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# Closures and Change of Use of Health Facilities

A handbook on the administrative processes involved

# CLOSURES AND CHANGE OF USE OF HEALTH FACILITIES

A handbook on the administrative processes involved

Compiled by senior administrators in the National Health Service



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## 1 INTRODUCTION

The closure or change of use of all or part of a hospital or other health facility used to be relatively rare and straight forward. Recently, it has become more common, more complex, and of more concern both to the general public and to those working in the National Health Service. Just at a time when the need to close certain units has become more urgent, so the difficulties of doing so have become more apparent.

Relatively little has been written about ways in which health service changes have been carried through effectively and to the satisfaction of the different parties concerned. Whilst much useful experience is available around the country, there are many managers in the NHS who are facing closures for the first time who would welcome practical help in dealing with some of the issues involved. Guidance on consultation is available in Circular HSC(IS)207*, issued by the Department of Health and Social Security, but this, of necessity, can only cover the broad principles, and needs to be clarified and supplemented by a consideration of good practices which have been found to be of value in the successful management of change.

The concern of the community and staff involved is genuine. What are needed are effective means of channelling that concern, to enable those involved to see and discuss the issues clearly, and to come to decisions which will be of benefit to patients, to the health service and all those involved.

This handbook has been produced to help to clarify some of the complex issues involved. It stems from an initial 'workshop' in April 1980 at the King's Fund Centre at which a number of senior health service administrators pooled their collective experience of closures with which they had been involved and agreed a general format for the handbook. The handbook itself has since been written by a sub-group of those who participated in the workshop. It is intended to be read primarily by administrators, for they have an overall responsibility for seeing that there is adequate planning of and consultation about closures and that change as a whole is managed effectively. It is thus a handbook written by administrators for administrators, but it may well be useful to the wide range of other people involved in this activity such as other NHS managers, Health Authority and Community Health Council members, professional groups and staff organisations, who not only have their own parts to play, but also need to have some insight into the role of the administrator.

The ability of health authorities to make and implement effective decisions entails the provision of adequate information for alternatives to be considered, making arrangements for proper consultation so that due consideration can be given to the views of all who may be affected, doing the necessary preparation and groundwork to ensure a positive approach to the making of decisions, and finally overseeing and managing the whole change process by which a different pattern of service is brought about. Chapter 2 of the handbook surveys the context within

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* This document and other guidance referred to in the handbook has been issued by the DHSS to Health Authorities in England. Similar guidance has been issued by the appropriate government departments to Health Authorities in Wales, Scotland and Northern Ireland. The text of the circular is reproduced in Appendix 2.

which changes take place, and examines the consideration of alternatives before a decision on a closure or substantial variation of use. Chapters 3, 4 and 5 deal with different aspects of the consultation process, beginning with broad policy issues and concluding with a discussion of the content of consultation documents. Chapter 6 deals with practical aspects of the closure itself, before a final comment in Chapter 7 which also briefly considers some alternatives to existing consultation procedures. For ease of reference, all appendices have been placed at the end of the book.

'Closures and change of use of health facilities' is a somewhat cumbersome phrase which can include the closure of a hospital in its entirety, the closure of a ward or part of a hospital, or changes in the way in which a service is provided (for example, time or location of clinic sessions). For ease of description the simple words 'change' or 'closure' are used in this book to describe the total process encompassed in the longer title. It is important however to recognise that a closure is frequently just one part of a number of changes which result in an overall development in services.

There have been many attempts to define and clarify the consultation process. This handbook attempts to explain and make clear the position as it appears to be in the Autumn of 1980. It is recognised that the process of definition and clarification continues, and may change in the future. Despite the difficulties of definition, consultation is of great value and importance in obtaining the support of a wide range of interest groups. An understanding of the ways in which it can be approached is vital.

Managing change is a complicated process. There can be so many variables involved in coming to a decision, so many individuals and groups with differing values, views, hopes and fears, such difficult constraints of time and money, that it would be foolhardy to suggest one 'right way' of managing the process, or even describing in detail what may need to be done. This handbook does not aim to be the final word on the issue. It should be seen as offering some ideas from what has been learnt from recent experiences. It may find a use as a check-list for managers concerned with change, to consider aspects they might not otherwise have thought about. It needs to be used flexibly, and is likely to need updating as time goes on to take into account new experiences and developments. This will be particularly so as the restructuring of the Service occurs.

One thing which seems certain is that the processes of managing change in the provision of health services require continuing attention; for in this rapidly changing world it is safe to assume that the management of closures and changes of use will be a frequent and continuing activity for most senior health service managers in the future.

## 2 THE CONTEXT OF CHANGE

Decisions about changes draw attention to many of the problems and opportunities, feelings and values which underlie the normal provision of health services – but which rarely come so clearly to the surface. Changes can be difficult and protracted because there is a wide range of issues which can be difficult even to identify clearly, let alone reconcile, in ways which are acceptable to the parties concerned. Successful management of a change therefore requires a thorough understanding by managers of these issues and calls for a high degree of managerial skill in ensuring that consultative and decision-making processes work smoothly.

