Healthwatch Kent
Seabrooke House, Church Road, Ashford, TN23 1RD
Tel 0808 801 0102
info@healthwatchkent.co.uk
www.healthwatchkent.co.uk

Healthwatch Medway
5A New Road Avenue, Chatham, ME4 6BB
Tel 0800 136 656
enquiries@healthwatchmedway.com
www.healthwatchmedway.com

6th November 2023

For the attention of: Lee Martin, SRO for Health Based Places of Safety service improvement.
Andy Oldfield, Director of Adult Mental Health
Louise Clack, Programme Director, Mental Health Urgent and Emergency Care

Re: Healthwatch Kent and Healthwatch Medway scrutiny of the Health Based Places of Safety consultation

Healthwatch Kent and Healthwatch Medway have a clear role and process for acting as a critical friend on consultations. This is based on our Best Practice Guides on Consultations and Pre-consultation Engagement available on our websites. This process is undertaken by Healthwatch Kent and Healthwatch Medway staff or volunteers and is based on the evidence of the activities and the planning and quality of what has been undertaken, from a lay person's view, but informed by extensive training from The Consultation Institute. For it to be objective, the person reviewing the process will not have been directly involved in supporting the engagement activities, ensuring our findings are purely evidence based.

Using this framework, we have reviewed the five stages of the consultation process and have shared our conclusions on how we feel the process has gone so far. We reiterate that these reflections are based on the process rather than the consultation result.

1. Case For Change

Item	Example	Discussion and any evidence seen
Is there clear evidence for the case for change?	Background documents explaining the need for change	The case for change is clear, centring around 4 key aspects, • Increasing availability of Health Based Places of Safety (HBPoS) • Reducing assessment delays • Helping tackle staffing challenges

Item	Example	Discussion and any evidence seen
		• Improvements to care including environments which allow more therapeutic and better access to care
Has there been a review of previous similar consultations?	Previous engagement, consultation or strategy documents	'Back in 2019 the KMPT "Improving Mental Health Services (IMHS)" capital development program included a plan for a new, single, "centralized" HBPoS, the plan didn't progress due to lack of funding' (PCBC) In the pre-consultation engagement report 'Improving the mental health urgent and emergency care pathway and developing proposals for section 136 service and the health-based places of safety' existing insights from the Kent and Medway listens, Healthwatch Kent and Mental Health Voice were analysed. 'stakeholders, clinical staff, front line emergency services and those charged with delivering section 136 assessments and keeping people safe from harm' were also listened to.
Has an initial impact screening been carried out? Has an equalities analysis been carried out?	Copies are available and is easily understood	See pre-consultation section
Have the public been involved in any way with developing the case for change?	Contacts with the public, e.g. via internal engagement groups or Healthwatch	As mentioned above, existing insight analysis and engagement have taken place within the wider urgent and emergency care pathway which included feedback and ideas for improvement in relation to health-based places of safety. KMPT community forum and council were involved at the outset in 2019, and then again when the engagement process was started in October 2022. Then Megan CiC helped involve patients in the winter who invited the ICB to five meetings with 27 people. (page 4 of the early engagement report.
Was there a written plan for the pre consultation stage?	Copy of plan	Yes there is a plan, highlighted in the PCBC and also in documentation to HOSC (Jan 2023). It sets out the engagement approach and principles including talking to staff. It also shares key themes from existing engagement. The learning from consultation engagement helped form the consultation plan – using the approach evolved with Megan cic to get VCSE organisations to support the NHS to have 'safe discussions' with service users and carers. Healthwatch have also seen evidence of a project plan which shows clear actions for the pre-consultation stage.

