (H5)

She went on to describe a recent experience where she had been given an urgent outpatient appointment at another hospital in another part of the town:

If I had to travel further than Hilltown… I wouldn't go. I didn't go… They gave me an appointment [at another hospital] and I just cancelled. I thought I'm not trekking all the way over there. (H5)

She explained why she didn't go:

> I could've got the forty six bus, but… it's way all over [the city], the bus. Also, the appointment was around half past three or something in the afternoon and I thought 'if they think I'm getting on the forty six coming back in the rush hour, not a chance.' So I just didn't go, you know. I actually picked [the appointment] myself…. I just could not tolerate this [problem]. I just couldn't… I couldn't stand it anymore and so I took the earliest appointment which was that one. I took it and then I cancelled it. I thought 'I cannot do that trek.' I mean it needs to be near. You know, people go to work and stuff don't they? And they have hospital appointments. If you've got to travel all that distance you need the day off work. (H5)

On the whole, interviewees in this group were positive about the care they had received at their local hospital in the past. Several in this category were interviewed in the outpatient department at Hilltown and this may go some way to explaining why they were particularly complimentary about the care they had received in the past. However, others were from the Greenville groups and they were equally positive.

Individuals in this category expressed few complaints, and where they described things going wrong they were perhaps surprisingly accepting in their accounts. As an illustration, one of the older Greenville participants described his recent experience in A&E:

> I am a very patient person. I know there's people before me and it depends how long they take to get seen to sort of thing, so I just accept it. I know some people are not but… [The doctor] forgot me at one stage in [A&E] from one o'clock I think and it was five o'clock before he realised… They apologised and you know… So I accepted it… It probably doesn't happen that often. I was thankful they sorted me out. (GO.5)

Virtually all the Hilltown patients fell in to this category, although many travelled to the hospital for outpatient care from another area. Whilst they presumably considered it reasonable to travel there for this type of care, most did not regard Hilltown as one of the local hospitals that they would look to in an emergency; in this situation they would seek to access care at the nearest hospital.

However, the category also encompasses many of the Greenville interviewees, including parents, older people and patient/ public representatives. It also includes participants of

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both genders, as well as a broad spectrum of ages and backgrounds. In many ways, this appears to be the default category in terms of hospital preference, supporting the findings of other studies, which have shown that proximity is the main reason why patients choose to go to a specific A&E.[173]

'Avoiders'

I have termed participants in the second category of hospital preference the 'avoiders.' This group was much smaller. Timely access was still important to them to a degree, but the thing that defined them was that all would seek to avoid accessing care at their local hospital, for one reason or another. Many were also critical of the services it provided.

GP.2, one of the Greenville parent participants, is a good example of an interviewee in this category. She described to me why she had begun to take her children to a neighbouring hospital, Yellowtown, if they needed to access A&E:

> I think Greenville Hospital is… um… Oh, how, how do I put this nicely? From my point of view, as a building, I think it's totally inappropriate for its function. Whoever designed it, you know, the design of it is shocking. I mean, the, the face of the building is literally, you know, a car park and a raised platform and your main point of view is the emergency. You literally have to walk past emergency services and ambulances wheeling you know bodies in and out to get to the front door. So you know, from, a layman's perspective, looking up at Greenville Hospital, it's everything wrong with hospitals exemplified at that building. (GP.2)

She went on to describe her experience of using the A&E service:

> The emergency facility [at Greenville] is absolutely shocking. I mean it's probably the worst I have ever, ever, been to. Quite recently we started going to Yellowtown A&E. The last couple of times I've had to go, I've actually gone there because I just think… Well the reason I have an issue with Greenville Emergency Service is, again, it's just not fit for purpose. Everybody goes through one door… There is no designated waiting area for paediatrics which is abysmal, because in this day and age, we should not be exposing our children to the gruesomes of what happens in A & E at three o'clock in the morning... Our children should not have to view that. So that's shocking. When you actually get through triage, and you end up in the paediatric facility… it's literally a room the size of this room, which is what a four by four room. And so you're waiting in that room with all the other mums who are

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there at all hours with their poorly children screaming and everything. Once you've got through triage, you go into this little room, which is dark, claustrophobic, totally unfit for purpose. It's literally a row of chairs and you are staring at each other and listening to each other's screaming children in a terrifyingly small space. I think the most concerning thing is that there's only two consulting rooms, which are off this space and do not have audible privacy. So once you are sitting there waiting and the consultants are dealing with distressed parents and children in these two consulting rooms, everyone else who's waiting in the central space can hear everything that's going on. You can hear everything. There's no acoustical privacy at all, and so there's no discretion. So from a paediatric point of view, the A & E at Greenville is shocking. I mean it's… Like I said, I've been to a few, and it is probably the worst. Yellowtown on the other hand… once you actually get into the paediatric area, it's a lot more dignified. You know, there's, there's, there's segregation of space.

Later she talked more about her decision to access care at Yellowtown:

I think I had no confidence taking a [tiny] baby to Greenville. I absolutely despaired at the thought of sitting… You know, these times that you take your child to A & E is always the middle of the night… Whatever time it was in the middle of the night when you realised that she was [unwell]. The thought of going and sitting in Greenville with drunken people and aggressive people with such a tiny small baby just wasn't an option. (GP.2)

It's important to stress that this participant believed very strongly in the importance of timely access. She was clear why she would not accept a longer journey to hospital:

In extreme circumstances that could be the matter of between life and death couldn't it? You know, an extreme situation, taking your child to hospital, minutes could be critical. So having a facility further away, no it's not ideal at all. (GP.2)

She had decided to access care at Yellowtown because of her past experiences of Greenville. However, crucial to this was the fact that it did not require a significantly longer journey:

I think in an extreme emergency, you know, being a parent, it's the nearest… I suppose it's a luxury really, Yellowtown and Greenville are equal distance. So, in that instance, you know, the shortest, it doesn't really play a factor. It's where we

think we can get triage quicker. See a consultant quicker, you know, that's… I guess that is all down to you're being seen quicker. And we know the waiting times in Greenville are longer. (GP.2)

Another parent participant, GP.5, shared similar views about the appearance of Greenville Hospital (notably, GP.2 and GP.5 both worked in design-related professions). The apparently poor reputation of the hospital had, however, also influenced her decision not to access care there.

It looks awful. It looks awful… It's on a horrible main road. It's a horrible looking massive block of a building and very foreboding, very unwelcoming. And I haven't heard… I've sort of met other people … You know, there's a lot of chat about where people have their babies, but people don't tend to talk about where they've been to A&E… There's people that say it's alright inside, it's fine, but it's not somewhere that I would particularly want to go. I've never heard particularly nice reports. It doesn't have… Yeah, I've never heard particularly nice reports about it. As I say it's, it's sort of… In the hospital area, there's quite a rough estate opposite. It's a bit of a no man's land there. I would not walk past it out of choice… It's one of those, it looks more like a prison than a hospital, you know. It's that kind of place. (GP.5)

Later she added:

I've never heard, I've never heard anything positive about Greenville at all. People are just very negative about it. Sort of generally, it's [Groans] 'oh you know, GREENVILLE.' (GP.5)

Most participants in this category lived in Greenville, and others also spoke about it having 'a terrible reputation as regards the care of patients.' (GA.4) However, the category also includes a Hilltown participant who explained why she would insist that she was not taken to her local hospital (which is not Hilltown) by paramedics.

I do plead to go to [another hospital]. I don't want to go to [the local one], I've heard bad reports. They've got a reputation. We've heard… most probably it isn't all true, but they have had some very bad publicity in the papers or on the news, television. They got told off, do you remember it? Women being left laying in the grounds having babies. (H8)

Aside from the hospital reputation, two participants in this category also noted that for serious problems, they would prefer not to be taken to Greenville: they would rather 'go for a proper teaching hospital every time.' (GO.1, GO.2) These two individuals both had worked closely with the medical profession, which may have influenced their views.

But what about timely access? In contrast to most participants, one or two in this category felt that getting to hospital quickly was less important in relation to other concerns. One explained why she would prefer to be taken further to a hospital where she felt more confident about the care:

> There are things that are time sensitive I think… [But] actually it's a very small number of cases where you have to get their super-fast and it'd be more about the quality of care you get when you get there. (GP.5)

On the other hand, others like parent participant, GP.3, described above, were clear about the importance of speed. They were only happy to access care elsewhere on the condition that it did not require a significantly longer journey. Participant GO.1 also reflected this in his interview. He was one of the older Greenville participants who would prefer to access care at a teaching hospital.

> If I was having a heart attack, I wouldn't want to go to Greenville. I'd rather go to where I think... It doesn't have to be Teaching Hospital X, it could be [one of the others in this region], but I want to go to a major teaching hospital. I think that's pretty damned important actually. (GO.1)

However, elsewhere in the interview, he observed that he would only go to Teaching Hospital X because it is relatively accessible from Greenville via a major arterial route. As he said, 'it's twenty minutes' drive':

> It's the ability to get to the establishment quickly. Teaching Hospital X is the obvious answer from Greenville because they've got the [arterial route] and provided it's not rush hour, that's extremely rapid. (GO.1)

This was because:

> I'm very keen on speed. Instant access, getting there. Getting in and started to be seen. If the, the final patching up takes time, fair enough but it's so important to alleviate that initial problem. (GO.1)

However, if he had to travel to another teaching hospital in the area he would be less keen:

> If I was in a different situation where it wasn't Teaching Hospital X, it was [one of the others in this region], I would be a bit upset because that's going to increase the time probably three fold. (GO.1)

It was extremely important for GO.1 to access care at a teaching hospital, however, this was held in tension with his desire to get to hospital quickly. On balance, the timeliness of that access was perhaps more important. He was only really prepared to travel to Teaching Hospital X as it involves a relatively straightforward journey; whilst he would want that type of care, he had reservations about the implications of travelling any further. This echoes GP.2's view, described above, that she was happy to access care at Yellowtown, rather than Greenville, but would be uneasy if this involved a longer journey.

This view was shared by many in this group: they would avoid accessing care at their local hospital, for a range of reasons, but only because there is a relatively high concentration of hospitals in the wider area, such that they would not have a significantly longer journey, because of their concerns about the impact this might have on outcomes. Whether this view would also be relevant in other less urban communities, where there are fewer hospitals per capita, is not clear.

'Loyalists'

The third category I have termed the 'loyalists.' Like the 'localists' these individuals reported that they would seek to access care at the hospital closest. However, the thing that marked this group out was their loyal defence of the hospital. All were Greenville residents.

I have described how the participants in the 'avoider' commented on the poor reputation that Greenville Hospital has amongst some sections of the community. Some in the 'localist' group also noted this, although it had not influenced their decision to access care there. However, interviewees in the 'loyalist' category took a slightly different view, typically relating these concerns to past hygiene problems at the hospital and dismissing them as inaccurate. For example, GA.7 described why he would want to be taken to Greenville in an emergency:

> I'd want to be taken somewhere quickly. I wouldn't have a problem going to Greenville. I wouldn't have a problem. I don't have a problem. There are some people who do have a problem with Greenville, 'don't take me to Greenville, I

don't want to go.' Remember it had very high rates of MRSA and C. difficile in the past and they've got those numbers down as far as I can tell. (GA.7)

GA.5 commented similarly:

> Greenville has this past reputation of being a dirty place. It was years ago, but it's not currently, but that tag has stayed with it. So people, a lot of people [in some areas of Greenville] prefer not to go to Greenville, they'd rather go elsewhere. It isn't like that now though. (GA.5)

A third took the view that the hospital had actually 'turned itself around.' She observed:

> [Greenville], it's a hospital that's actually turned itself round. It's put a lot of effort into things, so that... I'm not going to say it's the most brilliant hospital in the world but then again I would not say any hospital is the most brilliant hospital in the world... But Greenville... In areas where they had a poor reputation - you know, for a long time I know there were lots of concerns about maternity - they've turned it round. (GA.8)

Another in this category took a completely different view to other participants, describing instead Greenville's 'excellent' reputation:

> People who have used maternity services at Greenville say they're excellent... I know lots of people who recommend Greenville Hospital for orthopaedics. Lots of people who say its paediatrics is excellent. (GA.9)

This sits in contrast to the significant number of other participants who independently commented on the hospital's negative reputation. However, it is possible that the hospital has a better reputation amongst some sections of the community or that it really has 'turned itself around' but this hasn't filtered down to the wider community. It is, of course, also possible that this individual was seeking to defend Greenville in the face of closure.

In their study of public interest claims, Farrington-Douglas *et al* explored whether or not stakeholders put forward arguments against reconfiguration on the grounds of loyalty and civic pride. They drew on Healy and McKee's view that, alongside their clinical role, amongst other things hospitals also play a cultural role, generating civic pride and symbolising a strong welfare state.[6, 7] In the end, the views of only one of the interviewees in their study reflected this point of view; most instead emphasised the importance of access.

In contrast, in Study 2 there is some evidence that participants in this category are showing loyalty, but what is it loyalty to? The obvious answer would be loyalty to Greenville. Perhaps not surprisingly, all the participants in this category were actively involved in campaigning to save the hospital. Many went to some length to try and convince me that it provided a good standard of care, and – where they acknowledged them – that the concerns of the wider community were unfounded.

However, I don't think it is that simple. It is interesting to note that the majority of these individuals expressed specific political views about the NHS. This partly related to the current government's handling of the service. GA.9, one of the campaigners, is a good example of this:

> I'm in favour of a national health service, with nationally agreed standards. I know this government would like to do away with all of that, but I think it's really important and it's a protection. Also it means that there's a benchmark to measure services against to see if they're failing and to make sure resources are going in and I think if that's not done nationally… That's the whole point about having a national health service. I'd like to think it still [exists] but I think it's beginning to break up which is quite worrying because it's starved of money or… Privatisation and all of those things I think will break it up and that's why I'm so opposed to privatisation because it will break up that continuity. Break the links between different services and that's really worrying, really worrying. (GA.9)

GA.7, another campaigner, had similar expectations of what the state should provide:

> It's always the poor and the underprivileged who need good local hospitals. The idea that there are competitions between hospitals and schools is a complete anathema for me… What I passionately believe is that everybody can expect by paying National Insurance a decent adequate local hospital… Everybody should be within twenty five minutes of getting to a local hospital to be diagnosed to see if they're ill or they've got indigestion. (GA.7)

Another comment by this participant suggests to me that the loyalty is not to Greenville Hospital *per se*, but more to what it represents as the part of the NHS closest to them. I asked him whether he felt an attachment to his local hospital:

I don't think it makes any difference at all. I really don't think… Suppose I'm on holiday in Torquay, I want to go to the local A&E; I have no sentimental, romantic, relationship with Torquay hospital I just want to get there… Remember people do move around a lot. To me it doesn't make any difference. (GA.7)

Notwithstanding their political views, the emphasis this group placed on having a hospital available locally is almost certainly underpinned at least in part by the assumption that timely access is associated with better outcomes. I asked this same participant what he meant by a local hospital:

That you can get there quickly when you… What we all want is - and I've paid National Insurance for fifty years - is when I don't feel well I need to quickly get somewhere that can diagnose me and treat me. (GA.7)

Interestingly it was only participants in the 'loyalist' group, including GA.7, who commented on recent changes which mean that ambulances take some patients from Greenville directly to a specialist unit, in line with similar changes in other urban parts of England. However, they had mixed feelings about this move and their concerns reflected again the assumption that timely access is associated with better outcomes. Measures such as these typically mean that patients have to travel further to access care, because the ambulance bypasses the local hospital.

On the one hand, GA.8, welcomed the changes. Speaking about cardiovascular services, she said:

[I'd want to go to Greenville in the future] unless it was a stroke or a heart attack where they've centralised the services. But there's loads of clinical evidence to support that and I would not worry, as long as the ambulance got here quickly. If something happens, you know, [my partner] had a stroke or a heart attack, I'd want the ambulance here quickly and I want him with an expert team. So it's not that I see that a district general hospital A&E covers everything, there are specialisms. There are things where clinically you can show better outcomes. But, other than sort of the, the stroke trauma, heart attack centralisation, Greenville deals quite well with everything else. (GA.8)

Nevertheless, she still held this in tension with timely access:

If it's a stroke or, or heart attack you need the ambulance here quickly, because it's that golden hour. You need to get the interventions. You need the ambulance here quickly, then the ambulance could start the interventions and get you to the correct hospital to get the more detailed intervention, to get you to that specialist team. (GA.8)

On the other hand, others were more cautious. Returning to GA.7, he commented that economies of scale could be achieved by having expensive medical equipment on only a few sites, but – again – 'you need the urgent things close by.' He reported that patients he knew had previously been able to get 'dealt with very quickly' when there was a cardiac unit at Greenville. However, the fact it was no longer there 'is a bit of a concern.' (GA.7)

Another 'loyalist' spoke about the implementation of the measures to centralise services:

For some things, like strokes, it's generally been accepted that it's best to concentrate stroke services. Although having said that, I've talked to some sisters who work in Greenville Hospital who tell me they regularly get people still admitted for strokes and they have to care for them until an ambulance can then take them on to a specialist centre. So they don't really agree that it was a good idea to close our stroke unit. (GA.9)

In summary, the 'loyalist' group shared many characteristics with the 'localists' with their emphasis on the importance of timely access and their stated preference to be taken to the nearest hospital in an emergency. Some in the 'localist' group noted that Greenville had a poor reputation, even if it did not influence their choice to access care there. However, the thing that marked the 'loyalists' out was their defence of the hospital, allied with their distinct views of the political importance of communities having a local hospital. One did admit later in the interview that their family had chosen to go to other hospitals for outpatient and elective procedures in recent years, rather than Greenville. However, it seems to be the case that - perhaps because of their belief that the state should provide a comprehensive health service - when faced with plans to downgrade services at Greenville, many participants in the 'loyalist' category sought to try to explain away wider concerns about the hospital's reputation in a bid to defend it and oppose what many saw as evidence of the rollback of the welfare state.

The voice of campaigners typically has prominence in debates about reconfiguration and has previously been the focus of much of the research that has explored the decision-

making process. By comparing preferences across the groups, we begin to see that many of the campaigners have a slightly different perspective to the rest of the population, even if they share to some degree a belief about the importance of timely access. I will go on to explore this in more detail in subsequent chapters.

Summary and conclusions

In this section, I have explored the factors that influenced participants' decisions about where to access care in an emergency, and the role that risk plays in this process. I have described three different viewpoints. Participants in the 'localist' category generally looked to their nearest hospital, because it was the closest and therefore quickest to get to. In contrast, many in the second category, the 'avoiders', would actively seek care elsewhere, driven partly by concerns about the services provided by their local hospital. However, most of the 'avoiders' were only happy to go to an alternative hospital because they did not perceive the extra distance or journey time to be significant. The third group, the 'loyalists' shared some characteristics with the 'localists' but were marked by their loyal defence of the hospital.

There was no obvious difference between the 'localists' and the 'avoiders' in terms of gender mix, age or socio-demographic profile; there were Greenville and Hilltown participants in both groups. Previous research has not compared the views of those living in an area where reconfiguration is being considered, with the views of residents living in an area where it is not actively being discussed. In this study, participants from both areas expressed very similar views about what would be important to them, including stressing the importance of timely access, as I have described. None of these views can be assumed to be static and they simply reveal a stated preference, rather than necessarily representing what participants would definitely do in an emergency. However, my findings suggest that there is in fact little difference generally in terms of hospital preference in areas where a reconfiguration is being considered and ones where it is not. In both cases, most wanted to be taken to the nearest facility, but at least amongst the wider community a minority would also rather be taken elsewhere. This represents a key finding of the study.

Across the three categories, the presence of a hospital in Greenville appeared in fact to act as a reassurance to many, including some of the 'avoiders.' Several spoke about being 'grateful' or 'glad it's there.' (GO.3, GA.1, GA.9) Others have also described the concept of the hospital as a 'security blanket' or 'safety net,' which interviewees spoke about here.[174] According to Malone, the emergency department represents for many a last bastion of

public safety and public care.[174] Similarly, Timmins argues that hospitals still carry 'the medieval connotation of a place of safety and asylum.'[175] This is important for debates about reconfiguration, when there is a threat of the safety net being taken away. Hospitals are thought to serve a range of purposes, ranging from clinical and economic roles, to social and cultural functions.[10] However, participants' explanations of why it is important to have a local hospital were much more prosaic and usually allied to the widespread belief about timely access and outcomes.

A&E alternatives

The availability of alternative urgent care services may also be another factor that influences patient decisions about where to access care in an emergency. During the course of the interviews, I explored participants' knowledge of other services in their area, including both urgent care facilities and emergency care at their local GP practice.

Urgent care services

In the UK, the availability of different urgent care models has grown considerably over the past few years. 'Walk-in' health facilities, also known as Urgent Care Centres, have been established to deal with minor injuries, whilst telephone advice services such as NHS Direct have been expanded. In 2004, the new general practitioner (GP) contract also introduced changes in primary care affecting the organisation and delivery of care out of hours.

Here, across all groups, participants' knowledge of A&E alternatives was limited. There was no obvious pattern to this, except to say that knowledge was particularly limited in participants in the 'localist' category who would routinely look to their local hospital for care, rather than go elsewhere.

When asked if there was anywhere else in the area that they could get treatment for a minor injury, besides the A&E department, many of the responses were clear:

> Oh God, do you know, I wouldn't know. (GP.5)

> Erm, no, I think is the easy answer to that. (GA.1)

> Not that I'm aware off. (GP.2)

Nevertheless, a handful of participants did mention a walk-in clinic in an area of Greenville that I will refer to as Blueborough. Three of these individuals lived in Blueborough; another had been advised to go to the clinic by a health care professional. From its website, this

clinic apparently offers unscheduled NHS care for minor injuries and illnesses, but it is not advertised on the NHS Choices website, which seeks to help patients find and use NHS services in England. Three participants also commented that the A&E department at Greenville Hospital had been 'split in to urgent care and more serious things.' (GO.3) Patients can be 'pushed over to another section where they just deal quickly with minor things.' (GA.4) The Greenville Urgent Care Centre is located at Greenville Hospital, next to the A&E department, and provides care for minor illnesses and injuries that require immediate attention. Again, this facility isn't advertised on the NHS Choices website.

Even when participants knew about a local urgent care facility, this did not necessarily mean that they would choose to go there. I asked H6, one of the Hilltown patients, and a 'localist' whether there were any such services in his area:

> Not that I'm aware of, there probably are... [The local community hospital]... That is a walk in centre. That doesn't have a casualty but it does have a walk in... I've never used it but I would imagine you [could go there] if you thought something was wrong or you know a bad cut or something like that in the garden, you might go there. That's what I would go in there for, if I was local, but because I have [the hospital] on the doorstep, I go straight up to casualty. (H6)

Notably, participants identified two significant barriers that limited them from accessing alternative facilities. The first was the challenge of trying to find a new location in an emergency. One parent participant, GP.4, knew that there was a local walk-in centre in her area, but as she explained:

> I'd probably go to Greenville Hospital. I suppose I could go to one of the walk-in centres. But getting there... getting there... I know there's one somewhere, if you go somewhere up there [points], there is a walk-in centre but I use the satnav when I go there. My first thought would be, I'll just go to Greenville Hospital – default. I think it's the only hospital I normally use, because I've gotten so used to it. Whereas trying to find another place, like I said, there is a walk-in centre somewhere - I'd have to Google it first, take the postcode, put it on the navigation and then find my way there. (GP.4)

The second challenge lay in knowing what type of services are provided by alternative facilities, and thus what types of complaint could be treated there. This confusion relates partly to the nomenclature: participants were unclear how an urgent care centre differs

from a conventional A&E. For example, GA.7, one of the campaigners, described his understanding of the urgent care centre at Greenville Hospital:

> Urgent care centres. You know, the mind boggles. It took me a while to figure out what urgent care centres are. And of course there's one co-located in Accident & Emergency in Greenville. When you go in there, you look at these two and you think 'well what's going on here?' because if you got a dictionary out and look at Accident and Emergency, urgent you think it's all the same, right? So what it seems to be is like a sort of mega twenty four hour GP clinic… But, as I say, it's taken me a while to figure out how these things fit together… A&E is NHS but the urgent care centre is [run by a private enterprise] who are a for profit company. So you go in there and they say, 'right that way,' so you go into a for profit area, 'this way' you go into A&E. But that's the model at Greenville so, apart from reading about it, I've not seen any other models, so that's my maybe incomplete understanding of what it is. (GA.7)

Another participant, GP.3, one of the Greenville parents, spoke similarly about the challenges she felt the public face in distinguishing between different facilities:

> I am a bit clueless, to be honest, about what other facilities there are around here. I mean our GP surgery is just down the road and if it was something fairly minor I would go down there to be truthful. And they are fairly good at on the day appointments and things like that, so for really minor things I would probably just head straight to my GP. But I think one of the things that people need to… I think one of the things the NHS could work on would be educating the general population about what warrants an A&E trip and what can be treated at emergency care centres and all these other things that I hear floating around. But they need to make sure that the local people know that these things exist, know where they are and know what to take to them, because I don't know and I regard myself as fairly clued in to these things and I am still not sure. So it may well be that right on my doorstep is a perfect place to take, you know, children that have fallen off sofas and things like that for double checking and I just don't know that that's a facility that's available. (GP.3)

Underlying these concerns however seems to be a more fundamental uncertainty. Returning to GP.3:

I think that is one of the things that's tricky about A&E services and why people find it difficult to work out when they need to go and when they can go other places, it's because lots of things are accidents but not all of them are emergencies, and knowing what to take to A&E I think is very hard. (GP.3)

Participants were clear that 'a lot of other things that are important but not life threatening.' (GA.6) However, distinguishing between the two can be challenging. Disparities between patient perceptions of the severity and urgency of a health problem, compared with the views of health care professionals, have been reported in several studies previously, with patients tending to over-estimate both severity and urgency.[176] Nevertheless, interviewees in this study were concerned more about the implications of getting it wrong and underestimating the severity of a problem. As I have demonstrated, some feared that there could be catastrophic consequences if they were to go to an urgent care centre, thereby delaying access to diagnosis and and definitive treatment, because the problem actually required the services of a full A&E.

Given the lack of knowledge of A&E alternatives, and the twin challenges of knowing what complaints can be safely treated at an alternative facility and how to get to there in an emergency, it is perhaps not surprising that going to Greenville Hospital in an emergency was the 'default' for many participants (GP.4). As GP.3 put it, my brain would go 'someone is hurt - A&E.' (GP.3) These findings are important when the current policy direction seems to be to increase the number of urgent care facilities in the community to address demands on A&E.

GP availability

Alongside the challenges relating to urgent care, there is a well-documented relationship between A&E utilisation and access to primary medical care.[177] In Study 2, none of the participants reported having to attend A&E in the past because they could not access primary care. However, one did feel that many people had no option but to use A&E departments 'because the GPs aren't available.' (GO.2) On the other hand, some participants felt that they would have good access to their GP in an emergency, at least in theory. GO.1, the older Greenville participant who would be keen to be taken to a teaching hospital, described the practice he attends:

I think they've got a reasonably good practice in the sense that I think, if I were to charge in there with an immediate problem, they would readjust everything to take it on board. If I was going in there, I was bleeding badly, or something like that, or

> my partner was... They would clearly alter the schedule to try and organise... do
> something like that. They wouldn't let me down now. (GO.1)

Others had had a positive experience in the past accessing emergency appointments, particularly for children:

> I've phoned them up at you know three o'clock on a Friday afternoon and they've
> seen me. That's for my baby so they're really good at prioritising. And actually for
> me also. I've been able to see a nurse practitioner at least, at fairly short notice. So
> I've never had any problem getting an appointment there and it's about five
> minutes away. That's been really good. (GP.5)

However, others were uncertain about whether or not they would be able to get an emergency appointment for themselves; some felt they would be able to, whilst others thought it unlikely. Several participants particularly commented on the challenge of accessing routine, non-urgent appointments. GP.1, one of the parent participants said:

> [My practice] offer emergency appointments daily so you have to ring by a certain
> time and you have a triage on the phone with the GP and then they assess whether
> or not you go in or not. If it is a proper emergency obviously then you get an
> appointment, if not, if you wanted to make a routine appointment it's normally a
> two or three week wait. I think that's kind of normal.

Several recent UK studies have explored the relationship between poor GP access and A&E visits.[177] In their survey of A&E attendees, Penson *et al* found that a sizeable proportion of patients had consulted or tried to consult at least one other health care provider, such as a GP, before attending A&E. As a consequence, they suggest that patients do not present to A&E because it is more convenient or because they expect to be seen quicker.[178]

Summary and conclusions

Others have observed that the growing complexity of the urgent care system may be driving patients towards A&E because there is poor knowledge about the different services available amongst patients, carers and health care providers.[178, 179] As a recent Health Select Committee report noted, when faced with a confusing and fragmented urgent care system, 'patients are making the rational choice to go where the lights are on, which invariably is the local emergency department.'[180] Here, most participants anticipated that they would go to their local hospital in an emergency, almost by default. Previous studies exploring this have principally involved A&E attendees, who may represent a subset of the

population with particularly poor awareness of alternative services; this study suggests however that there is a lack of awareness amongst the public at large. This was compounded by their limited knowledge of alternative facilities, including what conditions could be treated at urgent care centres and how to get there. Previous studies have also largely relied on quantitative survey methods; the qualitative approach I have used has enabled me to offer more in depth information about patient choices in an emergency and particularly why many would still default to A&E.

Chapter 8: Study 2 findings – response to the case for change

The previous chapter explored the second research question about how the public evaluate the safety of hospital emergency services. This chapter and the next will address research question four: what other factors influence the way in which the public respond when proposals aimed at reconfiguring hospital emergency services are put out to consultation?

Together these chapters examine the way in which the public respond to a public engagement exercise, framed as a risk communication process. Here, I build on the findings of the previous chapter about risk perception to examine the second process encompassed by the theoretical framework: the factors that influenced the way in which a local community responded to the <u>content</u> of reconfiguration proposals, including the clinical rationale behind the plans. In Chapter 9, I explore their response to the third process, the <u>mechanism</u> of the engagement process, particularly focusing on the intersection of lay and expert knowledge, which the theoretical framework highlights as important.