### A FRAMEWORK FOR THE MANAGEMENT OF CHANGE

The literature onorganisations contains several models of the change process.* Such models can be helpful as a framework for understanding the process of managing change. Most models contain the following elements:

1 **Need:** consideration of the factors which give rise to the change: for example, population and geographical changes, financial pressures, changes in medical and treatment patterns, provision of new facilities, organisational changes, condition of existing buildings etc.

2 **Context:** understanding of the 'climate' within which changes are to take place eg local attitudes, political influences, feelings of staff, past history and traditions.

3 **Objectives:** clarification and agreement – why the change is necessary. What benefits should result? What disadvantages need to be minimised?

4 **Planning:** How does this change fit in with existing plans for the district? How is the change itself to be planned? Can broad agreement be reached on strategy before consultation on tactics?

5 **Alternatives:** consideration of the advantages and disadvantages of different means of achieving the objective.

6 **Consultation:** ensuring that the views of those who will be affected are properly considered. Reconciliation as far as possible of the views of different interest groups.

7 **Decision:** a clear indication and commitment to action supported by facts and well reasoned argument.

8 **Implementation:** as smoothly and with as little dislocation as possible.

9 **Evaluation and review:** to check the extent to which the change has achieved the original objectives, and to identify new problems which have arisen as a consequence of the change.

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* See Bibliography.

It is unusual for any change to conform neatly to such a model, but it may be helpful as a guide for managers in determining where they are at, at any point, in what can be a complex and confusing process.

## PRE-CONSULTATION

The pre-consultation phase is very important. Insufficient consideration of a proposal to make a change will only add to the problems and difficulties encountered at subsequent stages. The consideration of alternatives should be a normal feature of health care management, bearing in mind that patterns of health care and needs are changing continuously, and that services may have to operate within, at best, a reduced growth. The challenge of providing the best standards of care possible within limited and inadequate resources is becoming increasingly apparent, embracing as it does questions of choice and priorities. As the DHSS Consultative Document issued in 1976 on *Priorities for Health and Personal Social Services in England* states, 'Choice is never easy, but choose we must'.

Consideration of various options — that is, identifying the 'choices' — during the pre-consultative stage is among the most important and demanding feature of the whole process of change, bearing in mind that the variable factors in a complex service such as health care are great. The process is perhaps made easier in a 'growth' or 'betterment' situation, than when there is 'no growth' or a 'cut-back' in resources.

The importance of comprehensive service planning, of which appraisal of building stock and capital investment should be an integral feature, has been increasingly recognised. In looking at options during the pre-consultative stage, the multi-dimensional implications of change in relation to patient services within one district alone can be significant. For certain services there may be regional and supra-regional implications. Teaching and research may also be affected, particularly in teaching authorities. Staff interests will certainly be involved directly or indirectly and their training requirements influenced. Inevitably there are implications for the use of the estate, as well as capital and revenue expenditure — and possible savings. Other non-NHS services too may be affected such as those provided by local authorities and voluntary bodies. Different levels of management may be involved in identifying the various options, from those directly involved in patient care at operational level to the Regional or Departmental levels.

## STRATEGY AND PLANNING

There are some basic considerations during the pre-consultative process. First and foremost, management should be aware of the direction in which it wants to go. Planning provides the positive means by which rational discussion and decision-making can take place about expansion and contraction of services. Each health authority should have its strategic plan — interlocked with a Regional strategic plan. The strategic plan will indicate realistic objectives to be achieved on a time scale commensurate with the availability of resources. Strategic plans are part of an on-going management process providing the framework within which there are clearly defined priorities. It is against the backcloth of a strategic plan that management should consider its choice of options and their implications, and seek to gain an acceptance and commitment to plans by those who will be affected by them.

## ALTERNATIVES

Uncomfortable and awkward decisions are inevitably called for when priorities have to be set, including choices between 'care' or 'client' groups. For example, should the services of the elderly have overriding claim? How does one compare the importance of improvement in mental handicap services with the pressures to do something about inordinate waiting lists in the acute sector? These considerations cannot be divorced from the key decisions regarding patterns of capital and revenue expenditure. What is the right balance in terms of investment in new estate, plant and equipment? What is the rate of expenditure required to maintain existing facilities? In relation to the rationalisation of patterns of service, what are the likely improvements to be achieved? What is the price to be paid in order to generate savings in one sector to achieve more important improvements in another? These are but indicators of the complex and diverse issues facing management. Not the least difficult is identifying the true benefits and savings of alternative options. Indeed the advantages and disadvantages of various alternatives are subject at times to emotive and at best subjective judgment, such is the complexity and diffused nature of the elements involved. This can call for an astute understanding of the political processes at work, and skill in the weighing and balancing of alternatives and assessing the relative strength of different forces in a complex situation.

## FEASIBILITY STUDIES

Bearing in mind the complexity of the factors, a number of important lessons have been learned from practical experience. The most obvious is that there are no easy short-cuts during the pre-consultative process. The need for proper feasibility studies must be stressed. What may appear initially as a simple and straight-forward course of action may have far reaching and wide ranging consequences and implications.