Item	Example	Discussion and any evidence seen

2. Pre-Consultation

Item	Example	Discussion and any evidence seen
Was a more detailed impact assessment carried out? Did it clearly identify the communities that should be involved in pre-consultation engagement? Has the Equalities Analysis been updated?	Copy of Impact Assessment List of target groups	An integrated impact assessment has taken place. 'The following have been conducted as part of the Integrated Impact Assessment: 1. Health impact assessment (HIA) - identifies and assesses health outcomes, service impacts and the workforce impact of the proposed changes. 2. Equality impact assessment (EqIA) - identifies and assesses impacts on groups with protected characteristic under equalities legislation along with deprived communities. 3. Travel and access impact assessment - identifies and assesses impacts on travel and access for patients, visitors/carers, patient transport services and staff. 4. Sustainability impact assessment - identifies and assesses impacts across a range of sustainability issues.' (PCBC pg. 86) There is particular detail in the travel impact assessment. The EQIA suggests this change would result in all positive impacts especially for females and people with disabilities. The data included in the PCBC suggests a difference in outcome of section 136s based on ethnicity. The ICB worked to reach communities in north Kent through community organisations and in Medway and east Kent working with Mental Health support organisations who helped engage a range of vulnerable communities including BAME, veterans, disabled, neuro diverse, homeless and those in assisted living. Recommendations from the early engagement report suggested: 'Extending the breadth of involvement to those wider communities of need – to those with complex emotional disorders and serious mental illnesses impacted by any proposed change in services and carers and families. Those communities known to suffer from multiple health inequalities – BAME communities, those living in areas of deprivation, people with drug and alcohol issues or dual

Item	Example	Discussion and any evidence seen
		diagnosis, the homeless, those with cognitive impairment or autism/LD – and although this is an adult service under consideration young people, particularly those in transition, age 18 to 25.'
Was the most appropriate method of engagement used for each group?	Visits to communities Focus groups Surveys Events	There was a review of existing feedback that was held by a range of system partners. There was a recognition that KMPT and the ICB 'have focussed on the small complex cohort of patients and their loved ones' There were 1:1 interviews and small focus groups conducted, which recognised the sensitivity of the topics being discussed.
Were engagement plans in place?		The PCBC states that the 'consultation plan is proportionate and takes account of this being a very small specialist service with people having varying levels of interest and prior involvement in our proposals'. There is a detailed engagement plan for the consultation which includes aims, smart objectives and stakeholder mapping. This was shared with both HOSC and HASC.

3. Option Development

Item	Example	Discussion and evidence seen
How much time was given to the pre-consultation and was this sufficient to develop a robust set of options?		The PCBC acknowledges that the 'timescales for the proposal outlined in this pre-consultation business case are tight and the proposal itself predicated on a clear set of criteria, the engagement process. is streamlined, focussed and proportionate.'
Is it clear that the options have not already been pre-determined?		There is only one option being put forward to consultation. Although we would encourage multiple option consultations, which give the public a greater opportunity to influence how decisions can be shaped based on their feedback, the criteria for option development is clearly explained.
Did the engagement result in the identification of options to be considered in the consultation?		'We have used feedback from clinicians, staff, carers and experts by experience to inform the development of the preferred option and this has contributed to: • Understanding what is important to people in relation to mental health services- helping us shape the vision of the future. • Enabled the testing validity of the case for change. • Involvement in the options assessment process • Testing and affirming the clinical model within the proposals • Identifying concerns and developing mitigations • Confirming the single option for consultation'

Was the scoring and shortlisting a robust process?		Initial review of site options was with a limited number of stakeholders, due to a 3 week deadline to apply for national funding. Existing plans from 2019 suggested a single centre but didn't have capital to proceed to consultation. Base criteria was formulated which is set out in chapter 7 of the PCBC • Scale • Availability • Location Alongside other Acute Mental Health Services • Site Ownership (needs to be NHS) • Affordability • Accessibility This led to the identification of 2 options. After confirmation of funding the ICB and KMPT have 'worked with health and care system partners to develop a comprehensive long-list of possible options' Scheme objectives were used to assess the long list. The base criteria was then applied to those that made it through to the short list which revealed one option. There is explanation within a visual format and a short narrative within the PCBC as to why options were rejected at each stage of the analysis.
Were the options presented in such a way as to be understood by the wider population?	Consultation documents clearly communicate the reason for the proposed change and the options	There was only one preferred option presented which was presented well. The consultation set out what hurdle criteria were applied to the long list and why only one option remained.
Does the pre-consultation business case (PCBC), if it is required, provide all relevant information for the consultation to go ahead		The PCBC is a comprehensive document which includes: • Case for change • Clinical models • Option Development • Integrated Impact Assessment • Legal duties • Workforce • Finances • Implementation planning • Consultation Approach In our view this provides all the necessary information to proceed to consultation.