Reconfiguration in the news

To set these findings in context, at the time of the interviews, proposals to reorganise a range of hospital services were being considered in several areas of England. Some of these had provoked national debate. This was set against a backdrop of, on the one hand, a wider discourse about improving care standards in the NHS, for example in response to the apparent failings at Mid Staffordshire NHS Foundation Trust, and on the other, ongoing government rhetoric about the need for fiscal austerity.

Participants in Hilltown did not live in areas where plans to downgrade services at their local hospital were actively discussed. Nevertheless, several did raise the issue unprompted during the course of the interviews and expressed reservations about the impact of such proposals, as well as feelings of sympathy towards those were affected. I have mentioned already H5's remark that she '[felt] for people whose hospitals get shut down' because it would require them to travel further for care.

Participant H3, another Hilltown patient, is another good example of this view:

> If there's an A&E service in a hospital, then people are dependent on it. To take it away and say 'you have to go bloody miles away,' and then when you have an emergency… it can be terrible I'm sure. And then there's going to be more people

who are needing that one, because their hospital has closed. Their A&E has closed and they have to go to another one. There's a hospital [in another part of the city] and they want to close the A&E there. Well maybe they have, I don't know. Campaign went on for a couple of years. I mean people who live in that area, they have to… Well, I don't know where the other hospitals are around there. And it depends on the time of day as well, on the traffic, and how long they're going to be in the wagon and what not. (H3)

It is also interesting to consider why Hilltown participants believed reconfigurations were taking part in other parts of the country. The views of H1 reflect those of several others:

HB: You mentioned just now about closing A&E units?

H1:   They did. It's in the papers, not [in this area] but at the moment, it's… Well it's in [other areas]. So they're doing quite a lot of… trying to cut them down for some reason or another. I think that's wrong, because most of the people that go to A&E are people that are very old and they've got no chance of getting… They don't know where the other place… It might be another town or something like that. The poor people have to go, but again it's the cut backs.

HB: What do you mean?

H1:   Well they, I mean, hospitals, have got a target and they get so much money. If they get that money and then spend it, they they've got to cut back on something, so they've cut back on some things that they don't think they could do. They could cut back on the A&E, carry on, and let them go to another one. But it hurts the poor old people. It's generally old people that can't get about that's complaining.

In my field notes, I had noted that at the time of the interviews, one of the tabloid newspapers, known for its traditional conservative line, was in the middle of a campaign 'against the growing swathe of A&E closures.' Most other newspapers, including the broadsheets, were not really engaging with the issue at that point. The views of the paper were reflected in comments made by one or two participants, particularly in Hilltown. H6 was an older male patient, and his views perhaps reflect this stance best. During the interview, he told me that the A&E department at a hospital in another part of the city was closing. I asked him if he knew why this was:

All financial. Yeah, it's financial, they seem to have sold… We passed it the other day, and they seemed to have sold a lot of it for housing. So they're obviously, you know, looking for money, which I understand, but I do feel that you know we're closing too many hospitals and we have an increasing population, rapidly increasing, you know from outside influences. I find it strange that we do these things, I really do. We seem to be able to find money for so many other things, I'm thinking in terms of wars, and there doesn't seem to be any problem getting money for that, and yet when it comes to hospitals providing for people, they're ill or injured, yeah, well it's very, very difficult. (H6)

Notably, the newspaper in question is also well-known for its anti-immigration stance. H6 returned later to the theme of population increases, in the context of pressures on the health care system:

I'm sure we're not alone and it's going to be an ongoing problem isn't it, again, because of the population rise. There's just so many people wanting to see a doctor or needing to see a doctor. I mean, we never had a problem when I was growing up, seeing the doctor, but I mean the population has changed now from say the sixties or the fifties when, you know, there was never a problem to see a doctor. I'm sure that we are luckier than many areas because of the sort of people… I mean we don't have a large migrant population but you know it is… There are migrants with children, this, that and the other and I'm sure in other places [around here], that could be a big, big problem. Just sheer weight of numbers. Sheer weight of numbers. (H6)

The same newspaper had also recently run several pieces explaining that the 'crisis' in A&E departments was the result of a shortage of consultants. This was another theme H6 picked up during his interview:

H6:   Well there's no point getting you, rushing you to a hospital with a serious condition and there's no consultant there on a Saturday or Sunday. I think that's totally, totally wrong, I really do.

HB: Why?

H6:   Well people get ill at the weekend. If you're in that sort of work, then you should be expected to work… not seven days a week, but in a shift pattern, so that the whole thing is covered seven days a week, your area of

expite, so at least maybe three of you working, so that you can work in-between say three consultants so there's always one of you that is there.

HB: In the hospital?

H6:   Or physically available say within ten minutes. I've been fortunate. I can't say it's from personal experience but it's what one hears, or what one reads in the papers, you know, that try and see a consultant on the weekend is difficult.

In summary, A&E reconfigurations were part of a wider narrative about austerity measures and pressures on public services in the UK, at least amongst some population groups. Some population groups saw such proposals in a negative light, even when their own local hospital was unaffected, and indeed, amongst some in the Hilltown group, there was a degree of solidarity and sympathy for those in affected areas.

Reconfiguration in Greenville

Participants in Greenville were involved (or not) in the consultation process in a number of ways. Five categories of participant were evident, all of which differed in terms of the extent to which they were engaged with the proposals and consequently the engagement process.

No mention of the proposals

The first group did not mention the plans to downgrade local A&E services in Greenville at all, during their interviews. This does not necessarily mean that they weren't aware of the proposals. However, it seems likely that discussion of the hospital's A&E services would have jogged some memory; most other participants referred extensively to the proposals in the context of discussing their local emergency services, even when I did not raise the topic directly.

One of these individuals was a parent who had recently moved to Greenville from a neighbouring area, GP.5. She was one of the 'avoiders' in terms of her hospital preferences and would not want to access care at the local hospital, partly because 'it's a horrible looking massive block of a building and very foreboding, very unwelcoming' and partly because she had 'never heard particularly nice reports. (GP.5)

Her preference instead would be to return to a hospital she had previously used.

> If I really had a choice, I'd probably go back [there], you know. If the ambulance said to me you can go to any hospital you want, I'd probably say [take me there], because I know it's a really good, I know it's a really good hospital. I've been to their A & E department before. It's that familiarity. (GP.5)

Perhaps for this reason, she was not particularly engaged with the local services in Greenville. The three other participants in this group were older men, aged over 70, a group who are perhaps generally less engaged with the organisation of care, even if some regularly rely on their local services. One participant in particular was clear about his lack of interest in the topic:

> I really don't take a great deal of notice. I don't bother to read the newspapers hugely about this sort of thing. I worry about it on the day that I'm charging off in my taxi to get there and then I take an interest for a week or two and then I forget about it until the next time. (GO.1)

I noted in Chapter 1 that the push for public involvement policies assumes that citizens want to engage in 'active citizenship' and participate in decision-making. However, for some there may be limited incentive to take part because their contact with hospital services is typically involuntary, sporadic, and unplanned.[71] GO.1 is perhaps an example of someone who has a limited desire to be politically engaged and a limited sense of responsibility for their local services.

Participants in favour of the proposals

In contrast, the second group contained two participants who were broadly in favour of the proposals. One, GA.4 was recruited to Study 2 as a member of a local patient involvement committee; he was an 'avoider' who would prefer not to go to Greenville Hospital, because it has 'a terrible reputation.' He recounted two specific encounters that had influenced his view that services locally should be consolidated:

> I have been to meetings, particularly one by a local GP who is very well genned up on the proposed hospital reorganisation and I do appreciate and understand the need for a reorganisation of hospitals, how they're organised, so that they can specialise in particular aspects of medical work. (GA.4)

He went on later in the interview to describe a recent conference he had attended, organised for patient representatives:

I'd rather go to a hospital where I had confidence and where I was more likely to be dealt with promptly and efficiently, rather than go to a nearer hospital where there might be problems… It was an all-day conference, and they covered the reorganisation of hospitals themselves and the reorganisation of the hospital NHS service with regard to both general practice and hospitals really. So, you know, it was a question of how do we, how we try to make it more efficient and more responsive… It was very helpful to me certainly, and I got to meet the sort of head of reorganisation within the head office of the Department of Health. He came down and spoke towards the end of the day, and he was very, very helpful to talk to… I had a couple of questions but, erm – to be honest with you I can't remember offhand, but I know that he was able to answer questions, without having to say, I'll come back to you on that. Their point was that it might take longer to go to a specialist hospital, but once you arrive there you'd be dealt with that much more efficiently and with much more expertise because of the grouping together of specialists and therefore you'd be better, you're better off, be best served that way. [Most] other people of my own age are just concentrating on getting there quickly. But I appreciate that going to a hospital where they've got a concentration of specialities is much better. (GA.4)

It is interesting that he referred to himself several times as a 'past patient' and he described how he had suffered an acute medical event several years back, which had required a long hospitalisation. With regard to the centralisation of services, he added:

From my personal point of view, having a much greater access to specialities, say, in the stroke field would be, would be a great bonus as far as I'm concerned. (GA.4)

The second participant in this category, GO.2, was an older Greenville interviewee and one of the two who expressed a wish to be taken to a teaching hospital, in the event of an emergency. She had previously worked closely with the medical profession and she explained why she was a 'believer' in consolidating care on fewer sites:

I appreciate that you get a better outcome if you get to a more specialised place. I really believe that. I appreciate people's comments about convenience because many people are concerned that they can't get to the hospital easily, and maybe I would be if it were me. But I do appreciate you get a better outcome if you go to

the main hospital and then when you're fairly stable you'll be moved back to the local hospital anyway. (GO.2)

Later she added:

> [People are] used to things being cut back, they think there's no money and they think the shortage of money is what's driving this. There's no understanding of better treatment or better outcomes because I'm a believer in that, I've seen it and I know it. (GO.2)

Nevertheless, whilst she agreed with the principles, she did have reservations about the practical implications of downgrading the A&E department at Greenville:

> I've got an open mind because I'm waiting to see what comes next. We heard that A&E at Greenville… I think we're supposed to go to Redbury Hospital and I know the journey's horrific. Some people wouldn't say that, because it depends where you live. (GO.2)

She had also been unimpressed by one of the public meetings she attended:

> There was a long queue of people waiting to go in and I gave up and came home actually. It's not well organised you know, it was obvious that they were trying to impress people because lunch was laid on. Because of that, there was a long queue to get in, and I think well maybe people came just for the lunch, I don't know. Anyway I just came home. I thought 'some soft soaping going here,' you know. If people are giving you lunch instead of the facts, they've already decided and they're trying to make it softer for you. I thought, 'no I'm not hanging around for this, you know, I don't really need to know.' (GO.2)

One could make a case that these two individuals were not necessarily representative of the wider community as they had relatively privileged knowledge. One of them had previously worked closely with the medical profession. The other had access to a considerable amount of information about the proposals and – crucially it seemed – had had opportunities to talk through the implications. He also had extensive experience as a service user. Nevertheless, the same opportunities to explore the proposals had not changed the minds of other patient representatives. The presence of these two individuals demonstrates well that there may be a range of views about a reconfiguration amongst the local community, including those who are in favour of change.

Participants concerned about the proposals

The remaining Greenville participants fell in to one of three groups; all were concerned about the implications of the proposals, but each of the groups acted on this concern (or didn't) in different ways. These groups – the 'active campaigners', the 'consultation completers' and the 'worried uninvolved' – form the focus of much of the remaining analysis in this and the following chapter. First, each group is briefly described.

'Active campaigners'

The first group is the 'active campaigners.' I have already begun to describe many of the factors that characterised this group, as many participants in this category also fell in to the 'loyalist' category of participants I described in the previous chapter. These were individuals who strongly believed that the state should provide communities with a comprehensive local health service. Their opposition to the proposals had led them to get involved in a range of activities above and beyond the official consultation process. I will go on to describe these in more detail, but protest activities included arranging their own public meetings, campaigning in the street, assisting others to complete the consultation documents, and actively seeking to challenge the content of the case for change.

One described what had prompted her to get involved in campaigning, following a visit to Greenville Hospital:

> The week the consultation document was published, [the consultant] gave me a leaflet about a public meeting. Went along to the public meeting, when I saw the consultation document I was just… I was horrified and I was disgusted that… that people working in the public sector had the audacity to produce a document of this nature and a, a sort of, a series of questions to get the answer they wanted. I just thought it was so seriously flawed and I found it outrageous. Plus in looking at their preferred option, it's all the A&E's that have the closest links to Greenville so you… You'll have a [huge area] which will have no district general hospital, will not have an A&E, won't have maternity, won't have acute beds, won't have paediatrics, so you're basically left with a glorified health centre on very expensive premises, naturally, because you've got all these empty wards. (GA.8)

'Consultation completers'

The second group – the 'consultation completers' – were also concerned about the implications of the proposals, and had also sought to register their protest, but this was largely via the official consultation channels. This was the smallest of the three groups and

only included three participants. Two of these were parents; the other, an older interviewee, explained that she had been involved in active campaigning in the past, but circumstances prevented her from doing so at the time of the interview.

One of the parents explained that she believed she had a duty to get involved with the consultation process, and express her views. As she put it:

I'm responsible. If tomorrow, they shut down Greenville Hospital, it's my fault.

Similarly, GP.3 was clear about why she had chosen this course of action.

I run [a parent and toddler group and we] decided to do a big push to encourage people to do the consultation process because a lot of people were signing the council's petition which is great but actually is irrelevant. Because the health care planners can choose to listen to it or they can choose not to because it is not part of the formal process. The only way in my view to register your views so that they have to be considered by the people making the decisions is the consultation process. [The council] did a leaflet which was quite useful. It explained the two or three key questions in the consultation document that you had to answer in order to have a valid and useful response and they actually kind of said 'look even if you only answered these three questions do it' and that was actually a really helpful thing. We made it a big push to encourage people to actually participate in the consultation process and try to spread information around our groups so that people understood how to do it. Because the petition can be sat on the side. It doesn't have… Hopefully they will choose to listen to it but they don't have to because they can still have a perfectly valid process that can't be judicially reviewed and ignore it because it's not part of their formal process... and so I was concerned that people felt like they were expressing their views and felt like they were being involved and saying 'we don't want this,' they were objecting, but actually they were kind of doing the equivalent of sitting on a sofa and whistling in the wind because no-one that was going to make the decisions was necessarily going to hear it.

'Worried uninvolved'

The final group also spoke about the planned reconfiguration in negative terms, but were much less involved in protesting against it. None mentioned taking part in the consultation process, or any other activities. This does not mean that they hadn't, of course; they may

not have thought it relevant to the interview discussion. Equally, however, they may have chosen not to take part in the consultation, for whatever reason, or not had the opportunity. This group included two parents, one 'localist,' one 'avoider;' as well as three older men, all 'localists.'

Broadly similar concerns were expressed by the three Greenville groups opposed to the proposals — the 'active campaigners', the 'consultation completers' and the 'worried uninvolved' – with each of the groups emphasising specific concerns to varying degrees. In the next section of this chapter I will outline these concerns, highlighting differences and similarities where they exist and, in doing so, describe in more detail the characteristics of each of the groups.

Hospital preference versus degree of engagement with reconfiguration proposals

As I have already mentioned, most of the 'active campaigners' who were involved in protesting against the changes were also 'loyalists' in terms of their hospital preference. However, one of the 'localists' also fell into this category: this was an individual who was involved in campaigning via a local community group, who felt very strongly about the importance of access, and particularly the transport challenges that would be created if the proposals went ahead. Nevertheless, she was pragmatic about the standard of care currently provided by Greenville Hospital.

On the other hand, there were both 'localists' and 'avoiders' who did not mention the Greenville proposals at all, perhaps because they were unaware of them or did not see them as relevant. One of these was a parent participant (the 'avoider' relatively new to the Greenville area), but most in this group were older men. As I have described, two participants were also broadly in favour of centralising services locally: one was an older Greenville resident, the other a member of a patient involvement group. Both had taken on board the commissioners' argument that the plans would improve both care and outcomes.

Table 5 compares participants' hospital preference with the degree to which they were engaged with the reconfiguration proposals. Towards the middle of the table, we see the 'worried but uninvolved.' These were individuals who spoke about their concerns regarding the plans, but did not appear to have acted on these by getting involved with the consultation process. Most were 'localists' concerned about the implications of having to travel further for care, both in terms of travel logistics and patient outcomes in an

emergency. Participant GP.2 also fell in to this category: she was the parent participant who already took her children to Yellowtown Hospital, because of her past experiences at Greenville. Her concern was less about travelling further, but more that the reconfiguration would mean more people having to go to Yellowtown and consequently waiting times in A&E there increasing. In the bottom left, we also see the 'consultation completers. These individuals were all 'localists' and all shared similar views about the importance of access, which had led them to try and register their protest via the consultation. Their involvement had not extended beyond this, but two described feeling a sense of responsibility to express their views via the official channels.

Table 5: Participants' hospital preference versus degree of engagement with reconfiguration proposals

	Localists	Avoiders	Loyalists
Did not mention	GO.5, GO.11	GO.1, GP.5,	
Pro-centralisation		GO.2, GA.4	
Worried uninvolved	GP.1, GO.4, GA.2, GA.3	GP.2	
Consultation completers	GP.3, GP.4, GO.3		
Active campaigners	GA.1		GA.5, GA.6, GA.7, GA.8, GA.9

Practical implications of the proposals

The first broad area of concern, across all three groups who were concerned by the proposals, related to the practical implications of the plans and particularly the implications of having to travel further for care. Again, this was principally related to the belief, shared by virtually all participants, that timely access is associated with better outcomes.

Travel

Patients would use a variety of modes of transport to get to hospital in an emergency, but participants observed that 'many people are concerned that they can't get to the [alternative] hospitals easily.' (GO.2) For each of the major modes of transport, travelling to a distant hospital would involve overcoming a range of barriers. Some of these would be inconvenient, whilst others could potentially delay access and hence impact outcome.

Travelling by ambulance

In order to get to hospital in an emergency, some participants acknowledged they would have to call an ambulance, particularly if they lived on their own (GO.2). However, several expressed concerns about the implications of having to travel further in an ambulance. GA.7, one of the 'active campaigners,' summed this up:

> The problem we've got with this reorganisation is the idea that you would spend a long time in an ambulance. An ambulance, you know, isn't a kind of surgical theatre… You'd wait a long time if you're going to have remote hospitals, unless you're going to buy more ambulances and train more crews and somehow solve traffic congestion in [the area]. What we all want is, when I don't feel well, I need to quickly get somewhere that can diagnose me and treat me. (GA.7)

Although some acknowledged that paramedics 'can actually do a lot of care now,' (GO.2) the general feeling, shared by most participants, was that paramedics are limited in the interventions they could deliver. GA.7 continued:

> In the ambulance you'd be stabilized… but I mean to actually add value you've got to get to a specialist quickly. (GA.7)

GA.2, a patient representative in Greenville, also expressed a similar view:

> Paramedics are there to take you to the nearest, to the best place possible in their opinion. They can give you some sort of first aid, but they're definitely not going to do anything for you. If you're bleeding to death, well, what they're going to do? (GA.2)

This is important, because the case for reorganising A&E services often references the fact that the skills of paramedics, and the technology available to them, have increased significantly in recent years. Indeed, as the Greenville consultation document says:

It is important that we can still provide emergency care close to, or at, the scene of an accident. However, once someone is being treated by an ambulance crew, the time it takes to get to hospital is much less important. These days so much more care can be provided at the scene of accidents, actually within ambulances, or in the community.

However, as the participant comments here suggest, this is not necessarily appreciated by members of the public. At the same time, several interviewees also expressed the view that ambulances are dispatched from the local hospital, rather than ambulance stations.

The ambulances all sit out outside Greenville Hospital, so they're dispatched obviously from Greenville Hospital. (GA.1)

Say I had to ring an ambulance… I think the ambulance would come from Greenville Hospital. (GP.1)

It is not clear how widespread this perception is, but presumably where it exists, it adds to concern about local A&E closures – if A&E services are moved to a hospital further away, ambulances will have to travel further from their base hospitals to reach patients in Greenville in future, and thus take longer to arrive.

Participants were also concerned that the changes would lead to increased pressure on the ambulance service, with knock on effects and consequences for patients:

My concern is that there's going to be far more people calling ambulances when they don't necessarily need to, either because they don't have a car or because they don't want to risk getting stuck in the traffic or risk how long it's going to take them on public transport. I am really concerned that ambulance service is going to be significantly more stretched. (GP.3)

Travelling by public transport

Several participants in the study expressed a reluctance to call an ambulance unless absolutely necessary. Individuals spoke about not 'spongeing' on the service (H2), or not 'putting the ambulances out.' (H1) One of the parent participants GP.2, explained why she would be reluctant to do so:

In a panicked hour of the night you want the shortest [journey]. And obviously, I'm very anti using an ambulance or going down that route, because I know that there are lots of people who abuse that system. So for us it's always a case of we'll jump

in the car ourselves. Transport ourselves but, obviously, we need to get there as quick as possible in emergency scenarios.

In some cases, if participants were not going to call an ambulance, they would call a taxi to get them or a relative to hospital. (H1, GO.1, GP.5) Most would, however, rely on either public transport or use a car. Some participants did not have access to a car, and thus good transport links were considered really important. Describing her concern about the implications of the proposals, GA.1, one of the 'active campaigners,' said:

I was looking up some of the alternative arrangements but we don't have a car, so accessibility is really crucial. I mean unless you actually need an ambulance and cannot get the doctor or do 999 then you try to get to a hospital, A&E, visiting, whatever it might be, by public transport or even a mini cab but not … hopefully not too far. So, all of the hospitals that I was looking at seemed to be much … we almost have to go to Greenville to then go onwards in terms of public transport. (GA.1)

If the proposed reconfiguration goes ahead, depending on where they live, most participants in the Greenville groups would instead access care at one of two neighbouring hospitals, which I refer to here as Redbury and Yellowtown. Alongside the existing challenges of travelling on public transport, several interviewees identified further challenges they would face if they had to travel to those hospitals. Again, these issues were reflected in all three of the groups opposed to the proposals. Considering Redbury Hospital first, based on their knowledge of the local area, one of the older Greenville participants simply said:

If the idea is to send us all the way to Redbury Hospital, it's disastrous for anyone who lives here. We can't get there… I mean to get there, especially if you weren't able to drive… And it's car parking… One of my [relatives] had some tests there half a dozen years ago; the car parking then was a minimum of £4. Something like that. And anyone who hasn't got a car, I don't know how they're expected to get to Redbury. (GO.3)

When I asked another participant about travelling to Redbury Hospital, he responded similarly:

Oh, it would be like the other end of the planet. It would be impossibly far... I mean it would be an almost impossible distance to go… You'd have to get probably, I

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would guess, three buses at least. I mean, if I had to go there, say on an A& E basis, I wouldn't want to have to worry about 'which bus do I get,' 'where do I catch it' and all the rest of it. If I'm going into [the city], I know, I know my way about and I wouldn't have to worry. (GA.4)

Interestingly, GA.4 was one of the participants who were in favour of centralising services. He would currently avoid accessing care at Greenville, preferring to attend a teaching hospital, in a neighbouring area. Nevertheless, we see here his ambivalence about what actually this would mean for him in practice, if he had to travel to Redbury.

Redbury Hospital is approximately six miles from Greenville Hospital, according to one online route planner. During the course of the interviews I asked participants how far the alternative hospitals were from their home. Some described distances in miles, but most participants expressed distance in terms of time. For example, the time they estimated it would take to drive there or the number of buses they would need to take. For one participant, the distance from their home to Redbury Hospital would be:

At least 20, 25 minutes by car and up to an hour and a half by public transport. (GA.6)

As another observed, also when discussing the distance to Redbury Hospital:

I'd go by how long it would take me to get there. (GP.5)

Travelling in an urban area involves specific challenges, so this finding may not be representative of other settings. However, there was a sense amongst participants that a journey which involved more than two buses (i.e. more than one change) exceeded a threshold of acceptability. As I have just described, one participant observed that the journey to Redbury Hospital would involve 'three buses at least.' GP.4, one of the parent participants, expressed a similar view:

I don't even know where Redbury Hospital is. And when you're pregnant, with the public transport, even worse when you have a child. And you know how it is when it's raining, with our buggies, we become buggy fighters. It's a warzone! You get left by the bus, three buses can leave you. Where am I to leave my children? So three buses are going past, frostbite and you have kids. You could be sick and perhaps you'll be taking two or three buses now. At least it's one bus [to Greenville] now, which I think is important to me and many other people. Of course some people do

have two, but probably it's one bus… There is a good network of buses going past Greenville Hospital which is quite good, from different locations. (GP.4)

Describing how she had explored the journey she would have to make to Redbury Hospital, if services were downgraded at Greenville Hospital, one of the 'active campaigners' said similarly:

I genuinely don't know where it is. And when I [looked at the journey] just to get a sense of… It required four buses to get there. So it didn't sound very appealing. (GA.1)

Other participants raised similar concerns about the journey to Yellowtown Hospital. Again, Yellowtown Hospital is four miles from Greenville Hospital, as the crow flies. However:

There's no direct bus route between any part of Greenville and Yellowtown Hospital, it all involves changing. If you go by train, you know, it's two buses down to [the station], and then a seventeen minute walk, plus there's no access for disabled people at the train station. [My partner] prefers to go to the hospital by taxi; it costs him £7 by taxi to go to Greenville. We got a quote from the taxi company and they said about £14 to go to Yellowtown Hospital. (GA.8)

Travelling by car

Those who would travel to hospital by car also had two specific concerns. The first of these was traffic congestion on the routes to the alternative hospitals and to some extent there is overlap here with concerns about travelling to hospital in an ambulance - this could affect paramedics too. Participants observed that they lived in a 'very congested urban area' (GA.7) and this could have a significant impact on travel times to hospital. The length of the journey would 'depend upon which part of the day you go.' (GA.2)

This is the problem with [this area], the traffic is so uncertain and so we'd driven [to the hospital] in fifteen minutes, but it also could take fifty minutes. (GP.5)

As a result of this, participants reported that they would either seek to go via back routes, where they were familiar with an area, (GA.6) or would have to leave extra time to drive to hospital, for example to attend an outpatient appointment. (GO.2) Participants noted that, although other motorists would get out of the way for an ambulance with a flashing blue light, there was no option but to sit in a traffic queue if travelling by car.

[When they] come alone with their lights flashing, cars pull in to the side and create space for the ambulance, so, you know, that makes it much easier for ambulances to get round. Different matter if you're in a mini cab or you're driving, somebody's driving you, and you get stuck in the most horrendous traffic. (GA.8)

Similarly GP.3, one of the parent participants and a 'localist,' was very anxious about having to travelling to Yellowtown Hospital in the future. Drawing on her knowledge of driving in the local area, she said:

Some of the main ways to get to Yellowtown Hospital are proper rat runs and are always very busy. I can queue in traffic going to Yellowtown Hospital in the middle of the afternoon. So I am nervous about the ability of an ambulance to get through that traffic because a lot of it is single lane roads, so I am nervous about even the ability of an ambulance to get me to that hospital quickly because there isn't always the space for them to cut through and I've been stuck on that road when ambulances have been trying to get through and you have no choice but to mount the kerb to get out the way and it is very difficult. (GP.3)

As well as traffic hotspots where 'tremendous traffic jams' (GA.5) could delay access, participants also identified a number of physical barriers, which have to be negotiated and could make the journey difficult. For example, Yellowtown Hospital is 'the wrong side of the motorway.' (GA.8) As another interviewee explained, 'if something's wrong on the motorway, [the whole area] jams up.' (GO.3) Similarly, another noted that 'there's a particular bridge that cars can go over, no problem, but buses can't because of the weight... that does cause a problem.' (GA.6)

Negotiating the parking facilities on arrival at hospital represented a second barrier for car drivers to navigate. Although it was not ranked highly by participants during the prioritisation exercise, for many participants, it represented a significant challenge which several spoke about at length. Some had clearly had challenging experiences in the past when trying to access care. Although they relate to her experience of accessing maternity care at Greenville, GP.1's comments illustrate this.

The parking's awful... There's a small car park, which is very expensive and always full because of obviously being small and being that patient visiting times are within a certain time, it's full and I think that's during lunchtimes as well. So it's

always full. When we went, the parking meter, there was two meters, one of them was always broken, that kind of thing.

Later, she added:

> We had such a bone of contention when we went to Greenville. Every time we went for an appointment we would get there forty minutes before, maybe an hour before the appointment to try and find somewhere to park, would end up having to park in [the supermarket] car park and then walk all the way. Some days we'd find a space or my husband would have to drop me off and once was late coming to our appointment because again he had to end up going to [park at the supermarket]… That kind of thing, you know you want someone to drop you off in a car and then be able… You don't want to have to… I did get the bus once and it nearly killed me, so for that reason I would say parking is a really big thing. (GP.1)

GA.7, one of the 'active campaigners,' also described how the logistics of parking add significantly to the stress of an already difficult situation.