A sustained disciplined approach is more likely to identify the ripple effects of the options open to examination. For example, the option of whether the maternity service in a particular area should be centred on one, two or three units not only has implications on the resources directly involved in providing a maternity service, but directly on a whole range of supporting services including the use and disposal of accommodation and access to services by patients in different localities. A further example would be the consideration of improvements in geriatric in-patient services within a district general hospital and the effect of such a policy on supporting hospital facilities in peripheral units and on the wider pattern of service for the elderly.

Although it is a natural desire for health authorities to aim for self sufficiency in providing basic services, this may not be achievable. Additional complications arise when the choice of options involves services in adjoining authorities. For example, closure of a specialist orthopaedic hospital may require replacement facilities by three adjacent authorities.

It is also important to have a sense of realism in evolving alternative strategies. Public and staff are increasingly aware of the major resource constraints facing the health service and it is vital therefore that a high degree of honesty pervades in pursuing options for further consideration and action. Are the capital, revenue and manpower resources available to implement the plan of action? These questions need to be asked and answered in a positive way before public consultation on the proposals takes place.

## THE TIME ELEMENT

The pace of change and the time involved can be critical factors in the process. The time taken in managing a change can be far in excess of that originally anticipated. There is a case at the pre-consultation stage, for drawing up a 'Network Analysis' for the whole consultation and change process, identifying the 'critical path' as a means of cutting out unnecessary delays. The intensity of change is also important in that there may be limits to the amount of major change which can be absorbed in a given period of time.

There are difficulties in working to a realistic time scale. This is easier in the context of providing new modern additional facilities. It is infinitely more difficult and time consuming process when no such carrot is forthcoming and management is attempting to rationalise services, to cut out waste and minimise reduction in the level and quality of service.

## CONSULTATION

A wide range of people will be involved in considering alternatives. Foremost will be the planning staff, but others should include staff and other bodies likely to be affected (eg local authorities, voluntary bodies, CHC, trade unions) either on a formal or informal basis. Consultation will take place as part of the service-planning process and in relation to specific proposals. The method and manner of consultation needs to be carefully considered. This is considered further in Chapters 3, 4 and 5.

## ATTITUDE TOWARDS CONFLICTING INTERESTS

During the process of change conflicting interests will come to the fore. It is sometimes difficult to summon up and maintain the willpower to face up to conflict and have the tenacity to implement decisions. The process can, at best, be extremely demanding and often apparently unrewarding. It is vital that management maintains a positive attitude throughout the entire process.

It is important too that some thought is given to what status the evolving of options and consideration of alternatives should have in the process of public consultation. There is much confusion about what constitutes an informal management process, or an informal public consultation process, and what is formal public consultation.

Much emphasis is placed on consultation procedures, but on examination it appears that the process is often much more one of negotiation, whereby means are sought to reconcile different points of view, the power of different interest groups is recognised, and 'package' solutions, compromises and deals are made as a means of making progress. One should not naively ignore the influence of political considerations on the outcome of these decisions, despite apparently 'objective' and 'rational' assessment of the actions called for.

Lucid presentation of alternatives is important although the difficulty of identifying all the facts and summarising all the arguments for and against in a balanced and concise nature has to be acknowledged.

## HUMAN FACTORS

These are obviously important. Trauma amongst staff, patients and the public can be associated with the process of public consultation but inevitably these features are manifested during periods of pre-consultation when rumours abound. Management operates in a gold fish bowl and there may be an in-built hostility by vested interests (including professional staff, unions, action committees, Community Health Councils and even authority members) to the possibility of change. The support of staff and guarding of their interests are key aspects of any kind of organisational change, and good industrial relations and consultation procedures are needed to cope with them. Sound policies, trust and good judgement are needed in order to protect the security, conditions of service, and job opportunities of employees whilst at the same time ensuring flexibility for management in terms of location and patterns of working. Coupled with these human factors are the emotive and often subjective judgements of various interests involved in the process – the politician's view of what needs to be done can be distinctly at variance with those of professional aspirations. Aesthetic consideration of buildings proposed for closure may well have a higher priority in the final analysis than the improvements in services offered in alternative buildings.

Finally, one has to acknowledge, (often with limited managerial resources and expertise at one's disposal) the demanding self-discipline of reconciling the aspirations of a wide variety of interests during the pre-consultation stage and presenting these in a coherent form to include the identification of alternatives, a statement of the preferred option, and an indication of the course for further action. Undoubtedly, the present arrangements are somewhat haphazard, ill defined and subject to a good deal of misunderstanding. The procedural aspects and their place within the total context of the management process of health care need to be clarified. Failure to do this will inhibit improvements in the service and perpetuate wasteful and costly misuse of resources and expertise. We must aim for a streamlining of the system to effect a more equitable balance between the democratic process of decision making and efficiency in arriving at and implementing those decisions. Crisis management has been quoted as one of the hallmarks of health care decision making. The need for contingency plans for services in the event of emergency breakdown is complementary to an orderly, humane and sensitive approach to bringing about the process of change which will be an ever increasing feature of health service management.