4. Consultation

Item	Example	Discussion and any evidence seen
Was the timescale for the consultation proportionate to the impact, and realistic, to allow a considered response from all stakeholders?	Consultation plan Resources available Time pressures e.g. need to reduce budgets within certain timescale	The PCBC acknowledges that the 'timescales for the proposal outlined in this pre-consultation business case are tight and the proposal itself predicated on a clear set of criteria, the engagement process. is streamlined, focussed and proportionate.' The consultation was 8 weeks in duration which we feel is proportionate and allowed enough time for people to take part in the consultation if they wanted to. This included opportunities for stakeholders to share the opportunities on the ICB's behalf.
Was the Consultation Document available, including the case for change and information about the pre-consultation phase?	Information should include: Info gathered in previous stages Financial info Any new information	There was a comprehensive consultation document available to the public and a shorter summary document which is easily digestible as well as an animated video. The full consultation document was detailed, in our view including all relevant information for people to make an informed contribution to the consultation.
Was the questionnaire a good mix of quantitative and qualitative questions? Could the public give alternative views and ideas? Are questions leading respondents to a particular answer?		There were a mix of questions and multiple options to gather qualitative insights including asks for respondents to prioritise the importance they place on certain aspects. People were asked for their views on services that impacted on the HBPoS and new proposals for provision. The questions didn't specifically ask people for other suggestions (although this was referenced in the PCBC) but they were asked openly for any other suggestions for improvements. The statements used for people to agree or disagree with focused on positive change but they weren't leading.
Were multiple methods of access to the public used?	Information offered online and paper Available in different languages Braille, British Sign Language, easy read, etc. available	• Easy read versions were available on request. • Information in different languages was also available on request. • Online and paper options to take part in the consultation were available. • People were also able to take part by phone if they wished, 'the consultation document, a summary version, a survey, frequently asked questions, an animation explaining the proposals, as an alternative to complex documents, and the pre-consultation business case' were all published on the NHS Kent and Medway site.
What opportunities were available to allow public discussion of the options, and were these the most	Presentations of the information Visits to affected	This consultation included significant outreach which acknowledged sensitivity of the topic being discussed. There were 19 groups that were visited including, Mind, Porchlight, Local Mental Health Networks, Safe Havens

Item	Example	Discussion and any evidence seen
effective method to reach all groups?	groups or those that took part in pre-consultation Workshops Events	and Youth Ngage. There were a total of 476 people who shared views, with 59 completing the online consultation questions. 2,950 were made aware or received information relating to the consultation through various digital channels such as websites, newsletters and social media. The ICB's Have Your Say Platform also had a list of Frequently Asked Questions. People also had the opportunity to get further involved with the transformation of mental health services.
Were engagement plans completed?		SMART objectives set out in the consultation plan appear to be a mixed picture with awareness targets of 90,000 not being achieved. However, more importantly in terms separate, 476 separate responses were received clearly meeting the target of 250 set out. Other objectives such as discussions occurring in safe spaces to help people feel comfortable and supported in sharing their views seem to be achieved. It's more difficult to see if the objective 'one or two focus groups with each identified cohort, or 1 to 1 interview to give choice to individuals (People with complex emotional disorders, younger adults, BAME, homeless, people with dual diagnosis). 6-8 people in each focus group. ' has been achieved across all the cohorts mentioned. Although the demographics from the responses to the online consultation point to gaps the organisations who had conversations on behalf of the ICB have reach into a wide range of communities. As such the consultation engagement report highlights disability exclusion, access inequalities, culturally sensitive mental health services and support for carers as areas that people shared comments and reflections on. Despite not all SMART objectives being met, overall, the consultation engagement report and information in the draft DMBC that we've seen shows that there was proportionate effort made to engage people and give them the opportunity to share their views.
Were regular updates provided to the public during the consultation period?	Updates to information online	Updates could be found on the NHS Kent and Medway website as new event and opportunities to get involved went live. The Kent and Medway bulletin also included updates to the wider public. There was an update sent to all VCSE groups and MH networks who supported the consultation and engagement process. There have been regular visits to both Overview and Scrutiny Committees to share updates.