> If you go to Greenville you pay three pounds, your mother is seriously ill and you have to stay longer again, you've got a bloody parking ticket or you've been clamped. Well come on, not only do you need to provide more parking, almost certainly you need to provide the parking for free… You take your son who's, you know, very, very ill, you drop him off at A&E, you can't find anywhere to park, so you have to park you know like a mile away and or run in to see how he is and you think 'this can't be right.' You know, the point where it's traumatic, well I've got to put another two pound in the meter… I mean we're supposed to be the seventh richest country in the world and we're supposed to be the most enlightened civilisation in the world. Well in this particular area we're not we're a first world country, second world country perhaps. So it's alarming to people's dignity. (GA.7)

Why is this relevant to reconfiguration? As GP.3, the parent-toddler group leader observed, if the changes go ahead, she would feel she would have to drive to A&E in the future and consequently park:

> It is great to tell me that Redbury Hospital is the best place for me to go. I don't know how to get there using anything other than a car. I'll be honest, the last thing I want to do is drive a car to a hospital because parking is a nightmare and it's obscenely expensive and I don't want to be stuck in A&E with a potentially sick

child worrying about my parking meter and whether I am going to get out and find that I've been clamped or towed. So it's hugely stressful to have to add that kind of thing into the mix when you are thinking about going to the hospital. (GP.3)

She went on:

It's really expensive to park in hospitals these days, so if I can get there on public transport I wouldn't need to park, if I go to Greenville. But I do need to park if I go to any of the others because it takes too long on the buses. (GP.3)

The challenges of having to park do not necessarily result in increased risk, unlike traffic congestion, for example. However, they do result in an additional burden in terms of finding a space, but also in terms of cost. Interviewees felt that visitors to hospital were charged 'too much money.' (GO.11) Two Greenville participants noted that they had had to pay 'a minimum of £4' when visiting hospital recently (GP.4, GO.3); another spoke about parking being 'astronomic in terms of cost.' (GP.2)

Participants recognised that this issue was not unique to their hospital on the grounds that 'it's expensive everywhere now' (GA.9) and 'I don't think you get easy parking in any hospital today.' (H4) However, some questioned why it needs to be this way. GP.4, another of the parent participants, described her recent experience of parking at Greenville Hospital:

[Two weeks ago] I went to the hospital. I'd been there for less than half an hour, I paid £4. £4. Which I think is for up to four hours. Why do we have to pay for parking in a hospital? It's not like anyone can really abuse the parking. Why would I go to anywhere near to Greenville Hospital so that I can park at the hospital? It's not like there's anything I could do there. £4. We are sick. It's a need, and they're charging us so much to park. It's so fortunate that I had money on me that day. Normally I carry two pounds. I paid £4, but I think people should have the opportunity to go in and come out. Not just £4, if you're just there for 30 minutes like I was. (GP.4)

Many of the concerns here related to the possibility that access might be delayed by one of these barriers, with knock on consequences for outcomes. Granted, some of them are also less about risk, and more about convenience or at least not adding additional challenges to an already stressful situation. Reflecting on the findings in the light of the contextual model of risk, we see, however, how other concerns beyond probabilities and the potential

outcome also influence the way the public assess risk.[111] Participants drew on a on a range of experiential resources to make sense of the issue, including their social context. This included their immediate surroundings (their knowledge of the transport network, specific bottlenecks etc.) and their social relationships (worry about the burden of responsibility for getting a sick relative to hospital, for example), which all impacted the way in which they assessed the potential risks involved in the reconfiguration.

Urgent care services

In the previous chapter, I demonstrated that the challenge of locating unfamiliar facilities in an emergency currently represents a barrier to participants accessing alternative urgent care services, even before a reconfiguration takes place. As a consequence, some would rather go to an institution that they already know – the local A&E.

Allied to their concerns about travelling to alternative hospitals, if the A&E in Greenville is downgraded, actually finding their way there was another concern for participants, most of whom were unfamiliar with the other hospitals in the area, largely because they had not had to use them in the past. As GA.4, the patient representative who was actually in favour of the reconfiguration put it:

> People are worried about where they go in future to hospital, you know, which hospital they go to for which problem. (GA.4)

This was particularly raised as a problem by the two groups who were less involved in campaigning, the 'worried uninvolved' who were concerned about the proposals but not actively voicing their protest, and the 'consultation completers' who were seeking to make their voice heard via the official consultation. In Greenville, the preferred option for the commissioners considering how best to reorganise services locally would see Greenville Hospital become a 'local hospital,' with an urgent care centre, rather than a full A&E service. Interviewees anticipated that, if the reconfiguration goes ahead, it would only compound their confusion about which services are most appropriate for which complaints. GP.3, the parent-toddler group leader, is again a good example of this sentiment

> What we think is happening is A&E is closing and you therefore can't go there for anything. The hospital is effectively redundant, unless you are going for planned elective care. But actually reading the consultation document, that doesn't seem to be quite what they are planning on doing. They seem to be planning on putting

emergency care centres and things like that in some of these hospitals, but there wasn't really any clarity about what those were, what they meant, what they could treat. You know, do you go there with a sprained ankle? Do you go there because you've sliced your head open? (GP.3)

As she described, this also potentially has significant implications for how the proposals are perceived:

It is difficult for me to understand whether everything now has to go to Yellowtown Hospital or whether actually there'll be a facility in Greenville that can deal with the vast majority of the things that I would currently go to A&E for. If most of the bumps and scrapes that I would go to A&E for are actually still going to be treatable in Greenville I am kind of relaxed about A&E closing because I probably would still want to be in one of these bigger hospitals anyway for the really big stuff. (GP.3)

This also undoubtedly links back to the comments I highlighted in the previous chapter about participants being uneasy about having to decide what is urgent and what constitutes an emergency, especially where they believe that timely access is associated with better outcomes.

Implications for others

Aside from their campaigning activities, one of the key things that set the 'active campaigners' apart from the other two groups opposed to the plans in Greenville, was how they framed their concerns. Other participants were largely concerned about the implications for them personally. How would they get to an alternative hospital in future? How would they know which facility was most appropriate for which complaint?

In contrast, the 'active campaigners' almost all expressed their concerns in terms of the implications that the proposals would have for others. The most obvious illustration of this was the effect the changes might have on residents of Blueborough, which is a particularly deprived part of Greenville. It was really only the 'active campaigners' who made the case that this community deserved special attention. As several of them commented, Greenville is a very mixed area:

Greenville's one of those areas with a lot of the attributes of an inner city area. Yes, it's got very wealthy areas and things like that, but there's a lot of deprivation. You've got quite a volatile population, so you have people who aren't registered with GPs and so on. (GA.8)

Along with high levels of deprivation, Blueborough also has a large black and minority ethnic population. Several campaigners described how Greenville Hospital has worked hard to meet the needs of this community. GA.5, a member of a patient involvement committee observed:

> Let's face it, a lot of them are illegal, with very poor English, [but] some of these doctors are very proud of the fact that they can actually speak these languages and understand the particular complaints that they are very prone to. [The doctors] fear that they just won't be able to get this type of support elsewhere. (GA.5)

GA.7, another 'active campaigner' also commented on the particular health problems faced by the Blueborough community:

> Greenville Hospital is really Blueborough's hospital. Blueborough has a hundred and fifty thousand people living there and arguably it has a few thousand illegal immigrants. It has the highest level of tuberculosis, highest level of heart disease, highest level of diabetes. Very many of those people don't speak English, so that's a powerful cocktail for chaos… I don't live in Blueborough but there's anecdotally an awful lot of people turn up at A&E, turn up at Greenville Hospital… They just pitch up. I mean part of it is that, as I say, they don't have the language skills; they just pitch up there and it's there, it's in Blueborough. (GA.7)

The campaigners were therefore concerned about the impact the removal of services at Greenville would have on Blueborough residents. As GA.8 put it:

> [Greenville Hospital] serves the community; it understands its community and a lot of the staff live locally. They're part of that community, which gives them an understanding of the people they're serving and where gaps are and what the problems are. (GA.8)

Another campaigner spoke along similar lines:

> The big issue for this community is that Greenville Hospital over the years has developed its services, taken on staff, thought about the way it delivers services, thought about the whole way that it operates to meet the needs of a specific community and that's quite normal with a lot of local hospitals. And there are a lot of people who live in Blueborough even today who do not read and write in English, particularly older communities or communities for example that settled

here much later… [We went to speak to them] and I asked them what they would do if they had to go to the hospital through an interpreter and they said the only way they can go to the hospital is that they know the bus to get and once they get to the hospital they know that there's somebody there that will be able to talk to them and talk them through it. If they then had to go to Redbury or Yellowtown they wouldn't be able to navigate the different buses to get there and there'd be no guarantee that there would be anyone to talk to them.

She went on:

When I was petitioning in Blueborough, a doctor from Redbury Hospital stopped me and signed the petition and she said 'we're really worried because we cannot meet the community language needs of Blueborough and we're really worried if people come to Redbury, how on earth we're going to cope. There isn't a lot of us, there isn't enough doctors, the service hasn't been set up to meet the needs of that particular group because that's not the normal catchment area.' And I think that would be repeated at Yellowtown Hospital… Having used both those hospitals, they're not as geared up as Greenville is to the needs of those communities. And those communities need easy access. What will really happen is that people won't go to those hospitals, they'll fall back on their GPs and the GPs in Blueborough are pretty unanimously opposed to changes to services in Greenville. They will have to pick up the pieces and they won't be able to cope basically. So it is a really big issue. (GA.9)

Allied to this were concerns about the safety of the proposed urgent care centre at Greenville. As I said, many participants were concerned about what conditions they would be able to take there; the 'active campaigners' on the other hand again spoke more in terms of how other people might be affected. Returning again to the campaigner, GA.9:

Lots of people don't call ambulances when they're seriously ill because they don't know. They… their partners or friends or family put them in a car and take them to the nearest A&E. They get to the nearest A&E having perhaps spent, you know, 20 minutes, 15 minutes getting there. They then get rushed through and they go 'oh dear we need another ambulance to take you somewhere else because we've only got an urgency care centre here or our A&E can't deal with this…' That's what people are more likely to do or people may not go to an A&E when they're

seriously ill because they don't call ambulances because that's not part of what they do in Blueborough so they'll go to the GP the next... Whereas if the A&E... (GA.9)

She went on later in the interview:

A lot of people in Blueborough would probably go to an A&E because they may not be registered with a GP. A lot of GPs surgeries in Blueborough are incredibly busy. It's hard to get appointments so they'd probably go to the A&E. Apparently that's in the statistics. There's a very high use of accident and emergency by the community [here]. The [commissioners] seem to think that all you've got to do is educate people but it's not. They just go to the A&E because they feel safe going there and because they may not be able to access our incredibly overworked GPs. A lot of the GPs in Blueborough have shut down their lists so it is sometimes quite hard to get a GP. You are asking us I think, or asking the community to decide, is that a minor injury or isn't it. And I think that's... for me that's quite dangerous I think. I'm reasonable educated. I might be able to work out when it's appropriate for me to go to the poly clinic or when it's appropriate for me to go to an A&E or call an ambulance. But if you're poorer, if you're elderly or you live on your own or you've got a health problem, you may not understand that your health is getting that worse... And if the accident and emergency's not there anymore you might go to your GP or you might do absolutely nothing and what worries me is you might do absolutely nothing. And that's why a lot of us are very worried. (GA.9)

Why was there this difference in focus? Certainly, concern for marginalised groups is not incompatible with the political views that many of the active campaigners espoused. Given that significant inequalities exist in Greenville, there was in fact surprisingly little mention of this in the consultation document. It stated that inequalities would get worse, if the changes didn't happen, but didn't explain why this was the case, or explore the impact that the changes might have on inequalities or indeed on already disadvantaged groups.

On the other hand, was the focus on Blueborough a rhetorical device used by the campaigners to give legitimacy to their opposition? One described why she had explored the case for change in some detail:

I was involved with this campaign and we were doing a public meeting. And I was quite sensitive to the fact that, I'd been involved in a lot of sort of campaigning in

my past, and the risk is that it's always just 'nimbyism', you know, not in my back yard, you know, 'My hospital's very close-by so please don't close my hospital'. But actually, if you listen to people you think actually accessibility is key. (GA.1)

I will go on to explore the 'active campaigners'' response to the consultation process in more detail, including the way in which they framed their opposition, in the next chapter.

Impact on care quality

Alongside worries about the practical implications of the proposed reconfiguration, the second area of concern for Greenville participants worried about the plans related to the impact that they would have on the quality of care at the alternative hospitals. Whilst the existing literature indicated that access was likely to be a concern for study participants, little has been written before about how the public evaluate the effect that reconfiguration proposals will have on care quality. In this section I will explore the relative importance of different aspects of care quality for participants, using Donabedian's dimensions of 'technical quality' and 'interpersonal quality' as a framework.

Technical quality of care

For clinicians and commissioners, care is typically evaluated on grounds of technical quality: for example, patient outcomes, interventions offered to patients, or the level of senior care available. As I have mentioned, this is implicit in the IOM definition of quality, with its emphasis on patient outcomes and practice consistent with current professional knowledge. It also seems to lie behind many interventions aimed at improving quality, such as the reconfiguration in Greenville. With the exception of the 'active campaigners,' however, few participants mentioned any aspects of technical quality when discussing emergency care. The wider public are my principal focus here. The 'active campaigners,' in contrast, were much more engaged with the content of the case for change and their discussions reflected this. I will explore their perspective in the latter section of this chapter.

One participant, GO.1, an 'avoider' who had worked closely with health care professionals, commented on the care he had previously received at Greenville for a minor injury:

It was appallingly painful. But, as far as I was concerned, it was pain and nothing else. But when I got there, they said there are all sorts of ramifications. The potential infections and others from such an injury are immense, they said, and it was very important that they cleaned it up in a proper way; it wasn't just some

little nurse doing something superficial. It had to be done properly. So what seemed to me to be a relatively minor injury they said had much worse ramifications. (GO.1)

He understood from the medical staff that his injury required a certain standard of technical care. However, we returned to the issue of quality later in the interview. When I asked him what quality meant to him as a patient, his response was clear:

Well I think… quality would mean not having to sit around for hours waiting, in pain waiting for something to happen. (GO.1)

The experiences of GP.5, one of the parent participants, who would try to avoid going to Greenville Hospital, echoed this. Describing her experience in an A&E department at another hospital, she spoke about what quality meant for her.

I had a horrible experience…. I really didn't like it. I didn't like one male member of staff. He creeped me out. I was left alone for a long time, I felt very vulnerable and that's why it's really important that you feel you have some control over where you go to get medical care. (GP.5)

She went on:

It's like a really frightening time… You want someone who's really confident and calm dealing with you. It's very anxiety-inducing to have someone who clearly doesn't know what they're doing and I totally understand that doctors have to learn and I'm quite happy for a junior doctor to be there and present…. So quality of care… that's really difficult actually isn't it? It's quite a difficult question. I mean plenty of staff around, there's nothing worse than being left in a cubical, and not knowing what's happening and no one coming in to check on you. So I think for me, standards of care is about numbers of staff being on duty… (GP.5)

Finally, however, she concluded:

It's all smoke and mirrors basically. Your own experience and perception, I know it has no relationship to the actual standard of quality of care that you get, so it's all ridiculous… (GP.5)

GP.5's comments illustrate how quality for patients may be quite different from 'official' definitions: her care may well have been in line with the latest evidence and her outcome

ultimately was fine, the dimensions emphasised by the IOM. She also seems to suggest that her own perception is somehow less valid than the 'actual standard.' Nevertheless, the time she had spent alone, waiting in the cubicle, seemed uppermost in her mind when she recalled the experience. Her comments about the challenges for patients in assessing technical quality were also reflected by others. As GA.7, one of the campaigners put it:

> I want to go to a hospital where they're qualified. I don't want to go where they've made it up in their bedroom and they do surgery with knives and forks, but how would I possibly know? How would I possibly know? (GA.7)

Interpersonal quality of care

Like GP.5, what constituted quality care was a 'difficult question' for many participants. For some there was a sense that it was in some way intangible. H8, a Hilltown patient and an 'avoider' in terms of her hospital preferences, put it as follows:

> It's not black or white is it? You can't pick it up, you can't touch it. (H8)

However, for the wider public - participants in the 'localist' and 'avoider' categories - the quality of care in A&E was mainly assessed in terms of its interpersonal quality, and specifically its expressive quality. There were two key dimensions to this: the timeliness of their care and the attentiveness of staff. As GO.1 and GP.5, put it, quality care means 'not having to sit around for hours' and 'having plenty of staff around.' These two concepts are linked and their importance played a key role in how participants assessed the implications of the proposed reconfiguration.

Timeliness of care

Waiting in A&E

Waiting to be seen in A&E was a core issue for the wider public, in both Greenville and Hilltown. In many ways, it represents the final barrier, or hurdle, to be overcome, before patients can access care in the A&E department. For many, there was a degree of resignation; waiting in A&E is less than ideal, but has to be endured. The views of H2, one of the Hilltown patients reflect this:

> You can't expect to walk in and get seen to straight away… There are other patients in front of you and you are not royal. You have to take your turn, you know. If you're private and you go wherever, then you expect to get seen straight away but it's not private and so therefore it doesn't matter what it is, dentist or anything,

you have to wait and take your turn. People know if you go to A&E, you've got to wait. You know what I'm saying? (H2)

Others however, were less accepting. Speaking about her experience at Greenville Hospital, GP.1, the parent participant who described having to park at the supermarket before her maternity appointments, said:

Waiting times are the same as everywhere else, you know wait for about four hours in A&E which is kind of, you know, general but in terms of the service once we got through, it was very good. (GP.1)

She added:

I've been to enough A&E's to know, you know the rule, you're going to go, you're going to wait at least three hours. I've never been into any A&E anywhere in the country wherever I've lived, that I haven't had to wait longer than three hours. So you kind of know that's how it is and the experience was… I don't know, I mean they tend to sort of blend into one. Fine, you know there's a triage and then there's a wait and you know that other people are being assessed in front of you, so I understand the process and so I understand there's people that are being rushed in for emergencies that are more important than my gashed hand or whatever it is. But yeah… so I've overall had an average time there! [Laughs]… I understand why [waiting times] have to be so long sometimes, because it's not like the doctors are behind there just sort of kicking back and having a beer, everyone's being seen and everyone's being seen quickly and then there's paperwork and everything, so I understand why but the first thing that people would always say about A&E is 'oh how long have you been in there?' and that's always the one thing, the waiting time. (GP.1, emphasis hers)

Another participant, a patient at Hilltown spoke similarly about her experience at another hospital:

If someone comes in and they're obviously more urgent than you, you would understand why you're waiting. I would expect that. If somebody came in after us that needed much more urgent attention, yeah, for me they go first. You've got to suffer it haven't you, it's part of the deal. You have to wait… They've actually said to us before, 'sorry about the delay, but there's been an accident, it's all hands on deck.' [The doctor] had to disappear…   That you understand, I'm not going to say

I'm sweet tempered about it, I'm like 'blah, blah, blah,' but it is a natural thing that you would expect. (H8)

Nevertheless, many expressed concern about the length of time patients have to wait and the potential ramifications of this. This was partly because it was acknowledged that patients attending A&E are likely to be in discomfort or pain. GP.5, the parent participant who had previously felt uncomfortable and anxious about being left in the cubicle, also said:

You know you're going to have to wait once you get there to see someone, you've got to be processed while you wait to see someone, so you're just getting more and more anxious. I mean it's horrid, it's really horrible and you're in discomfort as well. (GP.5)

As I described earlier, another of the parent participants, GP.2, spoke about her previous experiences of waiting in A&E at Greenville with her children in an unsegregated waiting area. This had been a key part of her decision to take her children to Yellowtown Hospital in future, if they need emergency care.

We've been there in the past where we've sat in there, the main waiting area, for three, four hours which, as a parent with a poorly child, is very distressing, especially when your child is very ill and you don't know what's wrong with them. That can be very difficult. Average waiting time, three, four hours. And, you know, obviously, at Greenville you're in the main hub waiting area. There's no paediatric segregation which, you know, is a problem. (GP.2)

She went on:

I suppose it's a luxury really Yellowtown is not much further than Greenville. So, in that instance, distance doesn't really play a factor. It's where we think we can get triage quicker. See a doctor quicker. I guess that is all down to you're being seen quicker. And we know the waiting times in Greenville are longer. (GP.2)

GP.2's concerns reflect the perception that many participants shared, that patients need to get to A&E as quickly as possible, in order to be seen as quickly as possible: 'it's not about physically being in the building, it's about being treated in A&E.' (GP.3) Sitting in the waiting room for several hours was distressing for GP.2 as she was worried about her child, who she felt needed attention as quickly as possible.

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Alongside concerns that a patient's condition might deteriorate whilst they were waiting to be seen, one or two others also raised the concern that long waiting times meant that patients weren't being attended to or that the staff were in some way uncaring. In this way, waiting times and the attentiveness and availability of staff are intrinsically linked. For example, one of the Hilltown patients, H1, described attending an A&E department with his elderly parents in the past:

> The times I've been up there with my mum and my dad and you wait so long that you think 'are they looking after us properly?' [One time I took my mother] into the hospital and we was three hours before we see a doctor and that, for an old person… She was about eighty then. And, you know, you think, 'are they doing their job their properly?' but when you think about it after, you realise they've got so much work on; they can't just look after you. What I would always say is that when a person goes in, the person with a bit of knowhow, the doctor or the nurse, 'what's your problem? Oh yeah, that's not serious, we'll see you in ten minutes. Oh that's serious; we'll get the doctor straightaway.' But they don't do that, they just sit you here and they take your name and then you wait. And that's the only thing I have against the doctors that they don't sort of concern on individuals. (H1)

On the other hand, some cited examples of when they had been seen quickly and not been kept waiting as examples of good care. H5, another Hilltown patient, described her recent experience, having been referred to A&E by her GP:

> I was straight in to see the triage nurse, she had a look at it, they put me in a cubicle and a [doctor came]. And I was done in no time. And everybody seemed bothered, you know? They weren't like, 'oh sling her in a corner and she can wait half an hour,' none of that, the care was brilliant and I was sorted out. (H5)

The fact that 'everybody seemed bothered' marked this out as particularly good care. Nevertheless, part of the unease about waiting almost certainly also relates to the waiting environment itself, an issue that was raised by several interviewees. Alongside her concerns about the length of time she had had to wait at Greenville in the past, participant GP.2 also spoke about her experiences of waiting:

> You're literally sitting there with [a tiny] baby in your arms, who's very ill and literally there's a guy sitting next to you with a knife sticking out of his head. There

is no segregation of paediatric from general A & E which I think is shocking in this day and age… (GP.2)

As I described earlier, she had chosen to take her children to Yellowtown subsequently, where there is a separate A&E unit, partly because she 'despaired at the thought' of sitting at Greenville with a small baby. However, discomfort at having to sit in the A&E waiting room was not just restricted to those taking small children to hospital. GP.1, a parent participant, described similar feelings when she had been waiting to be seen in A&E herself.

Sometimes, if I've been there at night and you get the drunk people coming in, or people that seem unstable in some way and shouting, often… I've felt a little bit uncomfortable and it would be nice to know that these people are being dealt with, as opposed to sort of wondering what they're going to do next. But again I don't know if that's something that… you can't have security on the doors or anything like that but you know sometimes… Either there's been someone very shouty or aggressive shouting at the staff through the door and they're obviously behind their bullet proof glass or whatever and so they're kind of all safe. It seems a bit… sometimes. But that's only been like one off, when it's been pretty uncomfortable. (GP.1)

As I suggested earlier, the waiting room perhaps represents the final barrier for patients to navigate, once they have overcome the hurdles of getting to hospital, navigating the car park etc. The language participants used suggests the A&E department beyond the waiting room is regarded by patients as a form of inner sanctum into which they have to be granted access. Interviewees spoke about care 'once we got through' (GP.1), 'once I got in to see the doctor' (H1) or 'once I'd got past the receptionist' (H6).

Waiting in the future

As we have seen, being attended to promptly appears to be a key aspect of quality for patients attending A&E. Sitting waiting, either in the waiting room or the A&E department, apparently constitutes poor quality of care, partly because patients worry about the consequences of delayed assessment, but also partly because some worried that they are not being attended to appropriately.

Participant GO.1, one of the older Greenville residents who wanted to be taken to a teaching hospital, was one of the interviewees who explicitly made a link between waiting

times and the quality of service. For him, improving waiting times would be key to improving the quality of service:

> The most awful thing when I've been is waiting. Obviously, my things haven't been hugely serious, but I look around and… I don't know, perhaps I'm a bit more phlegmatic than others and I suffer in silence. But one looks around at the other people there… Because I've never been there, into an empty A & E department. Whatever time of day or night it is, it's always been relatively full. And you can see people are in serious emotional states, quite apart from whatever pain they're undergoing. And the fact that one has to wait at all in those circumstances is a disaster really… I think if any Government wants their A&E departments to be seen to be good, they need to get people in to the department quickly and seen by someone. People feel that as soon as they see somebody and start getting treated, then they feel a damn sight better than they do otherwise… There does seem to be a lot of emotional upset in A&E departments which would be alleviated if they were straight off the chair. As soon as they arrive, get them in with a nurse or whatever, so that they feel that they're being looked after. (GO.1)

However, alongside worries about the transport implications, one of the key concerns for those who were worried about the proposals in Greenville (apart from the 'active campaigners') was the impact the proposed reconfiguration would have on waiting times at neighbouring hospitals. In the consultation document, there is very little information about the changes that would be made to the services that remain, for example, what would be done to upgrade facilities at those hospitals chosen to provide full A&E services. This may be because these plans have not been finalised, but it was clearly a cause of considerable anxiety for some.

Two of the parent participants spoke particularly about their concern. The first, GP.4, was in the 'localist' category and, if the A&E department at Greenville which she currently uses were to close she and her family would have to travel to Redbury Hospital:

> They're trying to make us choose - which hospital would you rather save? Redbury or Greenville Hospital? Why should we have to choose? No, that's not how it should work because the minute they close one hospital, there's going to be more demand in another hospital. If I had to wait three to four hours to be attended one afternoon at Greenville Hospital, and everyone from Greenville Hospital is going to

the Redbury Hospital, and they all have to go there, how do they possibly make us want to believe that it's going to be less waiting times?

GP.2, the parent participant who spoke extensively about how her experience of waiting at Greenville had led her to seek care at Yellowtown Hospital raised similar concerns.

> I know there is a lot of talk of closing Greenville and I think you know as a parent and a local, I think we're just going to overload the other facilities. Like I said we're already waiting three or four hours when you go to Yellowtown, so if you close Greenville I'd say the majority of the patients will go to, to Yellowtown because for them to get anywhere else, it's further. It's almost three hour waiting time in A&E. It's going to increase to, what, six hours? Because the facility's at a max in terms of infrastructure, they've got no more consulting rooms and when we're there, every consulting room is full. The waiting room is overflowing. You know, I just can't see it sustaining additional patients. (GP.2)

She accesses care at Yellowtown already, rather than Greenville, partly because she felt she would be seen quicker there, and in more appropriate circumstances. Like many others, her concern about the reconfiguration proposals centred on the implications of the plans for her and her family. However, the key thing for her was that the A&E department at Yellowtown already appears to be at capacity. She was not aware of any plans to expand it, so perhaps not surprisingly assumed the department would struggle to accommodate increased patient flows, resulting in longer waiting times for patients.

Attentiveness of staff

Alongside timely attention in A&E, the perceived attentiveness of staff represented the second aspect of quality for participants. Again this relates to the interpersonal quality of care. I have already cited GP.5's account of being left alone for a long time by a member of staff in A&E, and how distressing this had been. As I have demonstrated, this is also closely allied to waiting times: several interviewees reported that they had not felt they were being properly looked after whilst they were waiting.

Participants raised concerns about specific pressures that hospitals currently face, which they believe impact interpersonal care quality. Several individuals perceived that hospitals in both study areas are already 'swamped' with patients. (H6) In some cases this was directly linked to immigration, again perhaps reflecting current political rhetoric about the challenges faced by the NHS. The views of H1 illustrate this:

I've got no complaints of the hospital service really. I mean, unfortunately, because of the influx of immigrants they're overrun by too much work. If they hadn't had these in, if you didn't have all these immigrants in… I mean, immigrants I don't mind because they work here, but what I do object to is these immigrants that come over from a country just to get hospital service or have a baby or something like that… My mother never had anything like that. We had nothing, you just lived on what you got. My dad earned a pound a week wages and he had to keep us, my mum used to do three jobs… Didn't get no help in them days. And I think this, making people in this country subservant [sic] on hospitals and not standing on their own two feet, 'oh I won't go work, it's cheaper to stay at home, because I only get two pound more if I went to work,' it's wrong.

Nevertheless, others shared the view that if staff are under pressure and are more stretched, for whatever reason, they would consequently have less time to give to individual patients. GO.4, one of the older Greenville participants described how he felt this might impact care:

I am frightened to [go to A&E] because, as I say, there is such a waiting list at Greenville for A&E. When you go in there you can see everybody sitting…. Some of the attention, you know the attention that you get can be good but I am always fearful of… sort of waiting and I should imagine the amount of people that they get there, that the doctors can't do their job properly. They're so rushed. (GO.4)

He went on to describe how he felt the reconfiguration proposals would affect this:

There are too many people and they're trying to get to them but they haven't got the time. I don't think people… To be honest, they should not be blaming them for it at all, just blaming the fact that it is overworked. If they close the A&E down and put it to another hospital that is going to double up again, so to be honest I think it will be for the worse. (GO.4)

Again, workforce plans are not explicit in the proposals for reconfiguring services at Greenville, so it is not clear how increased patient flows will be accommodated. GO.4 was, however, not alone in his belief that in a larger hospital, there would be more pressure on staff, with a detrimental impact on the quality of care, because staff would be more rushed and thus have less time for individual patients. H6, one of the Hilltown patients, contrasted

the care he felt he would get at his local district general hospital, compared with a smaller community hospital near to his home:

> One likes to think that if I went to [either place] I would get the same standards of care and attention. I think once I'd got past the receptionist as it were, and got in to see the doctor or the consultant, I would get that. The only proviso there, I would think, is that I would think if I was at the [community hospital], the consultant wouldn't be quite so harassed and he would be looking at me and talking to me and listening to me, as opposed to thinking 'well you know I've got sixteen other people outside, we're already running seventy minutes late.' I think that's a factor, I mean, it's human nature, he's got to listen, he's got to get through. That to me is part of the quality, I mean one assumes that the sort of… academically all these consultants, I think are educated and trained to the same standard. I just feel that in a smaller hospital, I would be [name] as opposed to patient number twenty four. (H6)

Summary and conclusions

When plans to downgrade an A&E department are being considered, the case for change typically focuses on the need to improve the technical quality of care. However, in this study, patients' descriptions of good quality care seldom reflected this aspect. As others have also observed, many participants here perceived that, because medical staff all undergo similar training, there would be little difference in the emergency care provided by different hospitals.[173] Apart from the 'active campaigners', participants focused much more on the interpersonal quality of care, raising concerns that alongside current demographic pressures, moves to centralise care would actually decrease the quality of care because staff would be more stretched and thus less able to focus on individual patients.