## 3 CONSULTATION – POLICY ISSUES

### INTRODUCTION

There is no single source to guide those with responsibility for the consultation process. Indeed, the lack of clear comprehensive guidance is part of the reason why this handbook has been produced. One difficulty is that the main guidance on consultation – a statutory instrument laying down the duty to consult, and a Department of Health and Social Security circular describing consultation arrangements – were framed at a time when the scale and pace of change now experienced was scarcely foreseen. A further difficulty is that these provisions adopt different approaches to consultation, and use different terminology: thus one refers to 'substantial variations in service', while the other relates primarily to permanent closures and changes of use of health service buildings.

An analysis of this original guidance, however, is by no means sufficient to give an understanding of the present state of the art, and three further influences must also be considered. Probably most important is the practical experience of consultation which authorities around the country have built up during the last six years. Despite slightly differing approaches, this has been useful in putting flesh on the guidance and establishing the limits of what is acceptable to Ministers and to those being consulted. Secondly, some formal 'case-law' now exists; the judgement in the 'Lewisham' case* in particular contains useful comments on the meaning of 'substantial' and on the question of urgency. Thirdly, further central guidance has been issued, both specifically from time to time in response to individual queries and, more generally, in the form of Ministerial statements (which have added new policy) and a letter to administrators (Appendix 3). This more recent guidance has removed some ambiguity, but still leaves a number of issues unresolved – for example, the handling of change when there is insufficient time for full formal consultation.

The advice in this section of the handbook relies therefore not only on the published guidance, but also on specific experience in the field (some of which, incidentally, has underlined how easy it is to go wrong!). Clearly, in such circumstances, it is impossible to be definitive but an attempt has been made to present a picture which is reasonably free of ambiguity and which at least identifies the areas still open to interpretation.

A final note of caution is needed on the question of terminology – for there are no prescribed definitions of key terms such as 'substantial', 'change of use' and 'temporary'. Indeed, 'consultation' itself could imply anything from a quick telephone call, to the full formal procedures set out in the circular.

### ISSUES REQUIRING FORMAL CONSULTATION

The main elements of guidance, which determine when and how an authority should consult, are as follows:

(a) the **statutory requirement** to consult is laid down in the National Health Service (Community Health Council) Regulations, 1973 (SI 1973 No 2217) Regulation 20 (See appendix 1). This requires health authorities to consult Community Health Councils

* (London Borough of Lewisham v Commissioners for the Lambeth Southwark and Lewisham Health Area (Teaching) and the Secretary of State for Social Services – Queen's Bench Division 12 October 1979).

on any **substantial variation** in service, unless there is no time to do so. Failure to comply with the Regulations could provide the basis for a challenge in the Courts.

(b) the **procedures** of consultation are governed by HSC (IS) 207, (attached as Appendix 2), which gives general guidance on the contents of consultation documents, the bodies to be consulted, and the timetable of consultation.

(c) further DHSS guidance is contained in a letter to Regional Administrators dated 7 December 1979 (the 'de Peyer' letter, attached as Appendix 3). This was written in the light of the Lewisham case and included Ministers' views on the need for consultation on all proposals for permanent closure or change of use.

The general rule is that if a **requirement** to consult is established within the terms of SI 2217, the **procedures** set out in HSC(IS)207 should be followed. The important factors in establishing a requirement to consult are whether the variation is **substantial** (page 16 below), and whether there is **time for prior consultation** (page 17 below). Where there is insufficient time for full consultation, the timescale and procedures may in certain circumstances be **modified** (page 17 below).

'SUBSTANTIAL VARIATION'

Consultation is required on any proposal which amounts to 'a **substantial variation** in the provision of the health service' (SI 2217 Regulation 20(2)). What is meant by 'substantial' is not further defined and this is therefore a matter of judgement, to be determined in relation to the effect of the proposal on patient services. There is no single criterion. Three issues which should be considered are:

(a) **the scale of change**

This will depend on the extent of the service affected, and the alternatives available. A change in the locality of a service may be as relevant as a change in the level of service. It may be helpful to consider the significance of a proposal in relation to planning norms: thus a proposal to reduce an 'under-provided' service even by a small amount would be more 'substantial' than a similar reduction which still left the service provided at a level above the norm. Obviously local needs should be taken into account, where these justify departure from the norms.

(b) **the period of change**

Ministers have made it clear that prior formal consultation is required on all proposals for permanent closure of change of use. Changes for relatively short, defined periods, for example for upgrading or maintenance may not be regarded as substantial (see section on temporary closures, below).

(c) **the existence of other related measures**

An individual proposal, which may not itself appear significant, may be considered to amount to substantial variation if taken together with other factors (whether planned or unplanned) which

affect similar or related services.