Item	Example	Discussion and any evidence seen
		The Have your Say platform has the independent engagement report and explains what stage of the consultation process things are currently at.

Commented [RG1]: We got a YSWD sent to us – where else did those go was it to everyone who took part who you have permission to go back to?

5. **Post Consultation**

Item	Example	Discussion and any evidence seen
How did the organisation demonstrate that it listened to the feedback from respondents to the consultation?	What changed in the final decision from the original proposal Decision making business case (DMBC)	Before the Decision-Making Business Case had been approved, a You Said We Did document was put together. This clearly outlines 5 actions that have either been taken or will be taken in response to issues that have been highlighted within the feedback gathered during the consultation. This has also been uploaded onto the Have your Say website.
Was the decision making process made clear?	Public council meeting Governing Body meeting	There were various publicly available papers including those from HOSC and HASC that identified the decision-making business case being considered at the September ICB Board meeting.
Has the final decision been communicated effectively?	Feedback to respondents Posted on website Public meeting	An update has been sent to interested parties. Decision is included in the ICB board meeting minutes which will be approved at the next meeting in November. In these people will be able to see any discussion on the agenda item. The board was also held in public. Healthwatch have seen a full decision comms delivery plan from Sept-Oct 2023
Have the next steps been defined? Are there mitigations that need monitoring of how they are implemented?	Implementation plan	The You Said We Did report has highlighted commitments to act on the feedback. In the briefing it set out the next steps as being a ' full design team to work KMPT and experts-through-experience to produce a design and selection process to appoint a main contractor. It is anticipated that construction will begin in Autumn 2024 and the unit will be in place from Spring 2025.'

Conclusions

Overall, we feel that a sufficient process has been followed within this consultation. The Case for Change is clearly explained and presented. There has also been an Integrated Equality Impact Assessment understanding who will be most affected by the changes of the option presented.

The criteria by which options have been assessed against hurdle criteria has been presented clearly and there is transparent reasoning why only 1 option was feasible.

We feel that the way engagement has shifted to greater outreach compared to historic consultations is positive as well as the attention given to make people feel safe in sharing their views on what can be an incredibly sensitive topic. The number of people engaged with is proportionate and although not all the people with suggested conditions from the pre consultation work were heard from, our view is that the engagement has been sufficient.

The relevant components of the Integrated Impact Assessment exist. We recognise that data on the outcomes following section 136 has been used to identify ethnicities who should be proactively engaged with due to, what seemed like to us, differing outcomes compared to those who described themselves as white. Attention has been given to hearing these views although it's been difficult to quantify exactly how many have contributed to the consultation. Aside from this consultation we are keen to see work to remedy the underlying reasons for this disparity in outcome.

We would also like to highlight the You Said We Did document that has been produced, showcasing how feedback has been listened to and what has or what is going to happen as a result. Having this produced before the outcome of the consultation has been finalised is helpful.

There is clear evidence of sufficient pre-consultation engagement taking place and a project plan supporting this stage. There may be an opportunity to strengthen the pre-consultation engagement strategy for future consultations to continue to improve the standard of consultations the ICB is responsible for overseeing. However, we understand this planned approach can be challenging with limited timeframes from external deadlines which were the case in this instance. Another improvement we would suggest is the reference to the term BAME in the documentation. We would recommend this is not used in the future. There is various guidance supporting this move including government sources which can be found here. One of the reasons is that this all-encompassing term can mask disparities between different ethnic groups.

In summation we feel that the necessary steps in the consultation process have been followed appropriately and proportionately. In addition, we want to acknowledge the outreach approach and the You Said We Did early development as being, in our view, particularly strong. We will be following up to ensure the future You Said We Did commitments do end up being actioned.

Kind regards,

Robbie Goatham

Healthwatch Kent Manager
On behalf of the Healthwatch Kent Steering Group

Emma-Sue Willows
Healthwatch Medway Manager
On behalf of the Healthwatch Medway Steering Group