Much of the research that has been carried out in the past to explore patients' views about waiting in A&E has relied on quantitative surveys. Additionally, whilst others have examined the risks to staff working in A&E, for example from disruptive patients,[181] there has been little exploration of how A&E attendees perceive the environment in which they have to wait. Here participants spoke in detail about the actual experience of waiting, and this study provides useful new insights into patients' perceptions of care in the A&E department.

The clinical case for change in Greenville

Certainly for the participants in Greenville who were concerned about the reconfiguration proposals, but not actively campaigning against them, the interpersonal quality of care seemed to be more relevant than the technical quality. Yet, the case for change focused very much on improving the technical quality. In this next section, I will explore how the various groups responded to the technical aspects of the proposals, examining their response to efforts aimed at decreasing existing variations in care and improving A&E staffing, both of which are fundamental to the Greenville plans.

Variations in care

Recent data from the College of Emergency Medicine demonstrate that there are currently significant variations in the technical quality of the care provided by different A&E departments, for example, in terms of levels of senior staffing.[34] The Greenville proposals were in part aimed at addressing existing variations in the type of care that is available to residents in different parts of the wider area.

The 'active campaigners' did not discuss this particular aspect of the case for change. However, it was clear from talking to other participants, in both Greenville and Hilltown, that many perceived there to be little difference between the care currently provided by different hospitals. Returning to H6, the Hilltown participant quoted above who compared his local district general hospital to the nearby cottage hospital, he was very much of the belief that the level of care he would get in any hospital would be similar:

> As far as I'm concerned, all hospitals should be the same. I don't think that they should differ. I think these people have all gone through nursing college, the doctors have all gone through their courses and done their five or seven years, so whether you're in Leeds or in London, it should be the same. (H6)

Several others had the expectation that their local A&E would meet at least a minimum standard. For some this should be 'a given,' 'something that I would expect.' (GP.1) This standard again largely related to the knowledge of the staff, rather than the technologies available to them, and again there was an expectation that all hospitals would be similar in this regard. As one parent participant put it 'I kind of take the knowledge of doctors and things like that as read.' (GP.3)

A&E staffing

In the Greenville consultation document, the commissioners state that changes are needed to provide patients with access to senior doctors 24 hours a day, seven days a week. As I described in Chapter 1, the College of Emergency Medicine has recently issued statistics which demonstrate that less than 20% of A&E departments currently have the recommended level of senior cover, and significantly fewer do so at weekends.[34] When participants were asked to select their top three priorities for emergency care, consultant presence in A&E 24 hours a day was selected by a large number (see Appendix 4). However, the reality of this observation is more complex.

There were marked differences in the views of the different groups on this issue. First, I will explore the perspective of the individuals who were not actively campaigning to save the A&E at Greenville. Importantly, none of these participants made reference to the fact that the proposals were aimed at increasing the level of senior care in A&E. Many, however, felt it would be important in some way to have a consultant present, but they were less clear about why this is the case, or indeed whether or not it happens currently.

Many participants were clear that they felt it would be important for there to be a consultant available. GP.4, one of the parent participants drew on her experience of maternity care to explain why she felt this was important. Two weeks before her due date she had attended the antenatal clinic, worried that there was a potential problem with the pregnancy:

> They put me into a room and this doctor, whoever it was, I believe it was a consultant, he came in and checked me out and he told me, 'no this is what it is, but at the moment, there's nothing we can do about it.' He actually explained, 'you know what, your baby's life is not in immediate danger, there's things which can be done about it, but you're two weeks from having a baby, we cannot do anything at the moment. Go home you'll be fine.' So yes you're being looked after, you have someone who knows what they're talking about, you've been cared for, basically that's what you want. (GP.4)

I asked her if she thought this was also relevant in A&E:

> It is, senior in itself means something, they have the experience, they have bounds of experience, so you need someone who knows what they're doing. As much as it's nice to have someone who's new in the field, they need experience to get

there, but I think it's even more important to have someone who's going to be able to act quick - I've seen this before, okay, do this, do that. (GP.4)

Another of the parent participants, GP.3, also spoke about why she would want a consultant to be present in A&E.

If I were ever in a proper life and death situation, I'd like to know that someone who was really highly experienced was there. Even if they weren't actively hands on involved in my care I'd like to know they were at least looking at what was going on and helping make decisions about how to treat me… That's what consultants are there for, that's what they are paid for, they are there to actually lay it on the line and say to you 'all of my experience tells me this is the way to go…' (GP.3)

However, when I asked her if she thought this happened currently, she responded:

It's very difficult for me to judge, I've never seen a consultant when I've been to A&E but then I've never had a very serious injury. I do know that [when I took my baby], the guy that was looking after us did phone his consultant and had a conversation on the phone with them while I was there, so that gave me some confidence. He ran through her symptoms, he said, 'I am fairly confident she's fine' and what have you, and that actually gave me a lot of confidence when they said we could go home. So that's the only real consultant involvement I've had in A&E trips. But again it was reassuring, and it gave me a feeling that you know everyone had been involved in looking at what needed to be done. So I don't think they necessarily need to be physically in the room with you, but it's nice to know that they have been consulted on what to do. (GP.3)

Nevertheless, she wasn't completely convinced that every patient needed to see a consultant:

I suppose there's some situations where I don't need someone very experienced to treat this, I just need it treated quickly. I suppose if I'd had a car accident and I'd got a broken leg or things like that or I'd got injuries that were serious and would benefit from being treated quickly but were not necessarily life threatening, then I am fairly confident that most doctors would be able to handle what was going to be presented to them. My focus then would be getting it done as fast as we could and what have you. Or obviously if there's blood pouring out of me, at that point I don't really care who is stopping the blood, as long as someone is trying to stop the

blood and so getting there fast is important and if it happens to not be a consultant I don't really care. But if I was, I don't know… I suppose if I'd fallen unconscious and no-one knew why I was unconscious, or I'd been particularly sick and I'd got some really weird complication, at that point I think I probably would want to know there was going to be a consultant waiting for me because obviously what I have got is unusual, it is not run of the mill, it might not be something that more junior doctors have experienced and I think you'd need to have someone with that greater breadth of knowledge ready and waiting for you to give you the best chance of surviving it. I'd rather know I was going to see someone that was going to know what they were doing… (GP.3)

Others, like GP.1, another parent participant, were similarly unclear.

Consultants on duty? I don't know if they… I guess… I don't know about that because when you go in they didn't say to me 'there's no consultants on duty.' I don't know how it works, I don't know if, you know if there's a major trauma came in, if they would then ring them, if they would be on call. I guess that… I'd always assume there was a number of consultants on a shift basis day and night that would work to cover it and I guess more so during the busier hours between what eleven and midnight or whatever the busiest times are. (GP.1)

Some participants, such as GP.2, who took her children to Yellowtown Hospital because of the waiting times at Greenville, knew from experience that consultants aren't always present. She felt that 'you want the consultant on tap twenty four hours a day when the need arises.' However she recognised that:

That's not always the case is it, because you often… Well, through my experience, we've been in A&E and literally been waiting for a consultant to come on duty because someone else has left and gone off duty. So there have been scenarios where we've been sitting waiting for a consultant who hasn't started their shift yet. And that's usually six am in the morning. (GP.2)

At the same time, others were unclear whether or not there was a role for consultants in A&E: one questioned whether or not there is 'such a thing as an A&E consultant.'(GP.5)

If it was an emergency you would never see a consultant unless you'd made an appointment and that wouldn't be an emergency. You wouldn't see a consultant in A&E, you'd see a doctor. And then if he thinks wisely that he needs to see you,

then he'll make an appointment. See what I mean, it's down the line, you'd never see a consultant by walking straight into the A&E. (H1)

I think they would be called in to A&E I don't think they… They should be on duty somewhere twenty four hours a day not necessarily in the A&E but available. I'm sure millions of people go into A&E and actually need somebody who knows more than… I kind of see A&E nurses and stuff as kind of resuscitators I think they keep you going don't they, the consultant decides what's what and they do the business, don't they? The doctors [in A&E] sometimes I think they can be a bit indecisive, I think they need someone above them, they're not absolutely… They make decisions which are then reversed because they're not quite the right ones and so, I just think you need the governor there, you need somebody who can say 'yeah you done that right or you need to do something different' because people's lives are at stake aren't they? (H5)

Participants also had differing views about the role of consultants, particularly in the A&E setting, and this may have impacted their perception of the importance or otherwise of consultant-delivered care. Some participants said they were not able to define the role of a consultant (H4), whilst others simply described him or her as 'someone who's knowledgeable' (GA.2) or 'somebody who knows.' (GA.7) For others the consultant was simply 'the top man.' (GO.4, GO.5) Others described the role in terms of what consultants do. One participant said, 'the consultant decides what's what and they do the business don't they?' (H5).

In summary, those participants who were not actively campaigning against the proposals in Greenville had mixed views about the importance of consultant-delivered care in A&E. Many had a sense that, in some way, it was important. However, there was a definite lack of clarity about whether they are currently present in A&E, and – if so – what role they might play.

In contrast, all of the participants in the 'active campaigners' category refuted the claim that consultants are needed in A&E. There were however two distinct perspectives within this group.

The first perspective was expressed by GA.1, who was a member of a community group that was campaigning against the changes. She described how, in an emergency, she would want to get herself or a relative to 'experts' as quickly as possible:

I think I just would want to get them to people... me or my mother or whoever; I would want to get the patient to experts. A team of experts of different kinds... I'm sort of hoping that in that immediate phase they're not a load of dunces and that they do meet the nationally standards but I'm sort of thinking that the urgency must be to get them to care and it's obviously the luck of the draw if you manage to get them to somewhere fast. (GA.1)

I asked her later who she felt the experts were:

More or less any one of the team. [Laughs] Nurse will do, erm, nurse, doctor. That's why the uniforms are important you see. [Laughs] Any doctor... Especially when it's an urgent thing, that's why I say, I think the whole issue of consultants and really, really expert specialists comes in to play it seems to me when you're talking about longer term illnesses or you you've got to diagnose something that's really unusual or something like that. Obviously, one can tell stories of people who went on too long assuming something is straightforward and then if they'd only seen the right doctor at the right time... But those seem to me to be the unusual ones. What we're talking about here, there seems to be more urgency to get them to the first stage, but then at the later stage you start to bring in you know, an expert in this and that. (GA.1)

For GA.1, consultant-delivered care was less relevant in A&E. This echoes what some members of the wider public also said, and represents perhaps another example of the public not realising that it is possible for doctors to specialise in emergency medicine – GA.1 regarded 'consultants' as specialists in particular body systems or patient groups. The job of A&E doctors was to stabilise the patient and pass them on to the relevant expert, beyond A&E. She did not mention during the course of the interview the local workforce challenges which the commissioners in Greenville identified as a key driver for change.

In contrast, other campaigners who held the second perspective did make reference to their role in Greenville, but disputed the commissioners' claim that it was necessary to increase levels of consultant-delivered care. Some simply did not see that having consultants available in A&E around the clock was necessary. As GA.8 explained:

Provided you've got a really good team in A&E, not having consultants there for three or four hours a day isn't going to make a big difference or even eight hours a day... If a consultant's needed, they can be got there quite quickly. And sometimes I

would actually prefer my doctor to have got a decent night's sleep. I think having support from somebody is much better for you than necessarily the grade of the doctor, because grade and quality are different things. So you may have somebody who's a consultant, who doesn't have a good bedside manner is not, is inflexible and things like that. You may have a more junior doctor who's maybe not as skilled and experienced but is actually a better doctor. (GA.8)

It is interesting to trace, however, how one campaigner wrestled with this issue over the course of their interview. The individual, who self-identified as an 'activist' began by saying that they did not 'accept the argument' about consultant-delivered care. They went on:

I don't accept the argument that they use that you have to have a specialist… if I needed a specialist then no doubt they'll take me to a hospital where I need it. But my understanding is - and I'm not an expert on health of course, I'm an activist - that for most reasons why people need A&Es you do not need to have a consultant. You just need to have good experienced A&E doctors and health care professionals to attend to you. From what I understand, it's quite a small percentage of people who require a specialist when they go to A&E so a small percentage of the overall numbers because most people go to A&E for things like there's a problem with my eye, you know, I'm feeling sick or something like that. (GA.9)

However, during the prioritisation exercise:

You want to be taken there, to an A&E as fast as possible. I still want my local hospital and I still think consultants should be on duty in the A&E. I think that's pretty important in case it's really serious. (GA.9)

A little later they added:

I accept that you need consultants but that's an interesting one because you don't necessarily need a consultant 24 hours a day for everything… But it would be handy to have them there for the more serious issues… Perhaps you don't have to… I don't know… You've got me now… Actually, I'm not sure we need them 24 hours a day. You probably don't need them for everything because we know you don't need them for everything… You've got me thinking now.   Maybe it's an assumption, isn't it, which I shouldn't have because I'm not clinical, that do you really need consultants because that's their argument that consultants should always be 24 hours a day. Whereas I've actually heard some of the doctors from

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Greenville Hospital say actually you don't need a consultant. They say a good registrar or senior registrar can stabilise a person, do all of those things and the consultant can see the person the next day. I mean a good A&E doctor should presumably be able to do everything. (GA.9)

Finally, towards the end of the interview:

You know, we might accept that if there is a strong argument that services should be... some services should be centralised and specialist. I don't have a problem with that, but that's not really what this is about. Apparently closing A&E saves relatively little money. It's a very efficient way of caring for people but really what they want to do... I mean it's all about the cuts because once you shut down the A&E you don't just cut the service off from the people you also start to lose the health care professionals who don't want to work in A&Es anymore... So then your hospital stops attracting good quality medical staff and then that gives you a further basis for running services down... They will argue that my chances are improved if they whack me off to a hospital which has got a specialist and my argument is that's fine then, put a specialist in Greenville Hospital. I don't have a problem with that. You know, if that were true, I'd rather it was at my nearest hospital. (GA.9)

I think the tension in this participant's mind is clear. On the one hand, it would be handy to have consultants present, but this would of course be difficult with the current configuration of services and this individual was resolutely opposed to change. As a result there is perhaps an element of cognitive dissonance here – a sense of discomfort arising from the fact that the participant holds two conflicting beliefs. The theory of cognitive dissonance in social psychology proposes that people have a motivational drive to try and reduce this discomfort, for example, by reducing the importance of any one of the dissonant elements.[182] GA.9 dismisses the need for consultant-delivered care, because to have accepted that this might be useful would have been a step too far in the direction of admitting that change might be necessary.

Another campaigner, GA.6, a member of a patient public involvement group, also grappled with the issue of whether or not consultant-delivered care was important. He was very clear about the importance of timely access.

In an emergency [you would want] the shortest travelling time to get you to that A&E because, as I said earlier, you want to get dealt with in A&E. Okay, yes in stroke and in heart attacks they've shown that going that extra journey… And possibly one of the arguments that they've got with the ambulances not having to travel much further in [this area] is true, but that's key. (GA.6)

Nevertheless, he added:

I would want to be taken somewhere where the consultants are twenty four hours and this is part of the reasoning that [the commissioners] are saying that they want to do this because not all hospitals… Greenville could not provide me with that cover because they've only got six A&E consultants. You can't have only six consultants on a twenty four system… I would want consultants on site at least sixteen hours a day and the rest of it by phone. But in A&E personally I would want that covered by consultants on site, at least one consultant on site twenty four seven… The only way you can do it is to have a department that is big enough to allow that number of consultants to be on site. That also then causes the problem that… you're having to pull away consultant surgeons from other places. The critical mass drops and therefore those places that you've taken them away from are not commissioned because the more a consultant sees a particular thing, the better they become… That's what they're trying to achieve in [this area]. In one way it's a good thing… However it's what it means to the rest of the areas that can't provide that service. They're going to have to be downgraded to something else. In some ways [the population will benefit], however for example getting to Redbury by ambulance at certain times will not prove very practical because getting over that way has times when they have tremendous traffic jams. (GA.6)

He went on:

Each of those hospitals have got to have more staff. The only other way of doing it is to reduce the number of A&E departments and push the staff out to the remaining A&Es. The move of shutting [departments in this area] will mean that they will end up forty five consultants to cover the work load. That is an increase of about three or four over the current, so that's more feasible than having sixty consultants covering all the hospitals that they currently have. So yes, there are good things within it and in some ways you could say that I was in favour of what

they're trying to do, but some of the reasons they're giving for doing it 'oh you'll get better treatment not necessarily...' You do hear of things going on. Things getting too big, or not being run properly. A classic example of not being run properly is what happened at Mid Staffs.

Finally, he returned to his original argument about access:

If I've got something wrong with me do I really want to go travelling across a long distance? We're not talking now about ambulance patients, we're talking about getting there walking or... I'd want to go somewhere convenient and I wouldn't be choosing which A&E I'd want to go to. I'd choose the easiest to get to... [In an emergency] I'd want the nearest possible point where I could be treated. From a personal point of view it would be Greenville Hospital because it's my local hospital... If you're suffering from a heart attack or something serious you know your life may depend on it. (GA.6)

Accepting the argument that you need a consultant clearly has consequences for the activists: if they acknowledge the current recruitment challenges facing emergency medicine, this would require them in turn to concede that some services may need to be consolidated. This perhaps also goes some way towards illuminating why many in the 'active campaigners' group were largely dismissive of Greenville's poor reputation amongst the wider community. They felt very strongly that they needed a local hospital, and to have accepted either that the level of care was not quite as good as it should be, or that patients might benefit from greater levels of senior cover – both core to the case for change – would have been to negate their own argument.

Summary and conclusions

In the prioritisation exercise, 32.1% of participants selected consultant presence in A&E as a key priority. This was second only to timely access (see Appendix 4). However, with the exception of the 'active campaigners' the transcripts demonstrated that most were not clear about the contribution of consultants, beyond them being 'the top man' or 'someone who knows.' This includes patients in the Hilltown Hospital group, who regularly attend a consultant-led outpatient clinic. This fits with the findings of other studies which have demonstrated that, although patients presenting to A&E feel it is important to know the level of training of the doctor caring for them, few understand what specific titles mean in terms of roles and responsibilities. Although patients may have a general idea that doctors undergo a form of apprenticeship, most have a limited understanding of this training

process.[183, 184] It may be useful to explore further the public's understanding of consultant-delivered care in A&E further, and their response to information about current staffing levels, including shortages of senior staff.

In contrast, whilst one of the 'active campaigners' felt consultants do not play a role in A&E, treating patients in the acute phase of an illness, most in this group recognised the role that the need to increase levels of consultant-delivered care played in the case for change. However, they dismissed this as unnecessary. Analysis of the interviews suggests that many of the latter group were conflicted: on the one hand, they saw that there might be a benefit from greater consultant presence in A&E. However, it appears that they could not explicitly state this, given their position campaigning against the proposals.

Trade-off exercise

As part of exploring the factors that influence the way in which the public respond to reconfiguration proposals, this study sought to explore for the first time the extent to which patients and the public are willing to accommodate the trade-offs that are inherent in reconfiguration decisions. Alongside the prioritisation exercise, this was one of the two exercises interview participants were invited to complete, using flash cards that documented eight aspects of emergency care identified as important in Study 1 and which are listed in Figure 7.

In the pilot interviews the trade-off exercise generated mixed results, as I outlined in Chapter 6. This was not least because many pilot participants were simply not willing to consider trading-off any of the priorities described on the cards. This was partly because they did not perceive having more senior staffing, for example, as a 'gain' worth having, compared with getting to A&E as quickly as possible.

The results were similarly mixed when I repeated the exercise with participants in Greenville and Hilltown. There may be an obvious explanation for this, in that inter-personal aspects of care appear to have more relevance to the public than technical quality. For example, the public appear to have mixed views about the value of consultant-delivered care, as I have explored in the previous section of this chapter. The text of the two flash cards relating to care quality and consultant presence in A&E had been modified in response to feedback from the pilot interviews, but it is possible that interview participants were not willing to trade-off partly because they held a very different view of the concepts depicted on the cards. For example, the findings outlined in the previous

sections of this chapter suggest that members of the public worry that the quality of care will decline if reconfiguration proposals go ahead, because of the impact such plans are perceived to have on the inter-personal aspects of care.

Nevertheless, there were one or two participants in the main study who were prepared to consider trading-off between these aspects of care. Crucially, they were GO.2 and GA.4, the two Greenville participants in the 'pro-centralisation' category. Broadly speaking, however, there were three distinct types of attitude to the exercise, as I will illustrate.

The first view was the most widely held. These participants were not prepared to consider trading-off these aspects of care with access. GP.2, the parent participant who would now take her children to Yellowtown rather than Greenville, because of her experiences of waiting there to be seen in the past, expressed this point of view. She had selected consultants on duty as her top priority for care in an emergency in the prioritisation exercise, and previously expressed concern that there had not always been a consultant present when she had been to A&E. Consequently, I asked her whether she would be willing to accept a slightly longer journey, if she knew there would definitely be a consultant on duty when she got there. Her response was clear:

> Er, no. Because in extreme circumstances that could be the matter of between life and death couldn't it? Um, you know, in, in an extreme situation, you know, taking your child to hospital, you know, minutes could be critical. So having a facility further away is... no it's not ideal at all…. Like I said it was a critical time and minutes counted, then that would be redundant by the time you got there. [Getting there] is critical… I think having a facility nearby is essential, absolutely essential.

GP.2 considered it important to have a consultant present in A&E, and she recognised that this does not always happen currently. However, at the end of the day, she considered timely access so important that she was not prepared to compromise on this.

Within this perspective, there were also others who were not prepared to consider trading-off the aspects of care outlined on the flash cards. However, this was because they did not consider the clinical factors relevant. Participant GA.1 was a good example of this. She was the campaigner who did not feel there was a role for consultants in A&E because she considered a consultant to be a specialist in a particular body system or patient group, rather than a front-line doctor. She also believed that there would be little difference

between hospitals in terms of the care currently provided in the A&E department. Whilst she considered access to be 'really crucial,' she was not prepared to consider trading-off access in favour of these two aspects of emergency care principally because she did not consider them to be relevant 'gains.'

Other participants, who held a second perspective, took issue with the concept of making trade-offs at all in the context of health care. This was the second perspective. Illustrating this, GP.4 was another parent participant, a 'consultation completer' and 'localist' who felt she had a responsibility to register her views on the grounds that, if she didn't and Greenville closed, it would be her 'fault.' I asked her whether she would be prepared to have a slightly longer journey, if there were to be a consultant in A&E when she got there:

> I suppose so. We touched on this earlier. If there's going to be a consultant on duty in one hospital, and there aren't in another… If it doesn't necessarily make me more sick or my life more threatened by travelling a bit longer, I would do it. But then again why should we have to? This is not something we should be made to choose. (GP.4)

She went on:

> Why should another hospital have better services in the first place? What they should be doing is upgrading the standards everywhere. It should be the same. This is the National Health Service; it shouldn't be that Greenville hospital is better than [any other]. We shouldn't be made to choose. Why should I have to travel thirty minutes further when there is a hospital? What they should be doing is upgrading all the hospitals. (GP.4)

Later in the interview, she added:

> I don't think trading off… we should never ever have to trade off with national health services. It's okay to discuss it, but it's not something that should be considered. Why don't they just upgrade services all round? (GP.4)

GP.4 is not prepared to contemplate trading-off aspects of health care. It may be that she is not aware of current workforce challenges in emergency medicine, but she also appears unwilling to accept the existence of any constraints on local services. Another parent participant, GP.1, who was also a 'localist' but fell into the 'worried but uninvolved'

category in terms of the reconfiguration, was similar reluctant to consider making trade-offs. She also recognised the difficulties involved in making such decisions at a system-level.

> I don't want to choose. I want it to be the best of everything. Make it all really good, but of course, again, you can't... because of the money, because of the NHS, over the cuts. And, you know, people keep getting sick and people need to be treated. There's a lot of horrible diseases out there that the money's being filtered towards and so if you're expected to treat a cancer patient within two weeks of them being seen by the doctor, then you know... Everyone wants a piece of the NHS money and cuts do have to be made because there's no more money. I understand that and that's what's really sad. I look at [the cards] and I go 'it should be everything' but it can't be. And then I start thinking 'gosh I'd hate to have to make these decisions' because for me it's hard enough. I was dithering over these bits of card on the table and for me to have to choose what would be the most important, I would choose specifically for my family. I mean it's unfair, 'you can have one or the other'... you can't... so it's tough, it's hard. (GP.1)

Finally, there were one or two participants who held a third perspective. This group recognised the complexity of trade-off decisions, and in some ways rejected the simplistic approach of the card exercise. Looking again at a parent participant, GP.3, the parent-toddler group leader who was a 'localist' 'consultation completer', I asked her too whether she might be prepared to travel a little further to see a consultant in A&E.

> That's a really tricky one for me to work out where I would make the trade-off. On the one hand, I think getting there as fast as possible is really, really important. But if you told me I was going to get to a hospital quickly, but that consultants were only on duty 12 hours a day and so I was potentially going to arrive when there was no consultants there, I would be quite nervous about that. I would probably prefer to ride an extra 10 or 15 minutes in an ambulance to get to a hospital where they did have all the people that were needed to treat me. But, again, so much depends on the actual severity of the situation. I suppose there's some situations where my call would be the other way, get me there fast because I don't need someone very experienced to treat this, I just need it treated quickly. (GP.3)

GP.4, another parent, who did not mention the reconfiguration, and was an 'avoider' in terms of hospital preference, had a similar view when I asked her the same question:

I mean it's all degrees isn't it? Extra ten minutes, no problem. Extra thirty minutes, I think problem. Thirty minutes is a long… it's a long time if you're really unwell. Half an hour can feel like an age… And the longer you have to travel, you know you're going to have to wait once you get there to see someone. You've got to be processed while you wait to see someone, so you're just getting more and more anxious. I mean it's horrid, it's really horrible and you're in discomfort as well, so ten… Ten or fifteen minutes. This is the problem with [this area], the traffic is so uncertain and so [getting to hospital could take you] fifteen minutes, but it also could take you know fifty minutes. So it's that uncertainty. (GP.4)

In summary, most participants were either only prepared to trade off within certain limits, usually in terms of the additional time they would be prepared to travel, or they were not willing to consider trading-off in this manner. In the latter case, this was either because they were simply not prepared to travel further for care, or because they took issue with the concept of trading-off in the health care setting. At the same time many participants were clearly conflicted, whilst they didn't consider consultant-delivered care a gain worth having in lieu of timely access, for example, many obviously felt it was important in some way, and thus struggled to hold the two concepts in tension.

Priorities for emergency care

In the final section of this chapter, I will bring together the findings of the previous two chapters to propose a model that illustrates participants' priorities for hospital care in an emergency. The model demonstrates the key differences between participants' perspectives on what makes safe, high quality care, compared with those of clinicians and commissioners. My analysis has also demonstrated that at least in Greenville, there appeared to be a difference in the perceptions of those who were actively campaigning against closure and the wider public. In my study, the public were more concerned about the implications for them, particularly in terms of timely access, and less engaged with the clinical details in the case for change. In contrast, the active campaigners framed their opposition largely in terms of the impact that the proposals would have for others. They were also much more engaged with the rationale behind the plans; they openly dismissed this, although their transcripts suggest that in reality some were quite conflicted in their views.

For this reason, the model I propose perhaps has more relevance to the wider population, although many of the 'active campaigners' did appear to share some similar concerns. My

analysis has identified two core areas of concern: timely access to care and the quality of that care. The first in particular was shared by most participants across the study, in both Hilltown and Greenville, which suggests that they are not just a concern of those whose hospital is threatened by a reconfiguration. In an emergency, most interviewees wanted to get to a care provider quickly because they believed that timely access is associated with better outcomes. In addition, they anticipated that they would either be in pain or uncertain about what to do for an acutely unwell relative. Five particular areas of concern were evident – navigation, transport, traffic congestion, parking and waiting – which I suggest act as barriers to access in an emergency, delaying access. I proposed that in the eyes of many local residents, the reconfiguration in Greenville would decrease the safety of care locally, because patients would have a longer journey to hospital. The additional journey would also cause these barriers to increase in size and complexity.

Donabedian defines access to care as 'use of services.'[45] I would argue that the people providing those services were the most important determinant of quality for participants. The key was not just to get to the hospital quickly, but to get to a health professional who could intervene quickly. Providing the interpersonal quality of the care was high, the technical quality seemed less important. In fact, participants perceived that there would be very little difference in the technical quality of the care provided by different hospitals. In this chapter, I have argued that from the perspective of the public, as well as decreasing the safety of care, the reconfiguration proposals in Greenville also threaten to decrease the quality of care locally, rather than increasing it as the commissioners promise. This is because interviewees who were concerned about the proposals, but not 'active campaigners,' believed that increased patient flows would place greater pressure on staff. Consequently, they would be more stretched, with less time to spend with patients. In addition, because staff are more stretched, patients will have to wait longer in A&E, thus delaying their access to care.

Figure 9 outlines a model of patient and public priorities which combines these elements. This considers the aspects of care that participants identified as most important, and the impact that a reorganisation might have. The top half of the diagram represents care currently; the bottom half, care as participants anticipate it would be after the proposed reorganisation. The priority of getting to a care provider as quickly as possible (safety) is indicated by the arrow. If the local A&E is downgraded, patients will have to travel further, and the time it takes to access care would increase. The second priority was the care

patients receive in A&E (quality). Given the importance of the interpersonal quality of care, this is represented by a picture of a health care professional. The availability of the clinician is reduced in the lower half of the diagram to represent the assumption that staff would be significantly more stretched if services are consolidated. The barriers to prompt access are represented as blocks. These include knowing which services to access and where they were located, negotiating the local public transport system, potential traffic congestion, parking, and waiting in A&E before 'getting through' to the doctor. Participants anticipated that the proposals in Greenville would increase these barriers, potentially delaying timely access. The barriers have therefore increased in size in the lower half of the diagram.