These and other issues are interdependent, and all need to be considered together in relation to an individual proposal. A universal definition of 'substantial' is therefore not practicable. It is worth emphasising that the question of whether a proposal is substantial is a matter of judgement. This means that an authority's decision on this point is open to review by a higher authority, and that in the event of a challenge, the scrutinising authority (or the court) is entitled to substitute its own judgement on the facts.

## TIME FOR CONSULTATION

The proviso to Regulation 20(i) of SI 2217 allows an authority to proceed without consultation where it is 'satisfied that, in the interests of the health service, a decision has to be taken without allowing time for consultation'. The question here is whether the authority is satisfied that there was insufficient time to consult; and therefore in the event of a challenge, the Court or scrutinising authority is not able to substitute its own view of whether there was in fact time to consult, and may only consider whether a reasonable authority, properly informed, could have reached the conclusion under review.

Ministers have made clear their policy that full consultation (ie in accordance with HSC(IS)207) should be undertaken on all proposals for permanent closure or change of use. This policy limits the use an authority may make of the proviso to Regulation 20(i) of SI 2217, and means in effect that changes implemented under the proviso without consultation should have temporary force only, and should be the subject of formal consultation before being made permanent.

The judgment in the Lewisham case confirms that the need to make savings so as to avoid overspending could provide grounds of urgency allowing a decision to be made without prior consultation; although in view of Ministerial policy such changes could only have temporary effect.

In the case of substantial change without prior consultation it is important to let the Community Health Council know, as soon as possible, of the decision made, and why no consultation has taken place. In all cases where the formal consultation procedures are not followed it is most important that the authority's decision is properly documented, preferably by means of a formal resolution recorded in the minutes, the wording of which is consistent with the CHC regulations.

## MODIFIED CONSULTATION

Apart from the formal consultation procedure laid down by HSC(IS)207 there is no other prescribed procedure, and terms such as 'modified' or 'shortened' consultation, do not therefore have a specific meaning. Nevertheless, it is possible, under certain circumstances, to vary both the procedure and the timescale of consultation.

As a general rule, where there is insufficient time for the full formal consultation procedure, authorities should consult as fully as circumstances permit. Regulation 20(2) of SI 2217 leaves

it to the authorities to determine the date by which comments are required, and in some circumstances a consultation period shorter than the three months suggested in HSC(IS)207 may be appropriate.

The scope for modifications to **procedure** is more difficult to describe, since this area is largely untested, and the guidance is not specific (although HSC(IS)207 and the 'de Peyer' letter clearly envisage the possibility of procedural modification). The term 'consultation' in regulation 20 of SI 2217 does not appear to be restricted in meaning to the formal procedures set out in Appendix A of the circular; moreover in strict terms these formal procedures apply only to **permanent** closures and changes of use of health buildings (although the spirit of DHSS guidance is that they should where possible be applied to all proposals for substantial change). Thus it would appear that, where time was short, and where the change envisaged was **temporary** (permanent closure or change of use in any case being excluded by Ministerial policy), an authority could consult (within the meaning of Regulation 20) following a shortened procedure in which case, there is no requirement to refer Community Health Council objections to the Regional Health Authority and the Secretary of State. Thus, a shortened procedure for a proposal on which the authority felt a decision was required within a deadline of two months, might simply consist of the issue of a statement describing the proposal and inviting comments, on the basis of which a final decision could be made at a meeting just prior to the deadline date. An alternative approach would be to decide under the proviso to Regulation 20 that there was insufficient time for (full) consultation, and to specify alternative arrangements. Whichever approach is adopted the procedure and timetable for consultation should be clearly stated in advance, together of course with the reasons why full formal consultation is considered inappropriate. The Department of Health and Social Security should be notified of the decision.

Regulation 20(2) of SI 2217 allows a Community Health Council which is 'not satisfied that sufficient time has been allowed or that consultation has been adequate' to appeal to the Regional Health Authority which has power to require further consultation if this is thought appropriate.

## TEMPORARY CLOSURES

The reference in Appendix B of HSC(IS)207 to temporary closure has given rise to some confusion, and it is important to recognise that this term has no statutory significance. When the circular was drafted it was assumed that most temporary changes would not amount to 'substantial variation' and therefore would lie outside the formal consultation procedure but it is now clear that the temporary nature of a proposed change would not **of itself** release an authority from the requirement to consult.

**Extended temporary closure should not be used as a device to avoid proper consultation on permanent closures.** The 'de Peyer' letter suggests that when there is no time for formal consultation on a substantial temporary closure or change of use, an authority should undertake full consultation immediately after the temporary closure has been made if there is a **possibility** that the authority might eventually wish – or be forced – to make the closure permanent. This should be a real and identifiable possibility – there should be a reasonable doubt that the service would be restored. In circumstances where there is too much uncertainty to make firm proposals, consultation should focus on the interim arrangements for service provision, and any plans for

restoring the service — and the circumstances under which those plans might have to be reviewed.