Figure 9: Model of patient and public priorities for hospital care in an emergency
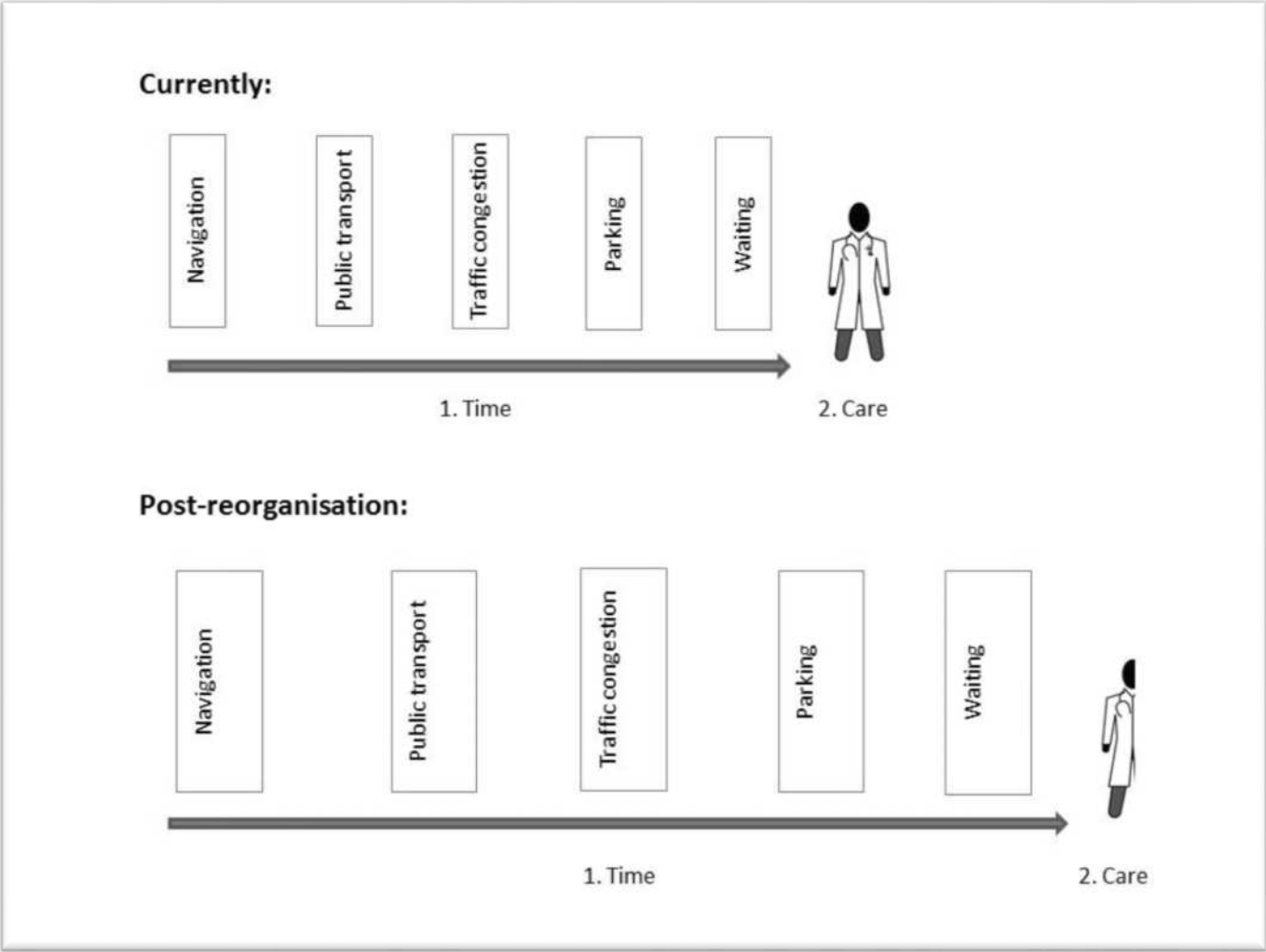
Summary and conclusions

In this chapter I have built on the findings of Chapter 7 to explore how patients evaluate the implications of a proposed reconfiguration. Together with Chapter 9, this chapter seeks to address research question 4, exploring the factors that influence the way in which the public respond when proposals aimed at reconfiguring hospital emergency services are put out to consultation. This chapter focuses on the public's response to the content of the proposals and the case for change.

I have demonstrated that there were a range of perspectives in Greenville in relation to the plans, ranging from those who were in favour of the proposals to those at the other end of the spectrum who were actively campaigning against them. My findings also suggest that the views of these 'active campaigners' are not necessarily representative of the wider community.

Reconfiguration is inherently a process of trade-offs and conflicts between the priorities of different stakeholder groups. The proposed changes will often have drawbacks for at least some sections of the community but the current consultation process perhaps assumes that if the public are given sufficient information, they will come to appreciate, for example, the importance of consultant-delivered care, and hence accept the need to trade this off with timely access. One of the unique contributions of this study is that it demonstrates for the first time that the public may not be willing to accommodate these trade-offs. It is not that the public do not grasp the concept; in many cases they are simply unwilling to consider travelling further, so important to them is timely access. These views were shared by participants in both Greenville and Hilltown, so it is unlikely that this reluctance is simply due to Greenville residents' opposition to the local reconfiguration plans. The importance that participants' placed on timely access was a key factor influencing their response to the case for change.

Alongside concerns about safety, I have also documented two significant areas of mismatch in the way clinicians and the public assess the impact a reconfiguration will have on care quality. I outlined how the proposals appear to decrease the quality of care in the eyes of the public, as well as the lack of clarity about why the commissioners consider it important to reorganise care to increase levels of consultant-led care in the area. These factors also played a role in influencing the way in which participants responded to the case for change. The Independent Reconfiguration Panel and others argue that commissioners often fail to convincingly describe and promote the clinical case for change.[1] The failure to recognise

these two areas of mismatch may provide some explanation as to why the public in Greenville were less than convinced by the case for change.

I have also demonstrated how a range of other factors influence the way in which the public respond to the content of reconfiguration proposals. For example, this chapter has shown how people draw on their knowledge of the local area to assess the implications of having to travel to an alternative hospital for care. Equally, rather than distances on a map, many participants automatically assessed distance in terms of travel times or public transport options. The findings also lend weight to what many others have said recently about the 'bewildering choice of services' available to patients in an emergency.[185] There is already confusion about which service to access in an emergency, and the proposals in Greenville would add an additional layer of complexity. Participants were unclear what problems could be taken in future to the urgent care centre, and worried about taking the wrong thing there, delaying access to appropriate care.

The model I proposed in Figure 9 outlines patient and public priorities for hospital care in an emergency amongst the wider community. It offers an approach to understanding some of the concerns that may be raised when proposals to downgrade a local A&E department are being considered. Like all such models, it is inevitably simplistic but it provides an interpretation of what is most important, as well as the concerns that are brought to bear on the way the public assess the implications of a proposed reconfiguration. It contains a number of factors which commissioners could seek to address before changes are proposed, either by ensuring contingencies are in place or proactively allaying public concerns, for example by providing more information about how increased patient flows will be accommodated. However, its principal limitation is that it does not necessarily represent the views of the 'active campaigners' who by nature are likely to be most vocal in a consultation. Their opposition seems to be principally driven by loyalty to the hospital because of what it represents as part of a comprehensive national health service. As such I suggest that many in this group are likely to oppose any proposal that involves a downgrading of services.

Chapter 9: Study 2 findings – response to the engagement process

In this, the final chapter of findings from Study 2, I will explore participants' responses to the way in which the consultation process was conducted in Greenville. This is the third process encompassed by the theoretical framework. Together with Chapter 8, this chapter addresses research question 4, examining the factors that influence the way in which the public respond when proposals aimed at reconfiguring hospital emergency services are put out to consultation. It also builds upon the findings of Study 1 to address research question 3, which explores the impact of of practices currently used to consult local communities.

It is first important to set this part of the analysis in context. As I have outlined, a handful of participants did not mention the planned reconfiguration at all, suggesting that they were not engaged with the consultation process. Three of these participants were older men, at least one of whom indicated that they had little interest in local health care matters. The other was a parent participant, who would seek to avoid accessing care at Greenville anyway. Alongside this were the 'worried uninvolved' who were anxious about the implications of the changes for them, but were apparently not engaged with the ongoing consultation process.

Three groups of participants were therefore involved in the process, to differing degrees. This includes of course the 'active campaigners,' as well as the 'consultation completers,' individuals worried about the implications of the reconfiguration, who had sought to register their concerns via the consultation process. Alongside these two groups sits the pair of participants who were 'pro-centralisation' and had also been engaged in the consultation process to varying degrees. The analysis of how participants interacted with the process therefore draws largely on the experiences of these three groups and I will compare and contrast their perspectives. It is important to keep in mind though that almost a third of Greenville interviewees did not seem to be engaged with the process at all.

Rationale for change

Before exploring participants' responses to the process of consultation, it is first useful to consider why participants thought the changes were being proposed. I have already outlined how the pair who were pro-centralisation believed the changes were being

proposed in order to make services 'more efficient and more responsive.' (GA.4) Considering first the two groups who were concerned about the proposals, but less engaged with the consultation process, the 'worried uninvolved' and the 'consultation completers,' there were a range of views about a) what was happening and b) why it was happening.

One view, which several shared, was that the plan was to close Greenville Hospital. One of the older Greenville participants, one of the 'worried uninvolved' explained:

> I have had people knocking at my door about they're going to get rid of the hospital. I said I don't think they ought to, because people will miss it. (GO.4)

I asked him why he thought this was happening:

> They can't give you an answer to why they are doing it. If we knew why they were doing it you might be able to think of something, but seeing as you can't think of why they are doing it, we just don't know. And to be honest, I don't think that they know otherwise they wouldn't do it, would they, without consulting and telling the people… It's all what my own GP told me. And it seems to be a bit of a bungle, if you appreciate what I am trying to say, you know, a real mess and they don't know how to get out of it. They just don't know how to get rid of the amount of people that go to these places. I am going to tell you the truth, all the people who come to this country, who live here they are entitled to good… but all these people who come here just for treatment and don't pay anything, they are clogging up the hospitals for other people and I think that is wrong. (GO.4)

Later, he added:

> I just entirely disagree with them. Entirely. I don't think it is fair to be honest. Like for me it is, just say I had to go to Redbury Hospital and my son wasn't available, how would I get there for a start? They say you can ring up and get an ambulance, but you can't always get an ambulance can you? So how would I get there at my age? I have a job walking; I have a job getting on a bus. If they was to do that for younger people, maybe that could work, and leave the old people to go to Greenville, something like that. (GO.4)

Again we see here the perception, which a few participants shared, that the NHS is 'clogged up' by 'all the people who come to this country.' We also see again an emphasis on the

practicalities of travelling to Redbury, rather than specifically on the risk that might be involved in travelling further in an emergency.

The view that the hospital is to be shut down was also shared by GP.4, a parent participant and 'consultation completer' who was also a 'localist' in terms of her hospital preferences. She also was not clear why the changes were being proposed:

> They're trying to make us choose - which hospital would you rather save? Greenville or Redbury Hospital? Why should we have to choose? No, that's not how it should work because the minute they close one hospital, there's going to be more demand in another hospital. (GP.4)

She added:

> I don't know why they want to shut down a hospital, seriously, I don't. I don't know, maybe I have a very, very small brain, but even if it's small, I don't see how closing certain services A&E and the maternity services at Greenville Hospital is going to give better service for us. We have to travel longer; we no longer have the choice. You have to go there. You just have to. How fair is that? (GP.4)

I asked her also why she thought the changes had been proposed:

> The little that I've seen, is - I suppose - they believe that if they shut down maybe the A&E at Greenville hospital, then they'll expand in other places and there's going to be better service there. Why should they do that? Why should we have to go to that place? Why can't they upgrade the services? (GP.4)

On the other hand, there were those who had a clear view about why they believed the changes were happening. GA.2 was an older Greenville participant, a 'worried uninvolved' interviewee with regard to the reconfiguration, and a 'localist' in terms of his hospital preferences. He believed that services at Greenville had already been downgraded:

> My closest hospital would definitely be Greenville here. But unfortunately that's under closure orders now. And they moved it all to Redbury Hospital. (GA.2)

Later, in terms of explaining why the changes were happening, he added:

> The NHS is filled with incompetent people and because they are filled with it, that is being dragged down. And wrong decisions are being made, they're sending people from, you know, all these places changing, A&E from here, from Greenville

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putting in Redbury, this is all to do with the political cuts. Cuts. This has nothing to do with trying to improve A&E. NHS. It's not going to be better. (GA.2)

This belief that the proposals were the direct result of ongoing financial cuts was undoubtedly a factor that contributed to the way many participants responded to both the case for change and the consultation process. It is probably not surprising given that the consultation was set against a backdrop of financial recession, in which 'the public are used to things being cut back.' (GO.2) Indeed, this is a common perception amongst local communities when reconfiguration decisions are being discussed.[1]

Participant GP.3, one of the parent participants, a 'localist' in terms of her hospital preferences, and a 'consultation completer' had a slightly different perspective. Although she doesn't go into the specifics, it is interesting to see how she accepts that change probably does need to happen, but at the same time she cannot reconcile this with her concern about timely access.

> For emergency services Greenville would always be my choice because rather than having to take the car and worry about can I park… worry about the meter once I get there and all that kind of thing. I can literally get on the bus and get [my daughter] there and in many ways I can probably get her there faster on the bus than I can by phoning for an ambulance. Unless she was incredibly sick, I would never choose an ambulance for her while we've got Greenville A&E which is why the threatened closure makes us so anxious, because A&Es that are going to be left after they've done that are all much further away. (GP.3)

She went on:

> I understand a lot about kind of why you can't have the perfect hospital and so you have to make do with the hospitals that you've got…. So I suppose I have opinions about what would be nice to have in my area but I am also pragmatic and realise that for example in [this area] there will be changes, there will be hospital closures and I am not naive enough to imagine that [the campaign] to save all of the services in our area is ever going to work. We can't make that work; the best we can hope for is to convince them that actually Greenville needs to be saved in favour of some of the others. It's not tenable to have all of them. I know that [there are more A&Es than] the area as a whole needs, more than the population justifies, and things like that. I have questions about whether they have picked the right

A&Es to save and I think the thing to me that they seem to have really failed to look at is the practicalities of how people are going to get to those hospitals. It is great to tell me that Redbury is the best place for me to go; I don't know how to get there, using anything other than a car... Let's face it, no-one goes to hospital for a day out, you go when something is going wrong, either you or someone that you care about is sick and so you go in stressful circumstances and so you know the kind of concern is they don't seem to be looking enough at the public transport links... it's not easy to get to Redbury, it's not easy to get to Yellowtown... They don't seem to have appreciated that it's actually quite difficult to get to places like [that] even though on the map they are right next door to us. (GP.3)

Turning our attention to the 'active campaigners,' most of whom were 'loyalists' in terms of the hospital preferences that they expressed, it is perhaps not surprising that this group had clearer views about what they thought was happening in Greenville, and indeed why it was happening.

To start with, this group were much more engaged with the actual content of the proposals, as I described in Chapter 8. GA.5, a member of a patient involvement group, explained to me what he believed was happening and why he was concerned:

The big argument at the moment is that the preferred option for hospitals in this area is to turn Greenville into a local hospital - i.e. no A&E department - and everything to go either to Redbury or to Yellowtown. That's big argument that's going on at the moment.... I can understand what they're trying to do. However, as a resident and a [patient/public representative], I would have to think about the rest of the residents in the area and what they would feel. And I would think... Well won't think, I know that in Blueborough they would be strongly opposed closing Greenville because they need it. (GA.5, emphasis his)

Many in this group believed that the changes were down to the coalition government. Nevertheless, although he was concerned about the implications for Blueborough, the most deprived part of Greenville, GA.5 rejected this position. He described attending a local trade union meeting about the closures:

We went to that meeting and quite honestly the closure of the Accident and Emergency Units at Greenville etc. were all due to the Conservative Government. That was the Union message which was absolute tommyrot because the first

shoots of the reconfiguration process were actually started under a Labour Government… I've got a document where I attended a meeting [as a patient representative] that actually started to discuss moving a lot of what's done in hospitals into the community which is part of the basis of this reconfiguration process and that was actually under Labour.

On the other hand, there were those who firmly believed that the changes were not related to clinical quality, but were part of the wider ongoing austerity measures. The views of GA.9, another of the 'active campaigners' illustrate this position.

The preferred option [the major hospitals] would retain A&Es, maternity, paediatrics, intensive care… but obviously Greenville [and the others] to basically have very little… Well, basically run them down to closure. (GA.9)

I asked her why she thought this was being proposed.

It's all about £20 billion worth of cuts over four, five years and really it's got nothing to do with improving our health… We definitely believe that that is the case. And when push comes to the shove and you really push these people, they admit that of course it's part of the cuts and all the GPs thinks it's part of the cuts. (GA.9)

One of the things that marked the views of many of the 'active campaigners' was a sense of suspicion about the commissioners' motives and actions, which in turn influenced their response to the consultation process. Alongside questioning the validity of the claim that the reconfiguration sought to improve care, there were also concerns about what was actually happening. Returning to participant GA.9, she described how an A&E department in a neighbouring area had recently closed at night:

Some A&Es have now dropped down to just being day time only… I think the A&E needs to be 24 hours with a guarantee of… I think maybe it doesn't have to be a consultant on duty but I think a consultant perhaps might need to be on call in the event that they can't handle the issue. (GA.9)

I asked her why the closure had happened:

That's part of making the closures. It's like stealth, if you close it at night so then people go to an A&E somewhere else. (GA.9)

This was the active campaigner who particularly wrestled with whether or not it she would prefer to have a consultant in A&E. Others in this group were also concerned that the public was potentially being misled by the commissioners. Or as one put, 'the way they are stating it seems to be a deliberate obfuscation.' (GA.5) Another campaigner spoke in more detail about this:

> What concerns me is that people aren't being told what it actually means. It's not that they're lying to people; it's just that they're not actually telling them what it will mean. Take away A&E, you take away maternity, you take away your in-patient work load and lots of other things. That's the bit that they are telling them, but they're not explaining it. They're doing it by tick boxes and, to somebody who knows what they actually mean, you can automatically see that it's not just a case of A&E going, it's a case of a hell of a lot of other stuff's going. (GA.6)

Trust was a core issue for GA.7, and a theme he returned to several times during the interview. Part of his concern was that, although the consultation process was ongoing, he believed the changes were happening already:

> I think they're making the changes already. They've told the care homes in Greenville not to send people to A&E. Told them, what, a year ago, 'stop sending patients to Greenville.' I think they want to make it look like it's a failing A&E, that's very cynical. (GA.7)

He went on to talk later about the role of the commissioners:

> I want to feel that I can trust the people who are making those [decisions]. It's about trust. These bloody meetings I went to, the person who never turned up was the woman who's going to run health care in Greenville, the clinical commissioning group. She never turned up at the public meeting at the Town Hall, she never turned up at a volunteers' meeting that I got up at seven in the morning to go to. She just never turned up. (GA.7)

Later in the interview, he added:

> We'd like to trust the people who are making the decisions about how you cut the slices of the cake a bit smaller. The way I would trust them is that they would show me the business case in more than just an Excel spreadsheet and talk it through with us and talk through the alternatives. You see where people present something

and don't present the rejected alternatives it's a bit concerning. Give me the full picture… I've run press conferences. I've run through all the difficult questions they're going to ask, so I know about aggregating arguments and dealing with objections. Also you don't go into these things unless you are perfectly confident about it. When [the medical director] turned up at my meeting, he was shaking at one point when I asked him local questions, 'where will you put these additional services?' And he didn't know. Well how can that engender trust? (GA.7)

In summary there were a range of views about exactly what was happening in Greenville, and why the changes were being proposed. The 'active campaigners' in particular were suspicious about the motives behind the proposals.

In the next section, I will examine the consultation process itself from the perspective of the community, or at least those participants who were in some way engaged with it. There were two key factors that influenced their response. The first of these was their interactions with the commissioners who proposed the reconfiguration plans. The second was the mechanism of the consultation process itself.

The commissioners

The Greenville consultation took place prior to April 2013, when clinical commissioning groups (CCGs) across the country assumed the responsibilities of primary care trusts (PCTs). The consultation document describes how the proposals were developed by the local CCGs, made up of GPs representing the PCTs, working with 'hospital doctors, nurse leaders, providers of community care, social services, patient and volunteer groups and charities.' In all the literature, the commissioners emphasised the fact that the plans had been developed by local clinicians. In making the case for change, particular emphasis was placed on the fact that many of these individuals had worked in the area for a long time and thus understood the local health care economy very well.

For those participants in the 'worried uninvolved' and 'consultation completer' categories, there was little sense from their interviews that they acknowledged the fact that the proposals were clinically led. Indeed, most referred to the people behind the plans as an anonymous 'them.' It was only the 'active campaigners' and the 'pro-centralisation' participants who had really engaged with the commissioners directly, rather than just the consultation document. The medical director of the PCT cluster, a local clinician, represented the public face of the reconfiguration for many of these individuals and had

obviously spent a considerable amount of time travelling around engaging with local community groups. One of the 'active campaigners' noted that he had visited the patient involvement group that they were a part of 'on numerous occasions.' (GA.6)

This reflects the recent trend of commissioners using an 'expert' to present the case for change. This is typically a senior clinician, whose view - it is thought - will carry weight with the community. Commissioners are encouraged to take this approach,[186] despite the fact that the literature on environmental risks strongly suggests that it is not sufficient for the provision of credible scientific advice.[148] It is questionable how far the 'advice' given by the commissioners had penetrated into the wider community in Greenville, but my analysis illustrates how, despite this approach, the campaigners remained sceptical and simply did not believe the claims put forward.   Why is this? Referring again to the medical director, one participant said:

> I think he's probably a very clever clinician, but this is not just about clinical factors. This is about a much bigger issue of logistics, of infrastructure, of access. I mean I'm sure he's a very clever man, but he's looking at it in a very cold, clinical [way]. (GA.7)

It was not only the 'active campaigners' who felt that issues of relevance to the public, such as access, had not been taken into account when the proposals were first developed. For example, GP.3, one of the parent participants and a 'consultation completer,' felt that 'they don't seem to be looking enough at the public transport links and understanding that Greenville… is strangely badly connected to the other places that are immediately next to it.'

Equally, the 'active campaigners' were also concerned that the concerns of the public were not being taken into account during the consultation process. GA.9 described the public meetings to me:

> They did run some public consultation meetings, but they weren't very genuine. You know, you could turn up and ask questions. And they'd have nice glossy boards around the room and then you ask questions but… (GA.9)

I asked her whether or not people had asked questions:

> They did. They didn't turn up in Blueborough because it's not what they do. Because it's the type of community, they don't go to that sort of thing. It was

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much bigger in [Greenville itself]. Yeah, people did. And obviously campaigners went along and said their piece. (GA.9)

She was not alone in her scepticism about the meetings. GA.6, a member of a public patient involvement committee, raised concerns about the cost of the meetings, some of which had been held at prominent venues:

I don't know if you're aware, but there have been loads of meetings and we've been... I mean there were two at [one major sports ground], there was one at [another] big place. They've spent an absolute fortune trying to convince people that this is what they're doing and trying to force upon us is correct, you know I think the money would have been better off spent on patients. (GA.6)

This perception was not just confined to the 'active campaigners' and it represents another factor which influenced some participants responses to the consultation process. I have already described the reservation of one of the 'pro-centralisation' participants, GO.2, who felt that there was 'some soft soaping going on' on the grounds that 'if people are giving you lunch instead of the facts, they've already decided and they're trying to make it softer for you.'

Another participant, GO.3, an older Greenville resident and a 'consultation completer,' also explained how the approach taken by the commissioners gave the public the impression that their concerns were considered trivial and irrelevant.

I haven't been to any of the meetings about the current consultation but I have gathered from press reports and what people have said, that the people running it have been somewhat er, arrogant in the way they've talked to clients and obviously that doesn't help so I mean you, you need genuine consultation with the, the professionals prepared to listen, [rather than] dismissing arguments as trivial... I mean clearly people have been saying, 'We need our local service'.

The consultation process

The public engagement events formed part of the wider public consultation process about the proposed changes to services in the region. A consultation document formed the basis of the process, and included a series of questions for members of the public to respond to. This process of collecting feedback was another key factor that influenced participants' responses to the overall consultation.

Participants who had been engaged in the process, expressed a number of further concerns about this as well. Considering first the 'consultation completers,' the participants who had sought to register their protest by completing the consultation document. I have already described in part the views of GP.3, the parent-toddler group leader who had tried to encourage her fellow parents to complete the document because she was concerned that petitions could be disregarded. She described completing the document herself:

> I did actually read the whole consultation document because I responded to the consultation process. I am such a nerd! It's a massive document, it's massive. (GP.3)

The main document was 84 pages long, and residents were asked to respond to 34 questions. Other 'consultation completers' also commented on the size of the document. GO.3, the older Greenville resident who felt the commissioners had been dismissive at the public meetings, also described as 'a massive questionnaire.'

GP.4, another 'consultation completer' and parent participant, described how she had come to take part. As I have already described, this interviewee felt she had a responsibility to register her view:

> I went to Greenville Hospital two weeks ago, but there were people there who said, that's five of the most important questions. And it's like they're trying to mess with your heads. I don't know how many pages it is - I have two kids, I want to take part, but how long is it going to take me? I'm pushing a buggy. So they're making it too long. It's just unnecessary. (GP.4)

Later she went on:

> If I didn't have to go to hospital two weeks ago, I wouldn't have filled in that questionnaire, believe me. So, was it this year or the end of last year, they sent us letters, [the council], they wanted to do improvements at our park, put some gym stuff. They sent letters to our houses. We want to do this, do that. This is recreational services, but which is better - health services or recreational services? If they can send us letters, I mean probably it's different, but if [the council] can send us letters to say 'what do you think about our proposed plans' why can't they do the same? I don't think I've received anything… I'd rather I'd see the letter and throw it in the bin. But you know what, I'm responsible. If tomorrow, they shut down Greenville Hospital, it's my fault. So there's people who've not had to go to

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hospital, so how do they have access to those things? Someone will say they're online but the reality is, yes, they can login online, the form is long, it's complex, we have children… So when do people really get time to do that? They should be engaging us more. They want to change our services, they should come to us and engage us more. Which they are not doing. They're not doing enough. (GP.4)

There were a range of similar concerns about the size and complexity of the document amongst the 'active campaigners.' GA.9 showed me the consultation document during the interview and described to me the process of completing it:

The actual questionnaire was quite long and in order to fill it in, you had to read all this document, which for people who are not used to that… I think the questionnaire's about 15 pages. So you had the questionnaire and you had to have the questionnaire with this document and you had to actually refer to the content in here in order to answer the question. So pretty nightmarish for somebody who is not articulate or who English is not their first language, or has any kind of health issue which would make it very difficult for them to plough through the document. (GA.9)

She went on:

[There was] no option to say actually 'I fundamentally disagree with all those proposals' so we just had to write all over our forms we strongly disagree and we think that you should keep our hospitals exactly as they are. (GA.9)

In addition, she described how some people had faced difficulties getting the document:

You couldn't get consultation documents. They came out three weeks late. There were very limited numbers. It was very hard to get them. They ran out regularly. They sent 50 to the local library in [this area] which is the main point at which you can pick them up… People went there on various occasions and couldn't get them. They arrived, some of them, after the consultation was over. (GA.9)

She described the consultation process as 'flawed' and 'undemocratic' several times, and I asked her what she meant by this:

It's undemocratic because it's only really accessible to the people who are able to (a) speak English, (b) read well, who can understand the issues and who will understand the nature of the questions. The questions were absolutely… Steered

you in the direction… So you would be ticking to say 'I don't mind you getting rid of maternity and other services from my hospital' because you didn't realise… You'd have to read the document that explained we're going to move maternity because it'd be so much better. And then you would say 'do you agree with question X in the document' and you'd go 'oh yeah, yeah, that sounds alright,' you know, or say 'do you think it's good to have centralised services with highly qualified specialists,' well, you all tick yes because you don't realise that that means your A&E shuts. (GA.9)

As I have already observed, some other 'active campaigners' also suspected that the public were not being told the whole truth. GA.5, a member of a patient involvement group described the approach of the commissioners as 'deliberate obfuscation.' Referring to the consultation document specifically she added:

It was outrageously complex and it, I mean it was just… It was not the sort of thing that you put before the general public. (GA.5)

Also within the 'active campaigners' group, another patient representative, GA.6, felt similarly about the consultation approach:

The problem is that the document they present to the public doesn't actually tell the public… Well it tells you the truth but it's not the whole truth. It's the way it reads because the problem is, the document, the consultation document consists of eighty pages. You cannot put a lot into eighty pages. The big amount of problem appears in what's called the Pre-consultation Business Case which is [a much larger] document….What concerns me is that people aren't being told what it actually means. It's not that they're lying to people, it's just that they're not actually telling them because what, a local hospital whether it's seventy five or ninety percent of what's actually going on there, it's the fact that that hospital will now be able to provide that service in one fifth of the site that it used to occupy with one fifth of the staff. And what it will mean that take away A&E you take away maternity, you take away your in-patient work load and lots of other things and that's the bit that they are telling them but they're not explaining it. They're doing it by tick boxes and you have to interpret the tick. To somebody who knows what they actually mean you can automatically see that it's not just a case of A&E going, it's a case of a hell of a lot of other stuff's going.

He also had reservations about whether or not the responses would be representative:

> The people that tend to fill in these questionnaires anyway have probably got… you know in some ways you're a little bit nerdy in a sense because you're actually thinking about… well you've got to read through that bulky document to actually answer the questions. So are you only attracting a certain group of people anyway?

Perhaps in a bid to circumvent this problem, GA.8, another 'active campaigner' had been involved in helping members of the public to complete the questionnaire:

> We had some suggested answers. If people wanted to oppose the closures we sort of say… Because it was more like market research than a consultation. And the way the questions were posed, led you into agreeing… I mean, it was a very, very ill… No, not ill conceived - they did exactly what they wanted - but it was not a consultation as I understand it, which is about getting agreement around the issue and then looking at how it could be tackled. It was very much, our preferred option is this, but if you want to vote for Greenville Hospital, you can close Yellowtown, so it was pitting communities against communities and hospitals against hospitals and things like that, so very, very flawed process. And you know, it all started off with, you know, 'would you like better services and more services?' And they all looked sort of, 'oh yeah that's a good idea' and then you get to it, 'well of course you've got to do what we say then.' (GA.8)

Once the consultation period had closed, the responses were analysed by a large market research company. However, there were also concerns about the process they had set in place, as GA.7 described:

> Those forms were so difficult to fill in. Also we were very worried about the forms. Not a full postal code on it, so nobody could do any research as to where the feedback actually came from and they weren't asked for a signature. So I could have submitted two thousand myself. Now again this is [a big company], how the hell could they do that? I mean I know some people who submitted ten and it never occurred to me at the time – I just laughed hysterically. I mean so they didn't even conduct the research properly… in a sort of a proper way. It's just remarkable. (GA.7)

Like the consultation in North London, the commissioners in Greenville seem to have taken a traditional psychometric approach to risk communication, assuming that the local

community has exaggerated fears simply due to inadequate or incorrect information. Consequently it is hoped that additional information – in this case a large and detailed consultation document – would help people better understand risk, and hence lessen their worries.[159] This is the approach advocated by groups such as the King's Fund, who argue that commissioners face opposition from the public, because the case for change has not been articulated clearly enough.[13]

However, rather than convincing the local community of the need for change and allaying their concerns, the mechanics of the consultation process served only to fuel their frustration. Considerable investment had obviously been made in the process, including employing the services of a market research company and hiring several prominent venues. However, there was still a lack of clarity about what the proposals entailed and a sense that the public had not been given adequate opportunity to express their opposition to the plans. The methods used limited participants' ability to state what was really important to them, further adding to the sense that their concerns were being disregarded.

The deficit model of risk communication, which attempts to decrease the gap between lay and expert perspectives by addressing the former's 'inaccurate perceptions,' has been widely criticised.[123] Here I am drawing on the accounts of local residents, many of whom were opposed to the principle of reconfiguration *per se*. Nevertheless, the deficit model seems to have been very much in evidence in Greenville. The consultation relied on local clinicians to put the case for change to the local community and the process appeared to be underpinned by the belief that medical science offers a uniquely privileged view of the world. The public were provided with a considerable amount of clinically-oriented information to convince them that the changes were needed, yet there was little acknowledgement of patient and public priorities for the organisation of emergency care. The behaviour of the commissioners only served to reinforce the community's view that their concerns were considered to be trivial and irrelevant.

Public response

Theory provides us with a means of exploring why people react in certain ways. In the next section, I will draw on the work of Michael on lay discourses about science to explore in more detail the reaction to the consultation process in Greenville. Michael observes that, whilst people are often highly critical of particular scientists or scientific views, they simultaneously manage to retain confidence in the pronouncements of other scientists and science more generally. He highlights a difference between a conception of 'science-in-

general'— used by the public as a distancing device whereby science is defined as 'other' from oneself—and a conception of 'science-in-particular' used in practical settings. For example, in a study on the perception of risk from radon gas, he found that when talking generally about science citizens exhibited the traditional view of science. But distrust in science was also seen regarding science-in-particular, where citizens saw scientists as dismissive of local knowledge or pursuing local interests. His work provides a framework for my analysis in this next section. This compares and contrasts the main discourses participants used about medical science in order to understand in more detail the public response to the consultation process, and in particular how the community interacted with the 'expert' scientific knowledge of the commissioners.

Reliance on medical science

One of the recurring themes in the interviews was participants acknowledging their lack of health knowledge, which rendered them reliant on health care professionals to inform their decision-making about both emergency and elective care. This could include either their GP or medically trained friends or relatives.

For example, GA.1, a 'localist' in terms of her hospital preferences and an 'active campaigner, described how, in an emergency, she would rely on the paramedics to know which hospital to take her to.

> I'm just giving that decision over to someone who I think has got better judgement about, you know, what I need urgently to deal with that. I would have no problem with ceding that decision to someone else or, you know, and if it was my mother for the same thing 'You're the guys who know which is the appropriate place to be'. (GA.1)

Similarly, in the context of other decisions about care, she observed that she would rely on a family friend who is a doctor to help inform her choices:

> I suppose if there was something really important in the family I would pick up the phone to him… You find someone who you think would understand. The family friend that I'm talking about, he doesn't even live in [the area]… What I'm trying to say is it's really just finding a professional whose judgement you'd trust…. There's quite a lot of the sort of medical criteria that I would just be completely incapable of assessing myself. (GA.1)

Another participant, GP.3, the parent-toddler group leader who was a 'localist' and a 'consultation completer' expressed a very similar view. When exploring her hospital preferences, I asked her which hospital she would want to be taken to in an emergency.

> I'll be honest, I would leave it entirely up to the ambulance people. I am not entirely sure if I get a choice anyway, but I would just tell them to take me wherever they thought was the best place to take us for whatever was wrong. I don't think it's my call as to where we go, simply because I would rather they made the call and took us to the place most likely to be able to treat us, than I say take us here and then find out that actually the place I've suggested can't deal with what we've got, and then we've got to get in another ambulance and go on another journey. That's all wasted time. So, yes, I would leave it in the hands of the professionals. And I suspect that if I was in the kind of situation where I needed to call an ambulance I'd be so stressed about that that I wouldn't be thinking about what hospital I was going to, I'd just want to get to the right place as fast as I could. (GP.3)

Although one or two participants acknowledged that they had medical family members (usually parents), this sense of reliance was common across all the study groups. Participants referred to themselves as 'layman' (GA.4) or 'not medical.' (GA.9) Many, like GP.3 and GA.1, were prepared to hand control of decision-making to the paramedics, because they 'know best' (GP.4). In fact one described it as 'the professionals' job' to know which hospital is the best. (GO.3)

Challenging the case for change

The second major discourse related to the science behind the case for change, or the clinical rationale for the proposals. I have already documented several examples of participants questioning the motivations of the commissioners. For example, participants argued that the changes were not aimed at improving care at all, but were instead part of a wider programme of financial cuts. Others felt that the commissioners were deliberately misleading the public about the implications of the changes for local services. In contrast to the discourse about reliance on medical science, most of the comments about the case for change arose in the interviews with the 'active campaigners' and this is another sense in which they are distinct from the other study groups.

There were several examples of participants questioning the competence of science in the context of the reconfiguration, including the methods used to develop the initial plans and

then later in the subsequent consultation. Interviewees also called in to question the skills and abilities of the commissioners, who were using science to make their case. When traditional approaches to risk communication fall short, Bennett *et al* suggest that one of the ways conflict and dissonance manifest is in lay people seeking to challenge expert prediction and advice.[114] There were two key ways in which this manifested here.

Exploring the case for change

There was widespread concern about the practical implications of having to travel further for care, as we have seen. As a consequence, several campaigners had gone to some considerable length to explore and demonstrate the practical implications of the proposed changes. For example, some had separately attempted the journey from Greenville to Redbury Hospital on public transport. As one explained:

> I did an experiment… going from here to Redbury Hospital. And it took an hour and twenty minutes. And it was a good journey. The bus came as I got to the bus stop, [etc, etc] (GA.8)

Some of the campaigners had also scrutinised the data underpinning the case for change, often in considerable detail. The same campaigner who had tried the journey to Redbury had also submitted several freedom of information requests for data about Greenville Hospital, and explained that this was 'part of building up evidence' to oppose the changes. (GA.8)

Another campaigner had spent time reviewing all the data tables in the pre-consultation business case. Noting that there 'there are several things that don't actually stack up' they went on: (GA.5)

> I know where the dodgy data is… I can pinpoint it exactly. Some of it's not their fault; some of it's the fault of the NHS's system of recording data anyway. Their own interpretation of data… they've used two different processes of data which are out. (GA.5)

Later in the interview they added:

> There's a lot of data and some of the data, as I've said, doesn't seem to add up. The funny thing was I didn't notice at first. There were these three different values, it was only the fact that I was double-checking or triple-checking everything. What each table showed you was a breakdown of age, breakdown of sex, breakdown of

something else and I thought 'well I better check this to make certain.' I wasn't actually checking in great detail and all of a sudden… 'I'm sure that said 11,000. Can't be.' And then when I looked at it - if I say one table in the first group actually says the difference between 11,000 and 107,000 for the same thing, you know it doesn't make sense. (GA.5)

Invoking the views of other doctors

The second way in which the campaigners sought to challenge the views of the commissioners was to invoke the views of other local medical professionals to support their case. Interviewees argued that other clinicians were largely opposed to the proposals.

One participant, GA.6, a member of a patient involvement group, described her encounters with local doctors at the public meetings:

> We've spoken to a lot of the doctors - consultants - who work [at Greenville Hospital], going to these various meetings and they are very concerned about it. I mean for one thing, the Blueborough community… I mean let's face it, a lot of them are illegal, but they're there with very poor English. Some of these doctors are very proud of the fact that they can actually speak these languages and understand these particular complaints that they are very prone to and they fear that they just won't be able to get this type of support elsewhere. I mean they have been very dedicated coming to quite a lot of these public meetings. (GA.6)

GA.9 also commented on the views of a local GP she had spoken to, whose practice is in Blueborough:

> She's very proud of what she does. And she speaks very passionately against the changes to Greenville which she thinks is a disaster for this community because she says one of the aspects is not just language but also knowing about the health needs of the community. (GA.9)

This participant also used the views of health care professionals to counter directly information commissioners had provided:

> They tried to argue that maternity services in Greenville, they don't have good results, but in fact the evidence from the staff within Greenville is that actually the maternity in Greenville does pretty well and has also tailored itself to meet the needs of the community. (GA.9)

She also challenged the data about travel times, if the changes were to go ahead:

> If you removed Greenville then I wouldn't get there as fast as possible to an A&E because I'd be going to a further A&E where there's a lot of traffic and it's not so quick… They're claiming unrealistically figures for how long it takes to get to A&Es. I used to do some training for [local paramedics] and they used to say getting through [this area] was a nightmare and I'm sure they wouldn't be very pleased to hear that Greenville Hospital wasn't going to still be there, because it means that you've got to try and get through all that traffic to get to Yellowtown Hospital. (GA.9)

I queried earlier whether or not this participant was experiencing a degree of cognitive dissonance, or discomfort, as she tried to reconcile her underlying belief that it may be useful to have consultants present in A&E, at the same time as opposing change. By questioning the motives of the commissioners, and invoking the views of other health professionals, it seems that she is trying further to reduce the importance of her underlying suspicion that it may be useful to have a consultant present, in order to maintain a consistent belief system and her sense of opposition to the plans.[182]

Science-in-general and science-in-particular

In sum, there were two principle discourses about medical science. On the one hand, the majority of participants acknowledged their lack of medical knowledge, which rendered them reliant on health care professionals and medical science in an emergency. This bears the hallmarks of Michael's science-in-general – science as an impenetrable entity that the individual perceives themselves to be at some distance from. In other words, scientists – in this case clinicians – are in possession of a particular type of specialist knowledge from which the individual is permanently barred from entering. [112] As Michael observed in his research, many participants in Study 2 saw themselves as having a sort of 'global scientific ignorance' when it came to medicine. By describing themselves as 'laymen' or 'not medical,' participants were bracketing scientific knowledge as inaccessible and 'other.'[112] My findings also support Bickerstaff *et al*'s observations that discourses of ignorance about science display not just a deficit of knowledge, but also serve as resources by which individuals fashion other relationships to science, for example co-operation or a division of labour.[118] In this case, participants considered it the responsibility of health care professionals to decide on the best course of action in an emergency. This is noteworthy in the light of the literature I highlighted in Chapter 1, and the implicit assumptions of policy

about public involvement in health care decision-making. Whilst Arnstein's ladder, with its goal of citizen power over decision-making, remains the touchstone for policymakers,[93] in Study 2 participants were clear that they lacked medical knowledge and would be reliant on health care professionals to assist them with treatment choices. It would be interesting to explore the extent to which these feelings of reliance extend to decisions about the organisation of health care.

On the other hand, however, as we have seen, participants - particularly the 'active campaigners' - soundly rejected the views of health care leaders proposing service changes in the area and sought to contest their competence. Scientific/ medical knowledge was downgraded both because it conflicted with their priorities and because the way it was framed effectively dismissed their local knowledge. This aligns with the discourses Michael identifies about science-in-particular: specific examples of science aimed at particular identifiable practical goals – in this case reorganising health care services to improve the quality of care. Whilst science-in-general is viewed by most people as a specialised and exclusive epistemological system, discourses about science-in-particular are concerned with two principal issues: the motivations and competence of science within specific contexts.

Like the Cumbrian sheep farmers, the 'active campaigners' found themselves in an ambiguous relationship to the commissioners. Whilst on the one hand they acknowledged their dependence on the medical profession in general, and may even deep down have felt some of the proposed changes were important, at the same time they were struggling against what they saw as a devaluation of both their own priorities and their local knowledge by the commissioners.

Michael observes that there is a complex interweaving of discourses about science-in-particular, and science-in-general 'that constructs and reconstructs science.' He notes

> People are not solely disenchanted or disinherited in the face of science; rather, they discursively manoeuvre around science in a variety of trajectories that can, on one hand, sustain the mystique and the status of science and, on the other, undermine them.[112]

How does this manifest in this study? I think there are two complementary examples which illustrate this interweaving well. If we consider first participant GA.9, the 'active campaigner' who wrestled with the issue of whether greater consultant presence was

really necessary and concluded that that's 'not really what this is about... it's all about the cuts.' She places decisions about reconfiguration in a much broader political context. For her, even if greater levels of senior cover might be better for her and for other patients, this issue would simultaneously detract from the real issue as she sees it, the threat to a comprehensive health service. In GA.9's interview, the commissioners' plans are embedded in a complex of other issues, particularly the government's austerity measures. She invokes an alternative set of interests to challenge the legitimacy of the commissioners' aims, just as Wynne's sheep farmers problematised the value and the validity of science post-Chernobyl by tying it to governmental interests. Michael's theory would suggest that, by constructing a narrative which depicts the commissioners as untrustworthy, driven by suspicious motives and acting contrary to the views of other medical professionals, GA.9 is able to dismiss the legitimacy of their argument about consultants, whilst simultaneously maintaining her own faith in the medical profession to be there for her when she needs it.

In contrast, participant GA.5 drew upon his own scientific background to critique the efforts of the commissioners. He was another 'active campaigner' who had put a great deal of effort into reviewing the details in both the consultation document and the pre-consultation business case. He explained:

> As a scientist, I'm used to looking… If somebody presents me with a written report I don't read the report I go and look at the results section first and look at do these results make sense to me. With this thing, there's a lot of data and some of the data, as I've said, doesn't seem to add up. (GA.5)

Because he identified errors and inconsistencies in the documentation, the commissioners' efforts were portrayed as 'bad' science within the broader scientific context to which he has relatively privileged access.

In summary, during their interviews, in different ways, we see how both GA.5 and GA.9 situated the clinical rationale behind the proposals within a broader context. In doing so, they rendered it somehow morally ambiguous, by critiquing the proposals within expanded horizons that addressed respectively competence and politics. Using Michael's theory here as a framework offers us further insight into the rationale behind the 'active campaigners'' response to the proposals in Greenville. I have demonstrated already the tension that was evident between their loyalty to the hospital as part of the NHS and their beliefs about the sort of care they might actually want for themselves. Examining the data from this

perspective also highlights their attempts to undermine the mystique and the status of medical science by challenging the motivations and competence of the commissioners within this context. It also highlighted that this type of rhetorical manoeuvring was confined to this subgroup, as we might expect, given the relative lack of engagement with the details of the case for change amongst other participants.

Risk and accountability

Alongside her suggestion that society today reserves the language for political talk about undesirable outcomes, issues of blame and morality are also central to the understanding of risk proposed by Mary Douglas. She observes that responses to risk are often directed towards governments and organisations that are perceived as being responsible for either causing or failing to prevent dangers. Risk thus becomes 'a stick for beating authority.' Jackson *et al* observe that within this framework particular risks may gather special salience and resonance and become battles over competing values, for example, when scientists are seen as imposing a particular view that is considered appropriate by the public. A group that perceives it has little power may select a risk as worthy of attention and dramatise its dangers to make their point.[135]

I think it is reasonable to say that there is evidence of risk being used in this way in broader debates about reconfiguration. Reconfiguration proposals often seem to be accompanied by media coverage which claims that 'lives would be put at risk' by the plans.[187] The implicit suggestion here seems to be that the authorities behind the proposals are responsible for causing that danger, or at least putting local residents in jeopardy. Interestingly though, most of these articles quote local politicians opposed to the plans, rather than members of the wider public.

Is there any evidence of risk being used as a forensic resource by participants in this study? Arguably, concerns about the implications of delayed access underpin much of the anxiety about the plans. However, there was in fact little attempt to dramatise the dangers or give them particular prominence, either by the 'active campaigners' or the wider public. The majority of participants, in both study areas, were simply not willing to consider travelling further. In fact, very few participants even used the word 'risk.' Certainly, none attempted to apportion blame directly, in the way Douglas suggests, by claiming that the commissioners were somehow responsible for putting patients 'at risk.' Where the term 'risk' was used in relation to reconfiguration it was the hospital or specific services that were described as 'at risk.' Notably, however, it was only participant GP.1, one of the

'worried uninvolved,' who used this phrase. None of the 'active campaigners' made reference to risk in this context, although they were certainly concerned about the impact of the plans for some sections of the community.

What does this tell us? Repeated references to patients' lives being put at risk suggest that the perceived risk involved in reconfiguration proposals may well have acquired a special salience in national discourse about plans to downgrade A&E. It has certainly been selected as worthy of attention by politicians and the media, but - in this study at least – there is little evidence of it being used explicitly by local communities to apportion blame or responsibility to the commissioners. One might argue that by dramatising the dangers of consolidating services, politicians are touting for more votes by demonstrating their solidarity with their constituents, and newspapers are seeking to sell more copies by playing on their readers' implicit fears. Nevertheless, there is little sign that even the 'active campaigners' were seeking to hold the commissioners accountable in this way; their approach was much more aimed at undermining the commissioners' claims, as I described in the previous section, and seeking to communicate their view that Greenville needed a local hospital.

The importance of trust

This chapter has explored how patient and public priorities influence a local community's response to a consultation process when plans to reorganise A&E services are being considered. A key theme in this chapter has been the issue of trust – trust in the commissioners who put forward the proposals for change. This was particularly a concern amongst the 'active campaigners' and its importance is perhaps not surprising given that trust and credibility are widely acknowledged in the risk communication literature as major factors influencing the uptake and understanding of scientific messages.[151] As others have said, however, trust is difficult to create and easy to lose; once lost, it is extremely difficult to regain.[188]

The commissioners had sought to build trust by emphasising that the plans had been drawn up with clinicians who had worked in the area for a long time and were thus familiar with local health care needs. They had obviously invested time and effort into communicating the case for change via public engagement events and a large consultation document. And yet the local community who engaged in this process doubted both their motives and competence. Why was this? In Figure 10 below I propose a model which illustrates the central role that trust appeared to play in this process. It has particular

salience to the 'active campaigners' as, again, these were the individuals who were most engaged with the consultation process.

Figure 10: The role of trust in the public response to the Greenville consultation
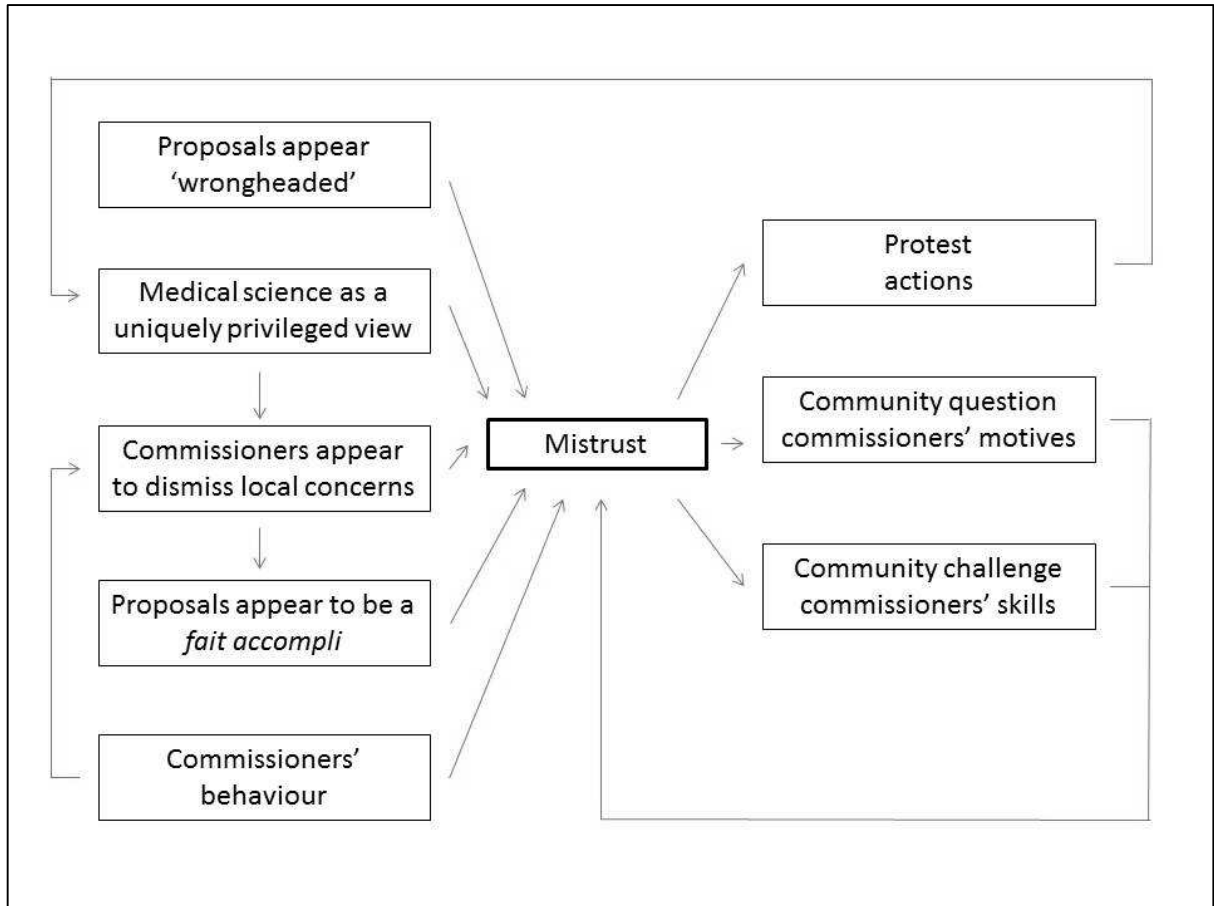
Causes of mistrust

Wynne argues that the public are likely to be sceptical, critical or hostile to scientific statements when such statements seem to emerge from an idealised and inappropriate model of real world conditions [149] and I think we see this evident here. The proposals in Greenville not only seemed to decrease both the safety and quality of care, they also conflicted with local people's knowledge and understanding, for example about travel in the area. At the same time, we have seen that for the 'active campaigners' there was a strong sense that the state had a responsibility to provide local communities with local hospitals, partly because of the importance of timely access – Greenville needed its local hospital.

The commissioners' expertise was ostensibly deployed in the community's interests; they believed they were doing the very best for local patients. However, their approach actually

encroached upon and often denied, rather than complemented, local people's own knowledge and beliefs. The importance of this cannot be overstated. Placing local clinicians at the forefront of the changes as trusted figures, providing a lengthy document explaining the case for change and organising a range of public events failed to change opinion in Greenville. In fact it had the opposite effect, because the proposals conflicted with the public's priorities for emergency services, their local knowledge and – in the case of many of the 'active campaigners' – their firm belief in the importance of local hospitals.

To compound this further, the commissioners were considered to not only be disregarding public concerns about the proposals, but also 'dismissing arguments as trivial.' As I have demonstrated, there was considerable strength of feeling about the risks and possible consequences of the proposals. Many participants wholeheartedly believed that travelling further would mean that 'people's lives are at stake' – their lives potentially and those of their loved ones. In addition, those who were involved in the consultation process at least considered that the decision was *a fait accompli*. There was very limited scope for them to express their concerns. The public engagement events were considered to not be genuine, largely because they focused on providing information, leading participants to feel that the proposals were being 'forced' upon them. Similarly, the consultation document provided no opportunity for the public to express their opposition or concerns. Finally, for those who were most involved in the process, the 'active campaigners,' the individual behaviour of the commissioners led to the public questioning whether they could be trusted, for example not attending key meetings, or being unable to answer attendee's questions.

Consequences of mistrust

Wynne argues that a failure to connect with the concerns of a local community will result in a loss of trust, conflict and dissonance. This again appears borne out in the case of participants in Greenville, and particularly so in the case of the 'active campaigners.' In the final part of this chapter, I used Michael's theory to demonstrate that although participants fully acknowledge their reliance on medical science-in-general, discourse about science can take on a conflictual form if that same science imposes a particular view that the public consider inappropriate.

As in Wynne's Cumbrian study, the commissioners in Greenville were seen to be imposing a particular view that the local community considered inappropriate and this led to scientific knowledge – in this case the clinical rationale for the changes – being consequently downgraded. Disenchantment with the commissioners and the case for change led

participants to question their competence and motivations. A number of participants were driven to protest against the proposals in a range of ways, whilst the 'active campaigners' were also led to try and seek loopholes in the documentation and to try and counter the commissioners' views with those of other local clinicians. Arguably, this and speculation about the motivations of the commissioners further fuelled the community's sense of mistrust.

It is interesting to question whether or not addressing the elements in the model would have been beneficial in terms of gaining the trust of the campaigners. I think the answer is probably not. Certainly, Michael's model would suggest that the campaigners actively sought to construct a narrative which depicted the commissioners as untrustworthy, in order to dismiss the legitimacy of their claims. As I have already said, it seems likely that those who place great emphasis on the significance of the local hospitals as institutions will always oppose plans that result in withdrawal of services. Nevertheless, the model in Figure 10 does highlight a number of issues that it may be useful for commissioners to take in to account.

As far as I can tell, none of the Greenville participants was knowingly receiving care from any of the clinicians involved in the reconfiguration. This is the first time Michael's theory about science-in-general and science-in-particular has been applied to the medical profession and the findings of this study appear to suggest that it applies in this context. Here, the clinical commissioners were framed as faceless bureaucrats, pushing through the changes. They were usually referred to as 'them', bracketing them as 'other', in contrast to participants own trusted clinicians who in many cases were seen to be on the side of the local community, opposing the changes. In the case of the commissioners, it would be interesting to know whether the perceptions of their own patients had changed because of their involvement in the plans. This is a potentially relevant area of future study, as the role of clinician-commissioners grows, in financially straightened times, and local doctors are increasingly called on to make difficult decisions about the organisation of care.

Summary of Study 2 findings

Study 2 set out to explore how the public evaluate the safety of hospital emergency services (research question 2) and the factors that influence the way in which they respond when proposals aimed at reconfiguring hospital emergency services are put out to consultation (research question 4). In terms of risk evaluation, it has demonstrated the relative importance of the magnitude of the potential outcome over and above probability,

as well as the significance of the widespread belief that timely access is associated with better outcomes. Within this view, a safe A&E department is one that can be accessed swiftly. Study 2 has also illustrated the ways in which this belief about access and outcomes impacts health care seeking behaviours.

With regard to the factors that influence the public's response to the consultation process, I have explored the ways in which participants' beliefs about both safety and quality impacted their response to the case for change, as well as the role that their local knowledge played in this. Amongst the Greenville participants, it was only really the 'active campaigners' who had engaged with the consultation process itself. Nevertheless, I have also described the ways in which their perceptions of the case for change, the commissioners' behaviour, and the mechanisms used to engage the local community all impacted their response to the process. Table 6 (p215) draws together the findings of the three previous chapters to summarise the findings of Study 2. It focuses particularly on the perspectives of residents in Greenville, but the Hilltown participants shared similar views with regard to access, inter-personal quality of care and hospital preference, even though service changes were not being proposed in their area. Within Greenville, we see that although most of the wider public were concerned about access, they held a range of views about the reconfiguration proposals, and hence had engaged with the consultation process to differing degrees. The table also demonstrates the ways in which the active campaigners differed from the wider public, in terms of their priorities for the health service, the way they framed their opposition to the proposals, and the degree to which they had engaged with both the case for change and the consultation process.

Table 6: Summary of Study 2 findings

	Campaigners	Wider Public in Greenville
Priorities	Timely access + provision of local services	Timely access + attentive staff
Hospital preference	Loyal to the local hospital, disputing claims about its poor reputation as inaccurate	Many acknowledge hospital reputation not good; either chose to go there regardless, or travel to another hospital
Extent of engagement with the reconfiguration proposals	Involved in campaigning to save the hospital, including activities over and above the consultation process	Various: some did not mention proposals; some pro-centralisation, others were concerned; only small proportion responded to consultation.
Concerns about the proposals	Concerns framed mainly in terms of impact for others (principally relating to access), especially deprived groups	Those who were concerned spoke about implications for themselves including increased travel time and impact of greater patient flows
Extent of engagement with the clinical case for change	Extensive	Limited. Most did not mention the clinical drivers behind the proposals
Views about consultant-delivered care	Most dismissed consultant-delivered care as unnecessary	Most felt it would be useful, even if they were not clear about the role of a consultant in A&E
Response to the consultation process	Process dismissed as flawed and undemocratic	Limited. One or two spoke about the long consultation document/ public meetings.
Response to the commissioners	Commissioners generally cast as untrustworthy and incompetent	None

Chapter 10: Study 2 discussion

The previous three chapters set out the findings from Study 2. This chapter will set these in the context of the relevant empirical and theoretical literature. First, the theoretical framework and relevant research questions are briefly revisited. I will then discuss the strengths and limitations of Study 2, before going on to review the main findings in light of the existing literature. The key messages arising from Study 2 are summarised in Figure 11 (p217). The next chapter, Chapter 11, will bring together the findings of Study 1 and Study 2 and set out the implications of the thesis for policy, practice and future research.

A number of bodies, including the Independent Reconfiguration Panel[1] and the King's Fund,[13] have called for urgent improvements to the process of public consultation about reconfiguration decisions. There is apparently an assumption that improved consultation processes will increase the likelihood of local communities accepting proposals for change.[5] Spurgeon and colleagues, however, suggest that consensus about reconfiguration decisions may be impossible because the differing emphases of stakeholder groups are largely irreconcilable. In particular, they argue, much of the public anxiety about proposals to reconfigure emergency services arises because proponents and opponents of change operate within different paradigms of understanding about risk.[5]

The theoretical framework for the thesis conceptualises the process of public engagement about reconfiguration decisions as a process of risk communication, which in turn involves stakeholders who each bring their own specific knowledge to the issue and seek to negotiate their differences. The thesis thus focuses on the way in which the public a) assess risk and b) respond to risk communication efforts in the context of reconfiguration decisions.