## THE REQUIREMENT TO CONSULT

The combined effect of the regulations, Department of Health and Social Security guidance, and Ministerial statements may be summarised as follows:

1 Proposals for **permanent** closure or change of use require **prior** formal consultation.

2 Proposals involving **substantial** but **temporary** variations in service require formal consultation unless the authority is satisfied that a decision has to be made without allowing time for consultation.

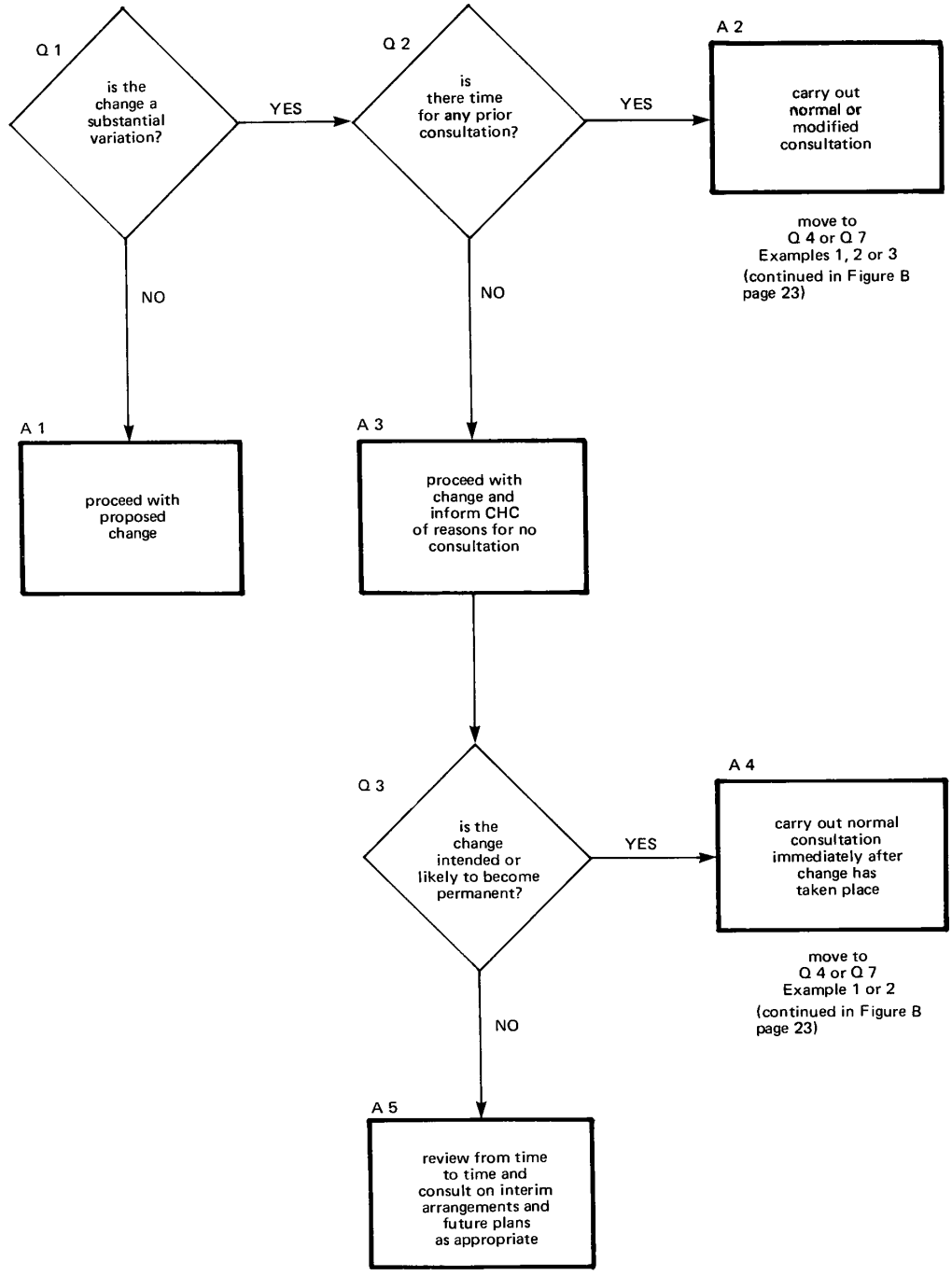
3 Where there is no time for prior formal consultation on a proposal for permanent change, the change should have only **temporary** force until formal consultation has been undertaken.

4 Where there is no time for prior formal consultation on a proposal which is intended to have only temporary force, an authority may vary the procedures and timetable of consultation but it should consult as fully as circumstances permit.

5 The requirement to refer Community Health Council objections to the Regional Health Authority and Secretary of State only applies in the case of permanent closures and changes of use.

Figure A illustrates 'when to consult' in the form of an algorithm of questions ('Q') and answers/activities ('A'). This diagram forms an unbroken sequence with figures B and C which follow in chapter 5 and illustrates the ensuing processes of consultation.

FIGURE A WHEN TO CONSULT




Example 4

## 4 CONSULTATION – PROCEDURES AND TIMETABLES

Guidance on the circumstances and process of consultation comes largely from the three sources listed in Chapter 3. Between them, these documents allow for a fairly wide variation in the timing, scope and content of consultation. Health authorities will rely on administrators, as guardians of due process, to have a thorough understanding of the formal requirements, to advise on the way to approach each situation, and to see that proposals do not founder simply because technicalities have not been properly observed.

The work involved in servicing a consultation process should not be under-estimated, particularly in the case of contentious issues which will attract voluminous correspondence and much press and public attention. This again is an area which administrators will be expected to handle properly and effectively.

At the same time administrators, and all others concerned with the consultation process, should be on their guard against a frame of mind where the mechanics of the process assume more importance than the real objective – which is to make sure that those who are being consulted have sufficient information and clear explanation to help them to reach balanced and objective decisions. Ideally this will have started well before any formal consultation stage is reached (see Chapter 2) and will continue with a carefully drafted consultation document as outlined in Chapter 5. But even then it will not be enough to adopt a merely passive role, just reacting in turn to others' reactions. Instead those most closely concerned should actively seek opportunities for informal discussions and make their willingness to do so widely known at the outset of the formal consultations. Meetings of staff consultative committees, local pressure groups, for example, can often provide opportunities to iron out misunderstandings, and to discuss issues in a less highly charged atmosphere than may otherwise be the case when the time comes for formal decisions to be taken by the Authority itself. The Community Health Council's special role in relation to consultation procedures means that it should always be offered all possible help and information for their own consideration of the proposals (see regulation 21 of SI 1973/2217).

The rest of this chapter is concerned with setting out the technical processes of consultation in a way which will provide a checklist for anyone who has to handle such a procedure for the first time. Because the whole thing can be quite complicated and because it may be varied to suit different circumstances, it has been presented in the form of diagrams and checklists which in turn relate to examples of the different kinds of consultation appropriate in different cases.

The figures use a sequence of questions and answers (or questions leading to action) to set out the steps which need to be taken. These then lead to one or more examples of the kind of consultation which would be appropriate in each circumstance. Four types have been given which between them illustrate the main variations which can occur. They are:

Example 1 the **normal process** envisaged in Appendix A of circular HSC(IS)207.

Example 2 the **normal process modified** only to take account of special circumstances such as those given in Appendix B of circular HSC(IS)207.

Example 3 consultations undertaken in **urgent circumstances** as allowed for in paragraph 20(1) of NHS(CHC) Regulation 1973 (SI 2217) where both timescale and procedure can be modified.

Example 4 consultations undertaken on changes which have already been carried out **without consultation** but which are not intended or likely to become permanent.

The diagrams form a single sequence starting with Figure A which appeared in the previous chapter (page 20). Figure B takes the process up to the issue of the consultation document and Figure C covers activities after the consultation period has ended.

The chart which appears in Appendix 4 tabulates all the formal activities and related administrative back-up work involved in carrying out a consultation procedure on the lines of Example 1, and also refers back to the diagrams and consultation circular where appropriate.

Those who make use of these guidelines should be aware that there is room for different practices to be adopted in the detailed arrangements. However the process shown here represents the kind of approach which has been used in more than one health authority and which has been accepted by those concerned as conforming with official guidance.

## EXAMPLE 1 – THE NORMAL PROCESS

This is the process covered by Circular HSC(IS)207, and illustrated in figure B and Appendix 4. It assumes that both informal and formal consultation takes place well in advance of the time when the Authority would be seeking to implement the change. The example given also assumes the most complex case in terms of time and effort involved ie a situation where following consultation, a health authority still wishes to proceed despite community health council objections, and the issue is referred first to the regional health authority and then to Ministers before final decisions are announced.