Study 2 set out to investigate research questions 2 and 4:

2. How do the public evaluate the safety of hospital emergency services?
4. What other factors influence the way in which the public respond when proposals aimed at reconfiguring hospital emergency services are put out to consultation?

Figure 11: Key messages from Study 2

- The belief that timely access to care is associated with better outcomes in an emergency is widely held. In terms of how participants assessed the risks involved in travelling further for care, the possibility of adverse outcomes played a more significant role than probabilities.

- Participants expressed a reluctance to access care at alternative urgent care facilities: they were uncertain about the location of such services and unclear what conditions could be treated there. There was also unease about the public being required to assess the urgency and severity of a problem, in order to decide which service to access.

- The case for change in Greenville had little resonance with participants, partly because it focused on technical aspects of care. Interviewees perceived that the proposals would decrease not only the safety of care, if patients had to travel further, but also the quality, as inter-personal aspects of care, such as waiting times, would be negatively impacted.

- Most participants were not prepared to accommodate the trade-offs inherent in reconfiguration decisions. This was partly because the proposed improvements to the technical aspects of care, such as consultant-delivered care, were not considered to be gains worth having, at the expense of timely access.

- The views of those actively campaigning against reconfiguration proposals may not be representative of the wider community. In Greenville, there was a range of opinion, with some participants in favour of change. Many of the campaigners perceived the proposals to be part of a wider plan aimed at dismantling the welfare state, which they opposed.

- Visible clinical leadership and detailed explanation of the case for change were insufficient to change the views of most of participants. This was not only because participants perceived that the plans would decrease the safety and quality of care, but also because they conflicted with interviewees' local knowledge and understanding.

- Trust played a key role in influencing the campaigners' reaction to the consultation process. Concerns about the case for change, together with the perception that the commissioners were dismissing the concerns of the local community, at the public meetings and in the wider consultation process, fuelled hostility to the proposals.

Strengths and limitations of Study 2

The literature review demonstrated that previous research and analysis concerning hospital reconfiguration has largely concentrated on policy issues; no studies have formally examined the views of patients and members of the public at large. Although the literature notes that safety and access are particular concerns for local communities, there is little in-depth information available beyond this. In addition, we do not know whether priorities for emergency care vary within different population groups, or indeed whether they vary in areas where reconfiguration is being considered, compared with areas where it is not. A major strength of Study 2 is that it has sought to address these gaps, by exploring the public response in detail and comparing the views of individuals from different population groups and geographical areas.

In Chapter 5, I identified the methodological limitations associated with using a case study research design in the context of Study 1. Concerns about the generalisability of findings based on a single reconfiguration are also relevant here. However, as with Study 1, it is also clear that the concerns raised in Greenville echo those raised previously by residents in other areas of the country.[1] Both the qualitative approach of the research design and the case study approach allowed for a robust analysis and in-depth consideration of the public response to reconfiguration proposals in a real life setting, at a time when discussions about change were ongoing. This represents another strength of the study.

Review of main findings and contributions

In this section, I review the main findings and contributions of Study 2 in the light of the existing literature. I will consider first the way in which local communities assess risk, then the way in which they respond to both the case for reconfiguring emergency services and efforts aimed at engaging them in the decision-making process.

Public perceptions of risk

As the literature shows, opponents of A&E closures frequently express concerns that the proposals will put patients 'at risk' if they have to travel further for care. Building on Spurgeon *et al*'s observation that opponents operate within a different paradigm of understanding about risk, Farrington-Douglas and Brooks propose that concerns about access arise partly because the public consider patient safety to be a function of travel time to A&E.[7] These perspectives formed a starting point for Study 2. Three main findings are reviewed in this section. The first relates to the way in which the public assess the safety of

hospital emergency services; the second and third to the impact this has on their health care seeking behaviours in an emergency.

Risk assessment

The first main finding was that there was a widespread belief, shared across all the study groups, that in an emergency, timely access to A&E was directly associated with better outcomes. The priority for most participants was not just to get to the hospital, but to get into the A&E environment as fast as possible, in order to be rapidly assessed and commence appropriate treatment. This view was shared by participants in an area where a reconfiguration was being discussed and in an area where it was not, suggesting that this perception is not just precipitated by the potential loss of local services.

Using Mary Douglas's work on the cultural role of risk as a theoretical focus helped explain the significance of this belief. Rather than a continuum of severity, for most interviewees there seemed to be a binary distinction between life-threatening conditions that require immediate medical intervention and all other conditions that require emergency care, for which time is less critical. Participants fully recognised that there was a low probability of them suffering a medical event that required a time critical intervention. However, because most believed that timely access is associated with better outcomes, the magnitude of the potential outcome if delays are incurred – death – was much more important. As Douglas suggests, the possibility of adverse outcomes played a more significant role in the way that participants in assessed risk.[133]

Conducting in-depth interviews with a range of participants enabled me to explore the belief about access and outcomes – or the way in which safety is a function of travel time in for the public[7] – in detail, for the first time. It also helped to illustrate not only how pervasive this perception is, regardless of whether or not a reconfiguration is being discussed locally, but also the role it plays in the way the public assess the risks involved in a reconfiguration. Using the contextual model of risk as a theoretical focus has helped me to demonstrate why local communities appear to operate in a different paradigm of understanding about risk, when a reconfiguration is being discussed, as Spurgeon *et al* suggest.[5] Study 2 has illustrated not only the influence of the perception about access and outcomes, but also the relative importance of adverse outcomes in the equation, rather than probabilities.

Impact on health care seeking behaviours

How does the belief about timely access and outcomes affect the public's decisions about where to access care in an emergency? The second main finding in this section relates to participants' choice of hospital; there were a range of views about this.

The 'localists' formed the largest participant group – individuals who would want to be taken to the nearest hospital if they were seriously unwell. For most, this choice was underpinned by their beliefs about access and outcomes. Most were positive about the care they had received in the past; one or two commented that the hospital did not have a great reputation amongst the community, but this would not deter them from going there.

In contrast, the 'avoiders' represented a small group who reported that they would prefer not to go to their local hospital in an emergency. In most cases, this was either because interviewees had had an unsatisfactory experience there in the past, or because they were aware that their local hospital had a poor reputation. Timely access still remained important for the 'avoiders': most noted that, living in an urban area, they were fortunate to have alternative hospitals relatively close by that did not require a significant additional journey. They would, however, be uneasy about travelling beyond this.

The third group were the 'loyalists.' Like the 'localists,' they reported that they would want to be taken to their local hospital in an emergency. The distinguishing feature of this group was their defence of that local hospital. Some described how the hospital had an excellent reputation, despite the claims of other participants, whilst others went to some length to explain why the hospital's poor reputation amongst the community was inaccurate.

The finding that participants held a range of views about where they would access care illustrates the importance of timely access to study participants. It is also important for two further reasons. First, Study 2 compares the views of patient and public representatives and active campaigners with those of the wider public for the first time. It demonstrates that, beyond the 'loyalist' active campaigners, the public are likely to be much more pragmatic about the standard of care at their local hospital. Many in both the Hilltown and Greenville groups acknowledged that their local hospital did not have a good reputation amongst the community, and in some cases, this had led participants to seek care elsewhere. The second reason is that it begins to illuminate one of the key factors that drove the 'active campaigners,' most of whom were also 'loyalists.' My analysis suggested that the focus of their loyalty lay not in the local hospital specifically, but rather in what it represented as part of a comprehensive national health service. Most of the campaigners

saw the reconfiguration proposals as part of a wider programme of government 'cuts' aimed at dismantling the welfare state.

The third main finding in this section relates to participants' choices about accessing care at alternative urgent care facilities, such as walk- in centres, rather than the local A&E. There was a very limited awareness of alternative options locally and, as a consequence, in an emergency, most participants would go to the local A&E by default. However, participants also reported a reluctance to seek emergency care at an alternative facility. There were two main reasons for this. First, they recognised that they would not know where the alternative facility was, so they would rather go to an A&E they know, than spend time looking up directions. Second, participants were unclear about which conditions could be treated by alternative services; the variable nomenclature used to describe such facilities compounded this (eg 'urgent care centre', 'walk-in centre', 'minor injuries unit' and so on). Underpinning both these practical problems was a widespread concern about having to distinguish between a problem that requires A&E care and one that could be treated at an urgent care. This related in turn to worries about the implications of making the wrong choice, and the potential consequences that might result – again – from delaying timely access to medical care.

There is a growing literature exploring the impact of the increasing complexity of the urgent care system on patients in England. However, much of the empirical research in this area has relied on survey methods.[176, 178] My approach here, again informed by the contextual model of risk, adds to this body of work by demonstrating not only why patients may be reluctant to access care at alternative urgent care facilities, but also the way in which beliefs about timely access and outcomes influence this. As I will go on to explore in the next chapter, this finding has important implications not just for UK policy aimed at increasing the diversity of urgent care facilities, but also for future reconfigurations which include proposals to replace A&E units with urgent care centres, in the belief that this will appease public concerns about having to travel further for care, if local services are downgraded.

Engagement with the case for change

Some argue that consultation about reconfiguration is marked by conflict because the case for change has not been articulated clearly enough to local residents. Consequently, improved public involvement and consultation, including stepping up efforts to explain the rationale for change, are seen as a solution.[9, 13] Yet, this approach – seeking to address a

'deficit' in public understanding – has been widely criticised in the risk communication literature, along with its assumption of 'public ignorance' in matters of science and technology, and the belief that science offers a uniquely privileged view of the world.[149] Instead, the contextual model of risk communication suggests that discontent with expert knowledge is likely to arise when 'expert' accounts of physical reality conflict with local people's knowledge and understanding.[152]

The second focus of the analysis in Study 2 was on the intersection of local and expert knowledge in the consultation process, specifically looking at the factors that influenced the way in which a local community responded to the case for change put forward by the commissioners. Three main findings are reviewed in this section.

The first provides context for the findings about the way in which participants responded to the content and mechanism of the consultation process, set out in this section and the next. Amongst the Greenville participants, there was a range of engagement with the local proposals, from those who stated that they were in favour of the changes, through to those who were actively campaigning against them. Equally some did not mention the plans at all. There was also a range of views about what was happening in Greenville and why it was taking place, with most participants linking the case for change to wider austerity measures ongoing at the time of the interviews. Beyond the active campaigners, only a small number of participants felt compelled to get involved in the consultation process. These were individuals who felt a responsibility to express their views.

Previous research exploring the priorities of different stakeholder groups has largely focused on the views of members of official patient involvement committees. Study 2 compared the views of this group with the views of the wider community for the first time. It demonstrated the breadth of views that exist, and particularly the clear distinction between the views of those involved in actively campaigning against the proposals and the public at large. In doing so, it supports Parkinson's argument that the views of those most often heard in debates about reconfiguration proposals are not necessarily representative.[66]

The second main finding in this section relates to the way in which the wider public evaluate the content of reconfiguration proposals. The model I proposed in Figure 9 (p184) illustrates how participants' local knowledge and understanding of health care were both brought to bear in the way that they evaluated expert knowledge in the form of the case

for change. The model encompasses both travel to hospital and the quality of A&E services. Drawing on their personal knowledge of the local area, participants identified a range of practical barriers that would have to be overcome in order to access care at an alternative hospital. These included traffic congestion hot spots, complex journeys on public transport, and the cost and challenges of parking. Many of these were issues of convenience, but some also had the potential to delay timely access in an emergency, thus posing a risk in the eyes of interviewees.

On arrival at hospital, to use Donabedian's definition again,[189] the inter-personal quality of care proved to be more relevant to participants than aspects of technical quality, which are often the focus of commissioners. For participants in Study 2, this related to the extent to which patients felt that they were being looked after and not being left to wait unduly in the A&E department. Because of the relative importance participants placed on the inter-personal aspects of quality of care, there was a perception that, if services were consolidated, increased patient flows would mean that waiting times would go up and staff would be significantly more stretched, thereby decreasing the quality of care. In terms of technical quality, whilst the campaigners mostly dismissed the commissioners' arguments about consultant-delivered care, for example, the wider public perceived that there would be very little difference between the clinical care currently provided by hospitals. Most were hazy about the actual role of a consultant in A&E and hence what value they might bring, which was central to the case for change. Farrington-Douglas *et al* observe a 'lack of public understanding' about the clinical safety arguments in favour of reconfiguration.[7] This research explains why arguments based on technical quality often do not resonate with the public.

Previous research has sought to describe the types of claims and arguments presented by different stakeholders.[5, 7] Study 2 goes beyond this to explore why the public respond to reconfiguration proposals in the way that they do, and the factors that influence their response. Specifically, it highlights a number of areas in which the views of experts and the public are discordant, for example around the safety and quality implications of the proposals and the way in which future services will accommodate increased patient flows (or not). The model outlined in Figure 9 (p184) represents one of the key contributions of this thesis. The insights it provides into the way in which the public evaluate proposals for change have a number of practical implications for commissioners considering reconfigurations in the future, as I will go on to explain in the next chapter.

The third main finding in this section also represents a significant contribution of the thesis. Reconfiguration decisions require trade-offs between the drivers of change that include quality and safety, workforce, cost and access. As a result, the proposed changes will often have drawbacks as well as advantages for stakeholder groups.[1] Spurgeon *et al* argue that although many of the professional organisations seem to downplay this aspect of the process, it is precisely these conflicts and trade-offs which make reconfiguration difficult.[5] Study 2 explored for the first time the extent to which the public are prepared to accommodate the trade-offs inherent in the case for change. With the exception of a small number of participants who were in favour of the proposals, most were not prepared to accept trade-offs between access and aspects of technical quality, including workforce concerns. This was not because they did not understand the notion of trade-offs. Instead, this was largely because they either did not consider trade-offs to be appropriate within the context of health care, or they did not consider improved technical quality of services, including greater consultant presence, to be a gain worth having at the expense of timely access. The model in Figure 9 (p184) illustrates how the public respond to the case for change and hence goes some way to explaining why this may be the case.

Engagement with the consultation process

Beyond the 'active campaigners,' with the odd exception, most of the Greenville participants did not appear to have become involved in the consultation process. Only one or two reported that they had completed the official consultation document or attended the public engagement events. It is not clear what led some to get involved, but not others. However, this relative lack of engagement is interesting in itself, especially as many interviewees were concerned about the implications of the proposals. As a consequence, the main findings reported in this section about the consultation process largely relate to the 'active campaigners.' In terms of the factors that influenced the way in which this group responded to the mechanism of the engagement process, there were two major influences, which I will consider in turn.

The first influence on the campaigners' response was the actions of the commissioners themselves. The commissioners had gone to some lengths to demonstrate that the proposals were led by clinicians who had extensive experience of working in the area. However, it was not clear that the wider community were aware of this or – if they were – that it had impacted their views. Many of the 'active campaigners' on the other hand had had some degree of contact with the commissioners, but the clinical leadership and endorsement of the reconfiguration plans had apparently failed to convince them to accept

the proposals. This may well have been because they were fundamentally opposed to the content of the plans, which many saw as an attempt to reduce health service provision, and therefore their view would not have been altered, whoever was fronting the reconfiguration. However, several commented that the commissioners had appeared to dismiss participants' concerns and local knowledge as either trivial or irrelevant. In addition, their actions – for example, hiring prominent venues for public meetings – gave the impression, not just to the campaigners, that the public were being given 'lunch instead of the facts.'

The reconfiguration of stroke services in London has been held up as an example of good public engagement practice for commissioners to follow when putting forward proposals for service change.[186] It is interesting to reflect on this recommendation in the light of the findings of Study 2. Some have argued that the changes in London were implemented relatively easily because there was a clear and strong case for change, and clinical leaders played a prominent role in delivering it.[186] In Greenville, it was only the 'active campaigners' who acknowledged that some aspects of emergency care had been centralised in their local area. These individuals held a range of views about those changes, which they mainly framed in terms of the safety implications of having to travel further for care. Reviewing the responses to the London stroke consultation, it is clear similar concerns were raised at that time. Whilst many consultation respondents in London agreed with the principles underpinning the stroke proposals, others were concerned that travelling further in an emergency would put patients at risk. Nevertheless, the stroke proposals were implemented with relatively little public opposition.[186] It may be that the case for change was put across in a particularly convincing way in London, but stroke is relatively unusual in that there is strong evidence to show that centralising services can improve outcomes.[18] Fulop et al studied the process and 'results' of hospital reconfiguration in three case study sites in the English NHS, involving a range of acute services including A&E and maternity care. They observed that the strength of local opposition was primarily related to the content of the proposals and particularly the extent to which services were being withdrawn. This in turn was influential in the outcome of the reconfiguration: where reconfiguration was perceived as a 'downgrading' of service provision, there was more conflict.[8] Crucially, reorganisation of stroke care has not yet resulted in a closure of frontline services. In London, the proposals involved withdrawing stroke services from some local hospitals; emergency care remained the same for the majority of other conditions, including the situations that participants in Study 2 particularly feared, where

the nature of the problem is unclear or particularly time critical. I suggest that the relative lack of conflict when the stroke reconfiguration was being discussed in London was at least in part due to this. In contrast, clinical leadership was not a sufficient influence in Greenville, when services were being withdrawn and there was uncertainty about the likely impact on patient outcomes.

The second influence on the campaigners' response in Greenville was the methods the commissioners used to communicate the case for change and then solicit the views of the local community. In addition to the public events already discussed, the commissioners had also sought to explain the case for change in considerable detail via a lengthy consultation document. Rather than allaying the community's fears, there was a sense that this document was both inaccessible and impenetrable, 'messing with our heads,' as one participant put it. Others feared that, despite its detailed nature, the consultation didn't provide the public with sufficient details about the full implications of the plans.

Trust played a pivotal role in the public's response to the engagement process, particularly for those who were actively involved. The proposals in Greenville were perceived as decreasing the safety of care, because patients would have to travel further to access care; they also conflicted with local people's knowledge and understanding, for example about travel in the area. At the same time the commissioners were perceived to be dismissing the community's concerns as trivial and not allowing them to express their opposition. This led to a sense of mistrust which prompted the active campaigners to challenge the competence of the commissioners and question their motives, feeding back in to the sense of mistrust.

In summary, drawing on theories of risk communication, and particularly examining the engagement process in the light of the literature about the deficit model of risk communication, has led to new knowledge about the impact of methods currently used to engage the public. In particular, my analysis suggests that rather than improving trust in the plans, the approach currently advocated by the King's Fund[13] and the IRP[1, 31] may in fact have the opposite effect and contribute to public opposition. Study 2 suggests that recommendations aimed at improving the consultation process by providing the public with more details about the case for change may fuel resistance amongst the local community, if commissioners continue to regard medical knowledge as pre-eminent and fail to acknowledge residents' local knowledge and perspectives on health care. This

represents a significant contribution of the thesis and has a number of implications for future policy and practice, as I will explore in the next chapter.

Theoretical implications

So far this chapter has discussed the main findings from Study 2 in the light of the theoretical and empirical literature. The next section will summarise the contributions it makes to knowledge about how the public assess risk more broadly and respond to both the content and mechanism of risk communication processes. First of all, I will review the conceptual framework in its entirety in the light of my findings, before going on to consider each of these processes in turn.

Using the theoretical framework

The theoretical framework conceptualises the process of public engagement as a process of risk communication. The concept of risk naturally lies at the heart of this framework, which informed the research questions, the data collection methods and the analysis. I explored the limitations and critiques of the individual theories that make up the theoretical framework in Chapter 2. However, it is worth briefly considering here the limitations of this broad approach.

In a paper written in 2009, Green observes that it has become popular to situate research within the field of risk, and use it as an analytical focus, as I have here.[190] She argues that, although it has proved a fruitful means of generating theoretical understanding about the ways in which individuals make sense of threats to their health, it may be time to 'abandon an over-reliance on theoretical accounts of risk' for framing empirical studies. One of her concerns is that working within this perspective creates a danger of over-interpreting data that do not necessarily even appeal to the concept of risk. Allied to this, is the danger that using risk as an analytical focus not only pre-empts empirical findings, but also the analysis of those findings, such that everything else is merely interpreted in relation to risk. In other words, researchers will continue identifying 'lay concepts of risk' if that is how they frame their research, and may 'find risk' even when it is not there.[190]

In the context of Study 2, there is of course always a chance that using risk as an analytical focus meant that 'risk' was prioritised in such a way that the analysis misrepresents the importance of other factors that contribute to the way in which the public respond to reconfiguration proposals. However, before I embarked on the research, it was clear that the concept of 'risk' was a key part of the wider national discourse about A&E closures, in

terms of the risks that may be involved in travelling further to access care in an emergency. It thus seemed important to explore the issue through this lens. In the previous section, I showed how this approach has furthered our understanding of the public response to reconfiguration proposals, and provided some apparently valuable insights, for example around the way in which the public assess the risk that would be involved in a reconfiguration.

The theoretical framework for the thesis was novel in the way that it framed the consultation process as a process of risk communication, but also in the way it combined the perspectives of Douglas, Wynne and Michael. Figure 12, below, sets out a more detailed version of the framework, revised in the light of my findings. In Chapter 2, I hypothesised that these perspectives would be complementary. Overall, this appears to have been the case, as Figure 12 demonstrates. For example, combining the perspectives of Douglas, Wynne and Michael proved valuable in terms of elucidating the way in which participants drew on both their evaluation of the risks inherent in travelling further for care, as well as their own understanding of the local area and its health services, to form an assessment of the proposals. Although many of the participants in Greenville had concerns about the risks involved in travelling further to access care, only the 'active campaigners' were involved in the engagement process in a meaningful way. However, the campaigners' perception that the commissioners were dismissing the public's concerns, perhaps reflecting a dismissal of other forms of knowledge beyond medical science, contributed to their dissatisfaction. The hostility that the campaigners then felt, as a consequence of both their assessment of the case for change and the public engagement approach taken by the commissioners, prompted them to seek to challenge the proposals by questioning both the competence and motivations of the commissioners.

Figure 12: Conceptual framework for the thesis – revised in light of findings
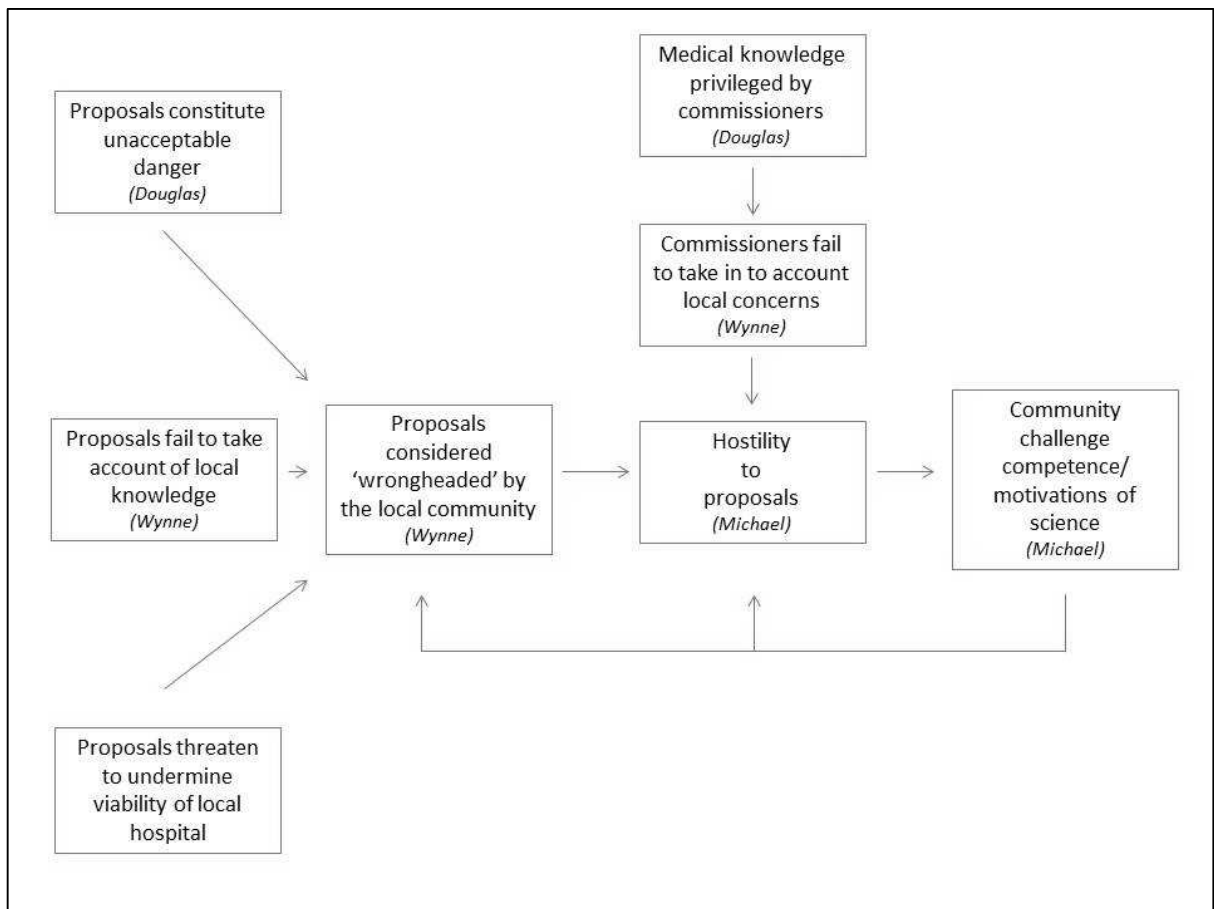
There is already a large body of literature on risk communication and public understanding of science. However, there are a number of ways in which the research described here adds to this body of work.

Contributions to knowledge about risk assessment

Study 2 offered a detailed analysis of how the public assess the risk involved in travelling further to access care in an emergency, including the factors that contribute to this assessment. It supports Douglas's assertion that, for the public, risk has weakened its connection with technical calculations of probability.[133] This is not because the public are weak on probabilistic thinking: here there was evidence that the public recognised that the likelihood of them requiring a time-critical intervention was small. Nevertheless they were still unprepared to accept the risks they perceived to be involved in travelling further to access care. This provides further evidence to support the contextual model of risk, which argues that citing the very low probabilities of a particular risk makes little difference to the public.[129, 134] This study also explored why the prospect of having to travel further for care was considered unacceptable and the answer was clear: most participants believed that

timely access was associated with better outcomes and, consequently, that delayed access could result in death. In other words, this risk was selected as important because interviewees especially valued what was under threat. This confirms the significant role played by the magnitude of the outcome in the way in which the public assess risk.[134, 135]

Together, these two observations also support Douglas's argument that the public today largely reserve the language of risk for talk about undesirable outcomes.[133] This has potentially important implications for other areas of medicine, such as public health, where the public's assessment of the severity of a particular risk seems to be at odds with the 'expert' technical assessment.[114]

Douglas also proposes that risk has become a forensic resource for holding others accountable and apportioning blame – a concept invoked to protect individuals against the encroachment of others.[134] Interestingly, although most participants had concerns about the implications of travelling further for care in an emergency, there was little evidence of them using this as a tool to hold the commissioners accountable, even amongst the campaigners. Nevertheless, there is plenty of evidence of risk being used in this way in broader debates about reconfiguration, for example by politicians claiming that 'lives will be put at risk' by the proposals. This suggests that Douglas's concept of a risk as a forensic resource[134] may only have resonance in certain settings, for example, the political arena, but more research would be needed to explore this.

Contributions to knowledge about risk communication

As highlighted earlier in this chapter, this thesis has provided a detailed analysis of the pitfalls of the deficit approach to risk communication, demonstrating how methods aimed at increasing public trust in engagement processes may in fact have the opposite effect. It also provides further evidence that relying on experts to communicate risk messages will not automatically lead to acceptance of those messages amongst the public.[148] In Greenville, the proposals were clinically-led, but this in itself had not led to acceptance of the proposals amongst most participants. Study 2 demonstrated that this was partly because interviewees perceived that the proposals would have a negative impact on the quality and safety of services, and also because the plans failed to connect with their knowledge of the area. The Cumbrian sheep farmers in Wynne's study rejected the scientists' advice as 'wrongheaded' for similar reasons.[151]

The risk communication literature already acknowledges that trust is a major factor influencing the uptake and understanding of scientific messages.[152] This study adds to this,

offering novel insights into the factors that lead to mistrust, as well as the pivotal role it can play in fuelling and perpetuating public hostility.

Study 2 also drew on Mike Michael's work about the ways which the public negotiate 'science' in discourses about risk,[112] to examine the ways in which the public relate to the medical profession when clinically-led reconfiguration proposals are being discussed. The use of this work as an analytical focus assumed that participants in Study 2 were aware that the proposals were clinically-led; in fact it was not clear that the wider public beyond the active campaigners acknowledged this. Nevertheless, many participants spoke about their lack of medical knowledge, which rendered them reliant on health care professionals and medical science. In Michael's research, interviewees regarded themselves as having a 'global scientific ignorance,' bracketing scientific knowledge as inaccessible and 'other.'[112, 113] In Study 2, medical knowledge was not just bracketed as 'other' by participants; interviewees expressed a strong sense dependence on the individuals who held that knowledge. Many interviewees regarded it as the responsibility of health care professionals to decide on the best course of action on their behalf in an emergency. On the other hand, whilst many acknowledged their reliance on the medical profession per se, the active campaigners also sought to challenge the case for change in Greenville and the clinical knowledge that informed it, by questioning the commissioners' competence and motivations. Although this challenge did not extend to the commissioners' clinical competence, rather their commissioning efforts, the campaigners sought to invoke the views of their own, trusted doctors, to challenge the case for change. In this way, Study 2 provides a detailed example of how discourses about a specific aspect of science can be used by the public to downplay the privileged status of science.[112]

In summary, this chapter has reviewed the findings of Study 2 in the light of the relevant empirical and theoretical literature, and outlined the contributions it makes to these bodies of work. It has also reviewed the conceptual framework for the thesis, and demonstrated the novel insights gained by framing the engagement process as a process of risk communication. The next chapter, Chapter 11, will bring together the findings of Study 1 and Study 2 and set out the implications of the thesis for policy, practice and future research.

PART IV – THESIS CONCLUSIONS

Chapter 11: Conclusions and implications for policy, practice and future research

Chapter 11: Conclusions and implications for policy, practice and future research

The main findings of Study 1 and Study 2, as well as the strengths and limitations of both individual studies, were reviewed in Chapter 5 and Chapter 10 respectively. In this chapter, I consider first the strengths and limitations of the overall thesis, and then its implications for policy, practice and research in the future.

Strengths and limitations of the thesis

Study 1 and Study 2 together paint a picture of the practices that are currently used to engage the public in decisions about hospital reconfiguration. Although the context of each reorganisation was different, we can see similarities in both the methods used and the way in which the public responded to those engagement efforts. They provide for the first time a detailed exploration of the determinants of the public response to reconfiguration proposals and the impact of the approach commonly used by commissioners and advocated by policy. By examining the proposals through the lens of socio-cultural perspectives of risk, rather than the psychometric perspective favoured by the biomedical literature, it has been able to offer a range of novel insights.

Nevertheless, both of these reconfigurations were taking place in urban areas, with a relatively high population density and a high concentration of hospitals relative to the population size. The findings may therefore be less relevant in other settings, for example rural parts of England. The field of investigation was also subject to rapid and ongoing political change, as is often the case in health services research.

As Bosk observed, 'all field work done by a single field-worker invites the question, "why should we believe it?"'[191]This is particularly relevant in the case of doctoral studies. However, this research was never an isolated endeavour. Throughout the process, my ideas were tested via regular academic supervision and peer review by both academic and service colleagues.

Implications for policy

Study 1 highlighted the current lack of clarity about the goal of public involvement in health care decision-making, and its consequences. Involvement is a key plank of health care policy, which promises patients and public a central role in decision-making.[56] In reality,

local communities are often left concluding that involvement initiatives are a sham, because their views do not seem to have had an impact.[7]

By nature, reconfiguration decisions require trade-offs between the interlinked drivers of change: quality and safety, workforce, cost and access.[13] However, one of the main findings of this thesis is that the public may simply not be willing to accept these trade-offs. What are the implications of this? First, we cannot automatically assume that in the future the public will be prepared to consider accepting service changes which may compromise timely access. Second, it suggests that efforts to convince local communities of the need for change, for example by providing more detailed information about the clinical rationale, are likely to fail, such is the pre-eminence of access in the minds of the public.

Over the past few years, there have been efforts to increase the diversity of urgent care provision, partly to divert patients away from A&E departments.[179] This thesis calls this approach in to question. Policymakers should note the fact that the public have significant reservations about accessing care at alternative facilities, partly because of their concerns about assessing the severity and urgency of a problem and potentially failing to identify something that requires the services of a full A&E. Whilst this anxiety may be difficult to alleviate, more work should be done to provide information about the services offered by existing alternative facilities, including information about access and the conditions which can be treated there.

Implications for practice

The thesis offers a number of practical recommendations for those considering hospital reconfigurations in the future. First, however, it is important to set these in context. My findings support Spurgeon *et al*'s assertion that within the setting of the current English NHS, there is a 'likelihood that conflict over hospital reconfiguration will persist.'[5] This thesis provides further evidence to demonstrate why this is the case. Whilst reconfiguration proposals involve the withdrawal of services, this thesis suggests that there can be no 'magic bullet' that will overcome resistance to change and lead to smooth acceptance of proposals by the whole community.

At the same time, because of the widespread perception that timely access is associated with better patient outcomes, a safe A&E for the public is one with a full range of services that can be accessed quickly. This thesis has shown that providing information to the contrary, even if it existed, would be unlikely to be sufficient to change hearts and minds.

Another factor also compounds this: participants spoke powerfully about the burden of responsibility relatives feel prior to arriving at hospital. Commissioners would do well to recognise this when putting forward proposals that involve longer journey times to hospital. Whilst it seems unlikely that concerns about delayed access can ever been completely allayed, the thesis has identified a number of other practical worries that could be better addressed. For example, when proposals for change are being communicated, work is needed to address the perceptions that ambulances are dispatched from the nearest hospital and that paramedics are little more than ambulance drivers.

I recommend that, going forward, commissioners should no longer rely on the 'deficit' approach in their public engagement efforts, striving harder and harder to communicate the case for change. Instead, there is a need for a new approach to engagement which views risk communication as a two way process, and does not regard the local community as lacking education, but rather takes into account the fact that the way the public process information is shaped by their previous experiences and personal circumstances. There are two aspects to this. The first is for commissioners to acknowledge that the public may well have legitimate concerns about the implications of proposals, based on their local knowledge and understanding of the health service: one of the significant factors that contributed to the public hostility towards the proposals in both North London and Greenville was that the commissioners appeared to dismiss the public's concerns as irrelevant in the face of the clinical evidence, rather than actually engaging with them. The second aspect builds on this to consider proposals through the eyes of the public, prior to consultation. The model of patient and public priorities I proposed in Figure 9 (p184) may assist with this. Such an approach would consider not only the arguments for change based on technical quality, but also the likely impact of the proposals for safety and interpersonal quality in the eyes of the public, and in turn how these concerns might be addressed at the planning stage.

Simply improving the way in which the case for change is communicated during a consultation, providing the local community with large amounts of information about the clinical rationale for change, is unlikely to reduce public opposition to reconfiguration proposals. However, notwithstanding this significant caveat, the thesis has shown that there are a number of areas where there is scope to improve communication between commissioners and the local community.

Information about additional travel times is typically framed in technical terms, for example, number of miles 'as the crow flies' or blue light ambulance times. In contrast, this study has demonstrated how the public assess the logistics of travelling to an alternative hospital in the light of their local knowledge. With the belief about access and outcomes always a consideration, there are very real concerns about local traffic hotspots, public transport options, and the challenges of parking. For many, travelling to an alternative hospital involves not only risk, but also potentially a burden of inconvenience and cost. It would be helpful for commissioners to set out the steps that are being proactively taken, for example to improve public transport links or expand parking capacity. In addition, certainly in the urban areas considered here, journey length was better expressed in terms of car travel time or number of modes of transport. Commissioners should also seek to express travel information in terms that are more meaningful to the local community.

In both Study 1 and Study 2, concerns were raised about how the alternative hospitals would accommodate patient flows. A lack of information about the way in which the remaining A&E services would be developed had led both local communities to surmise that facilities would not be expanded. Consequently, they assumed that because of increased patient flows, waiting times would go up and staff would be significantly more stretched, thereby reducing the inter-personal quality of care. Commissioners should make explicit credible plans that will be put in place to accommodate greater patient numbers, if the reconfiguration goes ahead.

Finally, the case for change typically focuses on the need to improve the technical quality of care. However, as Study 2 showed, the inter-personal quality of care is more relevant to patients' experience of A&E. Emphasising again that this alone is unlikely to be helpful in improving the engagement process, there are two particular, related areas where there seem to misperceptions, which influence the way in which the public interpret the case for change. The first of these relates to the need for consultant-delivered care. In Study 2, whilst many thought consultant-delivered care would be a good thing, there was a lack of clarity about the role of a consultant in A&E and therefore the value they may add. In addition, some believed that consultants dealt with specific medical conditions or patient groups. In other words, in an emergency patients are stabilised by generic A&E doctors and then referred on to the relevant consultant. If commissioners are seeking to communicate workforce reasons for change, I recommend that they should first make clear the role of A&E consultants and the way in which they are distinct from junior staff in A&E. The case

for change in Study 2 referred to unacceptable variations in care between the hospitals. However, the local community perceived that there would not be variations between hospitals, partly because they considered that all doctors would have undergone similar training and therefore offer a similar service. If commissioners draw on this argument in future, as well as providing information about how A&E is staffed as described above, they should provide simple, clear information about the nature of these variations and the impact they could have on patient care.

Implications for future research

I have already outlined areas where future research may be useful, for example around the impact on the doctor-patient relationship amongst patients whose own GPs are involved in making difficult decisions about health care services in the area. This will become increasingly relevant as the role of GP commissioners gains greater prominence.

In terms of urgent care services more broadly, I have outlined concerns about the direction of policy which creates an increasingly fragmented urgent care system and requires patients to not only assess the likely severity of their problem, but then identify which service to take it to. In order to address these challenges, there is scope for more in-depth work building on this research to explore in greater detail the factors that influence patients' decisions about where to access care in an emergency and the type of information that might help them in this process.

The risk of travelling further for care in an emergency is a significant concern for the public, and the evidence about this remains equivocal. For reasons I have already outlined, it is unlikely that evidence ruling out harms would completely assuage these worries, even if it existed. However, an experimental study to address this question would be challenging and potentially unfeasible, not least because it would need to be coordinated across a large number of centres, over many months, to ensure sufficient numbers of patients.

Concluding remarks

This thesis has illustrated how the current approach used to engage the public in reconfiguration decisions is not only out of step with best practice in terms of risk communication, but also fuels opposition to such proposals. My findings strongly suggest that current recommendations aimed at improving the engagement process are unlikely to be sufficient in terms of addressing the hostility that patients and the public feel towards reconfiguration proposals, and may even contribute to local opposition. Moreover, I have

demonstrated that patients and the public are simply not willing to make the trade-offs that reconfiguration decisions require of them. In this chapter, I have set out a number of recommendations for those considering reconfigurations in the future.

Appendix 1: Key to abbreviations and terms used in the thesis

A&E | Accident and emergency department of a hospital, also known as the emergency department

Access | Used in this thesis to describe patients' use of services

BEH | Barnet, Enfield and Haringey, three boroughs in North London

BME | Black and minority ethnic

CCG | Clinical commissioning group, organisation responsible for commissioning NHS acute care for a defined geographical area since 1 April 2013

CEM | College of Emergency Medicine, the body responsible for setting standards of training in Emergency Medicine in the UK

CHC | Community health council, bodies established in 1974 to provide a voice for patients and the public in the NHS in England, and then abolised in 2003

Commissioners | Individuals responsible for commissioning and purchasing health care for a defined population

DCE | Discrete choice experiment, an economic tool used to understand the preferences of patients and health professionals

DGH | District general hospital, a facility providing a range of secondary care services for a local community

EWTD | The European Working Time Directive, which has restricted junior doctors in the UK from working more than 48 hours per since August 2009

FT | Foundation Trust, part of the NHS in England that has gained a degree of managerial and financial independence from the Department of Health

GP | General practitioner, a primary care doctor

HOSC | Health Overview and Scrutiny Committee, local authority committee which looks at health issues and health services affecting local residents

IOM	Institute of Medicine, body which provides advice on issues relating to biomedical science, medicine, and health in the United States
IRP	Independent Reconfiguration Panel, body which has advised government ministers about re-shaping hospital services in England since 2003
LINks	Local Involvement Networks, local patient and public involvement fora, made up of individuals and community groups with an interest in improving local health and social care services. Replaced by Healthwatch in April 2013.
MP	Member of Parliament
MRSA	Methicillin-resistant Staphylococcus aureus
NHS	National Health Service
NS-SEC	National Statistics Socio-economic Classification, a UK social classification system based on occupation
Out of hours	Care provided outside of normal working hours, ie during evenings, nights and weekends
PCT	Primary Care Trust, NHS bodies responsible for commissioning care prior to April 2013
PFI	Private finance initiative, a method of funding public infrastructure projects with private capital
REC	Research ethics committee
Reconfiguration	Term used to describe a deliberately induced change of some significance in the distribution of available in each hospital in a locality or region
Teaching hospital	Hospital that is affiliated with a medical school and is usually a centre of secondary or tertiary care in a major city
Urgent care centre	Facility offering treatment for minor injuries and illnesses, usually with no appointment necessary
WHO	World Health Organisation

WRT   Working time equivalent

Appendix 2: Study 1 – background information

ANALYSIS

Hospital service reconfiguration: the battle for hearts and minds

Will Andrew Lansley's four tests for reconfiguration make decisions less controversial? **Helen Barratt** and **Rosalind Raine** discuss the challenges they raise

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Proposals to reconfigure NHS hospital services are always contentious. In 2001, Dr Richard Taylor won a parliamentary seat on the strength of his campaign against the decision to close acute services at Kidderminster Hospital.[1] More recently, plans to centralise surgical services for children with congenital heart disease have prompted opposition across the country.[2] The Independent Reconfiguration Panel (IRP) advises ministers about re-shaping hospital services and, by the end of 2010 it had undertaken 17 full reviews of contested proposals for health service change in England and offered written advice on several others.[3]

During the 2010 general election campaign, the Conservative party promised to stop "centrally dictated" reorganisations of NHS services.[4] Writing in the *Daily Telegraph* on 21 May 2010,[5] days after the coalition government came to power, the Secretary of State for Health, Andrew Lansley, declared a moratorium on such programmes. All proposals—even those at the implementation stage—were put on hold and planners were instructed to demonstrate that plans met four new tests: support from general practitioner (GP) commissioners, strengthened public engagement, consistency with patient choice, and clear evidence for change.

One high profile reconfiguration affected by the moratorium was the proposed downgrade of acute services at Chase Farm Hospital in north London (box). We provided academic input to the review of these proposals. In this article, we draw on this experience to reflect on the difficulties of applying the Lansley tests and propose ways to strengthen the evidence base to aid decision making.

Clarity on the clinical evidence base

The research evidence used to justify reconfiguration focuses on volume-outcome relations. A growing body of research shows improved patient outcomes when a range of procedures— including surgery for colorectal cancer [11] and elective repair of aortic aneurysm[12]—are carried out in larger units that serve bigger populations. However much of this research has been done in the US, where organisational differences may limit

transferring the findings to the NHS.[13] Furthermore, many of the studies are poorly controlled for the effects of confounding variables.

In contrast, an English study of retrospective data from ambulance call-outs for immediately life threatening symptoms found that increased journey distance to hospital was associated with increased mortality.[14] After case-mix was adjusted for, every additional 10 km in straight line distance was associated with a 1% absolute increase in mortality. These findings reflect the performance of emergency services between 1997 and 2001, and journey time may be less relevant now that paramedics commonly start definitive treatment.[15] In addition, the results may apply only to patients at high risk of immediate death. Indeed, preliminary data suggest that centralising specialist hyperacute stroke units across London is associated with reduced mortality compared with national rates.[16] This is likely to be because patients receive rapid access to thrombolysis. Findings such as these highlight the need for a thorough understanding of the interaction between geographical access and patient outcomes.

These data are largely drawn from observational research. Although such studies have limited power to demonstrate causality, experimental designs of major service reorganisations are usually not feasible.[17] In these circumstances, the case for change often relies on a combination of observational research evidence and expert clinical consensus.

Consistency with patient choice

This test is defined by the Department of Health as the extent to which proposals affect patients' ability to choose between providers, settings, and interventions.[18] However, research suggests that choice of provider is not, in fact, a priority for patients having elective care; respondents placed it as the 11th most important aspect of their healthcare in a list of 16 items.[19 20] It may be even less important for patients needing emergency care.[21]

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Chase Farm reconfiguration

Proposals to downgrade services at Chase Farm Hospital in north London were first raised more than 15 years ago.[6] They included replacement of the emergency department with an urgent care centre and consolidation of women's and children's services at Barnet and North Middlesex Hospitals, which are six to seven miles away. Other places will be grappling with similar decisions.[7]

In July 2009 work began on implementing the proposals, including building work on the North Middlesex site to accommodate increased patient flows. However, implementation was put on hold while the proposals were assessed against the four new Lansley tests.

May 2010: A panel of clinicians (mostly local GPs) was convened to review the clinical evidence underpinning the plans. The panel concluded that no change was not a possibility because the current situation was both "unstable and unsustainable" and would result in declining quality of care and worsening health inequalities.[8] All local GPs were invited to comment on the panel's conclusions. Patient and public engagement was sought through a series of public meetings and a supplement in local newspapers explaining the rationale for the proposals. Local involvement network representatives were involved in assessing the strategy against the patient choice test

January 2011: The strategic health authority, NHS London, concluded that the four tests had been met and that the reconfiguration could recommence

March 2011: The health secretary held a closed meeting with local MPs and Enfield council representatives, who were opposed to the proposals. Afterwards, Mr Lansley invited this group to submit alternative options to maintain services at Chase Farm

May 2011: The secretary of state referred Enfield Council's report to the IRP. The report did not include an alternative plan, but requested more investment in healthcare for the borough[9]

July 2011: The IRP concluded that the council's submission did not present a credible alternative to the current proposals and that the "status quo has real downside risk in terms of the current safety and sustainability of local services"[9]

September 2011: Andrew Lansley announced that he accepted the IRP's recommendations and that the proposals to downgrade services at Chase Farm could go ahead[10]

Moreover, the germane question is whether the plans are consistent with patient choice when people are presented with a trade-off between the perceived advantages and disadvantages of the current service compared with reconfigured services. Such trade-offs have not been formally examined but are likely to be influenced by community loyalty to local hospitals. Hospitals have an important social role, helping the public to maintain trust in the NHS.[22] Mixed methods (qualitative-quantitative) research exploring determinants of public opinion and the importance of the various components of the trade-offs (for example, proximity versus improved survival) would help us gain a better understanding of public and patient priorities. This could in turn inform future service reconfigurations.

Strengthened public engagement

Meaningful engagement requires that the public should be able to affect decisions.[23] Intensive stakeholder engagement and clear messages about the need for change help build a legitimate case for reform.[24] In reality, commissioners have been criticised for consulting on service redesign after decisions have been made.[3] To meet this test, commissioners are recommended to seek the views of local involvement networks and health overview and scrutiny committees. Beyond this, however, strengthened patient engagement remains challenging to quantify.

The previous government introduced several reforms aimed at increasing public involvement and local scrutiny of healthcare, and the IRP, established in 2003, was part of this.[25] The panel provides independent advice on reconfiguration proposals when local agreement cannot be reached, and its members include clinicians, management representatives, and lay members with experience in delivering health service change. One of the main reasons why reconfiguration proposals are referred to the panel is that commissioners have failed to convince affected communities of the clinical case for change.[3] However, there is little research or consensus on the best methods to secure public engagement.[26]

In terms of the economic rationale for change, the public are often deeply suspicious that reforms are a cover for spending cuts.[27] This may be a particular concern now that the NHS is under pressure to make efficiency savings.[28] In reality, the economic case for reconfiguration is seldom clear cut because it depends on the costs that are included (such as transaction costs and, where relevant, repayments on private finance

initiatives). In addition, long time frames, uncertainty about the future, and changing conditions make it difficult to predict future costs. Even if the changes are likely to save money and not harm health outcomes, public acceptability may be tempered by other important determinants of patient and carer experience such as travel times and costs.

Effective public and patient engagement requires explicit presentations of the clinical and financial risks, benefits, and implications of service change. The way that such information is framed is also important because it affects the way that it is interpreted.[29] The media sometimes exploit this by using sensationalist language to raise fears about large numbers of lives being put at risk, often with little or no supporting evidence.[30] As part of strengthening engagement, commissioners and providers must therefore disseminate transparent, comprehensive information in a form that can be understood by all sections of the affected community.

Support from GP commissioners

The fourth test reflects the coalition government's commitment to devolve decision making power to general practitioners. At the time of the Chase Farm review, commissioning groups were not yet established in the three main affected boroughs, so this test was assessed by inviting all local general practitioners to indicate whether they agreed with the recommendations. Response rates and percentage levels of support were then described for each borough.[31] However, in south Hertfordshire, which is also affected by the Chase Farm reconfiguration, the two general practice consortiums were asked to submit a written indication of their corporate views about the proposals, as suggested in the Department of Health guidance.

Since the Chase Farm decision commissioning groups have been broadened to include other health professionals, and the government will need to think again about how best to obtain the views of local GPs. A dichotomous indication of GP support is relatively simple to obtain. However, this gives no indication of the strength of their views. Such data could be obtained by asking GPs to provide more in depth information and respond to questions using a Likert scale. This approach is obviously more resource intensive and requires more sophisticated analytical techniques.

Additional drivers for change

Reconfiguration schemes are commonly driven by additional factors that are not scrutinised by the Lansley tests. These should also be taken into account when evaluating the rationale for change. First is the shift towards greater provision of services in community settings because of factors such as increasing day case surgery and a higher burden of chronic disease as the population ages.[28]

Workforce related factors that may affect patient safety are also important. The implementation of the European Working Time Directive tends to drive reconfiguration proposals in acute services with high emergency workloads.[32] It is argued that consolidation of acute services is required to ensure both a critical mass of junior doctors to maintain adequate standards of patient care and sufficient numbers of patients for satisfactory clinical training.[33]

Several royal colleges are also lobbying for higher levels of senior staffing to promote safer practice.[34][35] They argue that achieving this without service reorganisation would require a substantial increase in consultant numbers. Once again, it is not possible to apply experimental methods to prove such assertions. We therefore have to rely on observational data, and here there is some evidence of worse outcomes in patients who are admitted to hospital during evenings and weekends when fewer consultants are available.[36]

Future decisions

The Department of Health guidance does not set thresholds for meeting the four new tests, arguing instead that the process should be locally led and designed.[18] Furthermore, many of the requisite data are qualitative and require value judgments about their importance, relevance, and representativeness.

Research evidence will always comprise but one determinant of reconfiguration decisions, and there will be a trade-off with other factors, including local and national political concerns. Although organisations including the British Medical Association, the NHS Confederation, and the King's Fund have called for the IRP to become the final arbiter, thus distancing politicians from decisions,[37] it is naive to expect politicians not to support their constituents' concerns, even in the face of clinical consensus, particularly in marginal constituencies.

The relevance of the research evidence is also likely to be contested by stakeholders with different perspectives and values. It is therefore crucial to pay close attention to the transparency, comprehensibility, and comprehensiveness of the evidence and to ensure it meets the needs of all decision makers

Furthermore, there is room to strengthen the evidence base through a programme of national research that is generalisable to local circumstances. For example, a better understanding of the relation between geographical access and patient outcomes would be valuable. We would also benefit from a better understanding of what concerns the public and the trade-offs that patients and their families are prepared to make when considering major service change.

Another problem is that the four tests could produce conflicting outcomes. For example, the evidence may suggest clinical benefits from reconfiguring services on fewer sites. But this could reduce patient choice of provider. It may be more acceptable and transparent to define the relevant components of benefit and patient choice and their order of priority with local stakeholders before plans for reconfiguration are made.

Finally, changes set out in the NHS Bill could raise additional challenges. The extent of involvement of multidisciplinary clinical commissioning groups, clinical networks, and senates, as well as the potential role of the National Commissioning Board, is currently unclear and will need to be considered. Without regional structures to guide the process, it is unlikely that single commissioning groups will have the resources to conduct the necessary analyses required to assess the case for change or wield sufficient power to initiate reform across large geographical areas. Decisions concerning service integrations involving multiple hospitals may also be influenced by the promotion of competition between trusts.

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Appendix 3: Study 2 - topic guide

Helen Barratt - interview topic guide

Introduction

Aim: To introduce the research and set the context for the proceeding discussion

- Introduce self
- Introduce the study: who is it for, what is it about
- Talk through key points:
    - Purpose of the interview
    - Length of the interview
    - Voluntary nature of interview
    - Reasons for recording interview
- Confidentiality and how findings will be reported

1. Background and personal circumstances

Aim: To introduce the respondent and highlight any background issues that might influence their use of emergency health care

- Household circumstances (children etc)
- Length of time they have lived in the area
- Age

2. Local health care services

Aim: To establish what participants consider to be 'local services' in their local health care economy and their views about these services

- Discuss which hospital they consider to be their local hospital
    - Reasons
    - What do they think about their local hospital? What do they feel about it?
    - What sources inform their views about Local Hospital (media/ friends/ experience)

- Explore what other hospitals are nearby
    - What do they think about this hospital
    - How far away is it (time/ distance/ ease of access)
    - What sources inform their views about this Hospital (media/ friends/ experience)

- Find out which hospital would they chose to go/ be taken to in an emergency
    - Reasons

- Explore what other health care facilities they are aware of that would be available in an emergency (walk-in centres, urgent care centres)

- Discuss whether participants feel that they have easy access to their GP

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3. Introduce trade-off factors

Aim: To introduce the trade-off factors and clarify participants' understanding of these concepts

- Introduce service characteristics based on factors that have been identified as important in the literature/previous consultations or by patient/public representatives (and add in any other factors they bring up in Sections 2-3).
  - Convenient location for patients and their families
  - Good public transport links
  - Hospital close by in an emergency
  - Plenty of parking spaces
  - *** Senior doctors on hand in A&E 24 hours a day
  - *** Patients receive a level of care that meets national standards
  - Patients have a choice of A&E departments to go to
  - Local services for local people

- Clarify their understanding of the trade-off factors – what do they understand by them?

- Is there anything they would add?

4. Ranking and trade-off of key service characteristics

Aim: To establish which aspects of emergency care are important to participants and whether or not they would be prepared to consider trading these off with each other

- Discuss which three factors they consider to be most important
  - Reasons

- Explore in what order would they rank these factors
  - Reasons

- Find out if they would be prepared to trade-off any of the factors, for example:
  - Greater distance in an emergency v more specialist care
  - Less convenient location vs care from a senior doctor 24/7

5. Conclusions

Aim: To obtain information about the feasibility of using trade-off methods in this context

- Explore how they found the interview process
  - How did they find the trade-off exercise?
  - How realistic was the trade-off exercise?
  - How has the process impacted the way they think about health services?

Trade-off exercise

1. Introduce service characteristics

2. Check understanding and explore what they think happens now

3. Anything to add

4. Rank priorities – minor, then major

5. Trade offs

6. Introduce arguments used

   a. Consolidate A&E services on fewer sites
   b. Easier to meet targets for senior staffing
   c. Meet national guidelines such as paeds and surgery

7. Does this change anything?

Current service characteristics:

- Convenient location for patients and their families
- Good public transport links
- Hospital close by in an emergency
- Plenty of parking spaces
- *** Senior doctors on hand in A&E 24 hours a day
- *** Patients receive a level of care that meets national standards
- Patients have a choice of A&E departments to go to
- Local services for local people

Possible alternatives:

- Consultants on duty in A&E 24 hours a day
- Patients' care meets or exceeds nationally agreed standards of quality

Appendix 4: Study 2 – data from prioritisation exercise

Table 7: Participant priorities in the event of a major incident

	Hilltown Patients (n=8)				Greenville Public (n=11)				Greenville Activists (n=9)				Total (n=28)			
	Overall*	1st**	2nd	3rd	Overall	1st	2nd	3rd	Overall	1st	2nd	3rd	Overall	1st	2nd	3rd
A local hospital to serve the local community	37.5	0	12.5	25	9.1	9.1	0	0	44.4	0	11.1	33.3	28.6	3.6	7.17	17.9
Good public transport links	0	0	0	0	0	0	0	0	11.1	0	0	11.1	3.6	0	0	3.6
Easy to park	0	0	0	0	9.1	0	0	9.1	0	0	0	0	3.6	0	0	3.6
Patients can choose which A&E to go to	25	25	0	0	0	0	0	0	11.1	11.1	0	0	10.7	10.7	0	0
Sick patients taken to A&E as fast as possible	87.5	37.5	37.5	12.5	90.9	54.5	18.2	18.2	77.8	44.4	22.2	11.1	85.7	46.4	25	14.3
Consultants on duty in A&E 24 hours a day	75	37.5	37.5	0	90.9	27.3	63.6	0	66.7	33.3	22.2	11.1	78.6	32.1	42.9	3.6
Patients' care meets nationally agreed standards of quality	25	0	0	25	54.5	9.1	18.2	27.3	44.4	0	22.2	22.2	42.9	3.6	14.3	25
A&E convenient to get to for patients and their families	12.5	0	0	12.5	45.5	0	0	45.5	11.1	0	11.1	0	25	0	3.6	21.4

* Participants were asked to select three main priorities from the eight options. This column identifies the percentage of participants who selected each component of care as one of their three main priorities

** This and subsequent columns identifies the percentage of participants who selected each component as their top, second or third priority.

Table 8: Participant priorities in the event of a minor injury

	Hilltown Patients (n=8)				Greenville Public (n=11)				Greenville Activists (n=9)				Total (n=28)			
	Overall*	1st**	2nd	3rd	Overall	1st	2nd	3rd	Overall	1st	2nd	3rd	Overall	1st	2nd	3rd
A local hospital to serve the local community	**25**	0	12.5	12.5	**18.2**	9.1	0	9.1	**44.4**	11.1	11.1	22.2	**28.6**	7.1	7.1	14.3
Good public transport links	**50**	25	12.5	12.5	**18.2**	0	9.1	9.1	**33.3**	0	22.2	11.1	**32.1**	7.1	14.3	10.7
Easy to park	**12.5**	0	12.5	0	**18.2**	0	9.1	9.1	**0**	0	0	0	**10.7**	0	7.1	3.6
Patients can choose which A&E to go to	**37.5**	12.5	100	12.5	**9.1**	9.1	0	0	**11.1**	11.1	0	0	**17.9**	10.7	50	3.6
Sick patients taken to A&E as fast as possible	**25**	12.5	0	12.5	**9.1**	9.1	0	0	**11.1**	11.1	0	0	**14.3**	10.7	0	3.6
Consultants on duty in A&E 24 hours a day	**12.5**	0	12.5	0	**27.3**	0	27.3	0	**11.1**	0	11.1	0	**17.9**	0	17.9	0
Patients' care meets nationally agreed standards of quality	**12.5**	12.5	0	0	**27.3**	18.2	0	9.1	**22.2**	11.1	0	11.1	**21.4**	14.3	0	7.1
A&E convenient to get to for patients and their families	**50**	25	12.5	12.5	**36.4**	9.1	9.1	18.2	**33.3**	11.1	11.1	11.1	**39.3**	14.3	10.7	14.3

* Participants were asked to select three main priorities from the eight options. This column identifies the percentage of participants who selected each component of care as one of their three main priorities

** This and subsequent columns identifies the percentage of participants who selected each component as their top, second or third priority.

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