## EXAMPLE 2 – THE NORMAL PROCESS MODIFIED

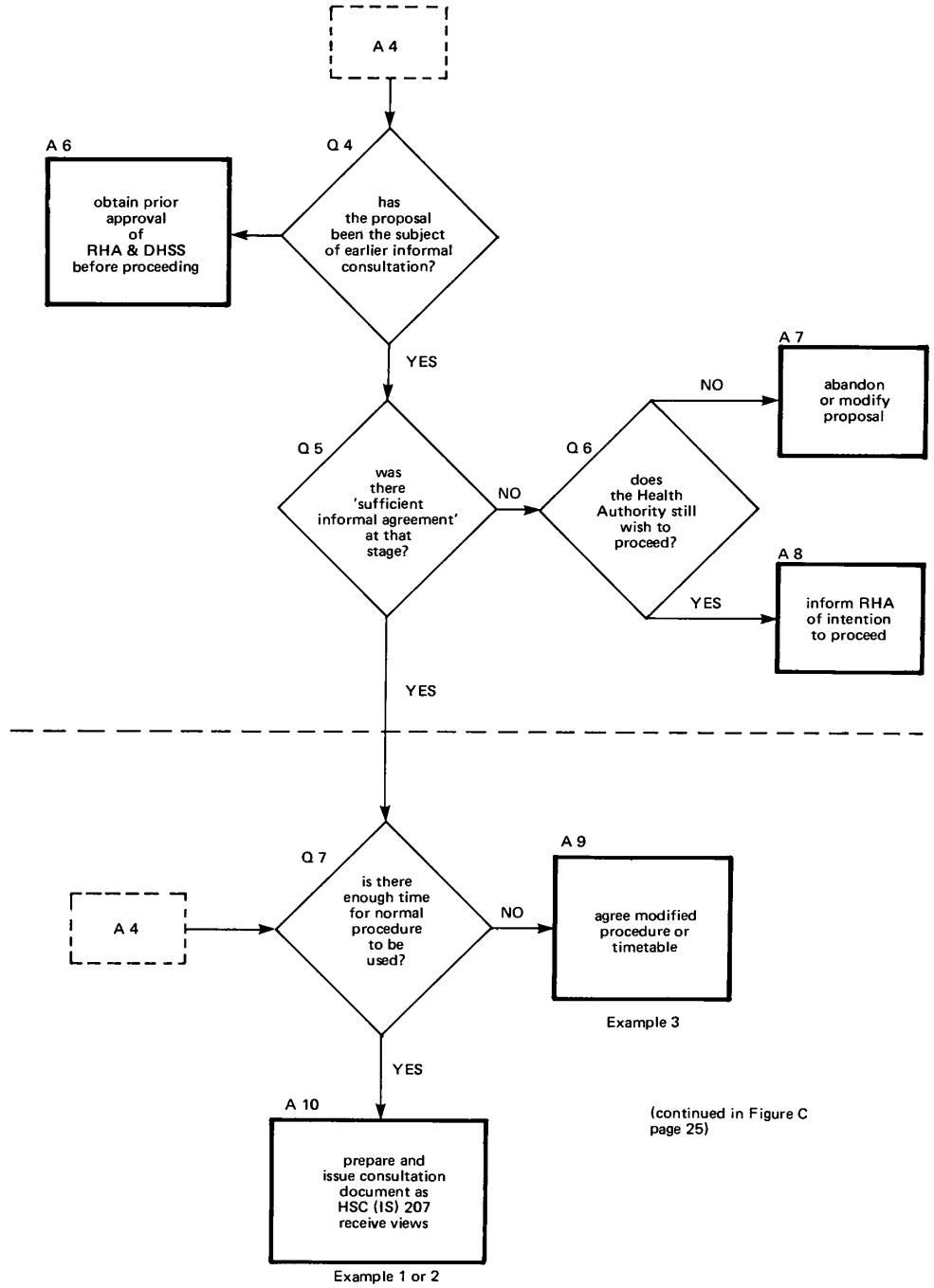
Appendix B of circular HSC(IS)207 gives some circumstances where special procedures are appropriate. It should be noted that Appendices A and B of the circular should be read together – they are not mutually exclusive – and in particular that :

> for 'buildings serving no given area' the requirement in Appendix B of the circular for the Secretary of State to be consulted on the arrangements for consultation does not mean that he is automatically involved in making the final decision. The note at the end of paragraph 2 in Appendix A of the circular still applies: a proposal will be referred to Ministers only if it is opposed by the Community Health Council or if it is specifically called in by the Secretary of State.

The process and procedures will still follow the same pattern as given in Example 1, but there will usually be a list of national bodies to be added to those consulted in the usual way.

FIGURE B

## HOW TO CONSULT
## 1 UP TO ISSUE OF CONSULTATION DOCUMENT




(continued in Figure C page 25)

**NOTE:**
The processes above the dotted line deal with the 'informal' stage of consultation which is normally fulfilled by the inclusion of proposals in planning statements which themselves have been through a consultation process. In many instances it will be possible to move straight to Q 7.

## EXAMPLE 3 – CONSULTATIONS IN URGENT CIRCUMSTANCES

These consultations take place not under the guidance given in the circular but under the statutory authority given in NHS(CHC) Regulation 1973 (SI 1973 No. 2217). Depending upon the circumstances it may still be possible to undertake some consultation, even though only a limited time can be allowed for response. No guidance exists on the procedure to be followed, but it is clearly sensible to try to follow the normal process as nearly as possible – that is to prepare as full a consultation document as time allows and to give as long as possible for those being consulted to put forward a view. But it is important to note that where limited consultation is undertaken in this way, the fact that the normal process is being used does not trigger the whole process of referring an opposed proposal to the Regional Health Authority.

Where there is no time at all for formal written consultation and the decision is implemented straight away, authorities are required by the Statutory Instrument to notify the Community Health Council immediately and to give the reasons why no consultation has taken place. No particular form of documentation is suggested for this process, other than the reference in the de Peyer letter (Appendix 3) to the need for a formal resolution to be included in the health authority's minutes.

Any closure decision taken on the grounds of urgency and implemented without consultation can have only temporary force. If it is then intended or likely to become permanent, then the normal consultation process (examples 1 or 2) should be set in train. The 'likelihood' that the change should become permanent has to spring from a real and identifiable possibility, not just the abstract possibility that the future is uncertain and anything might happen.

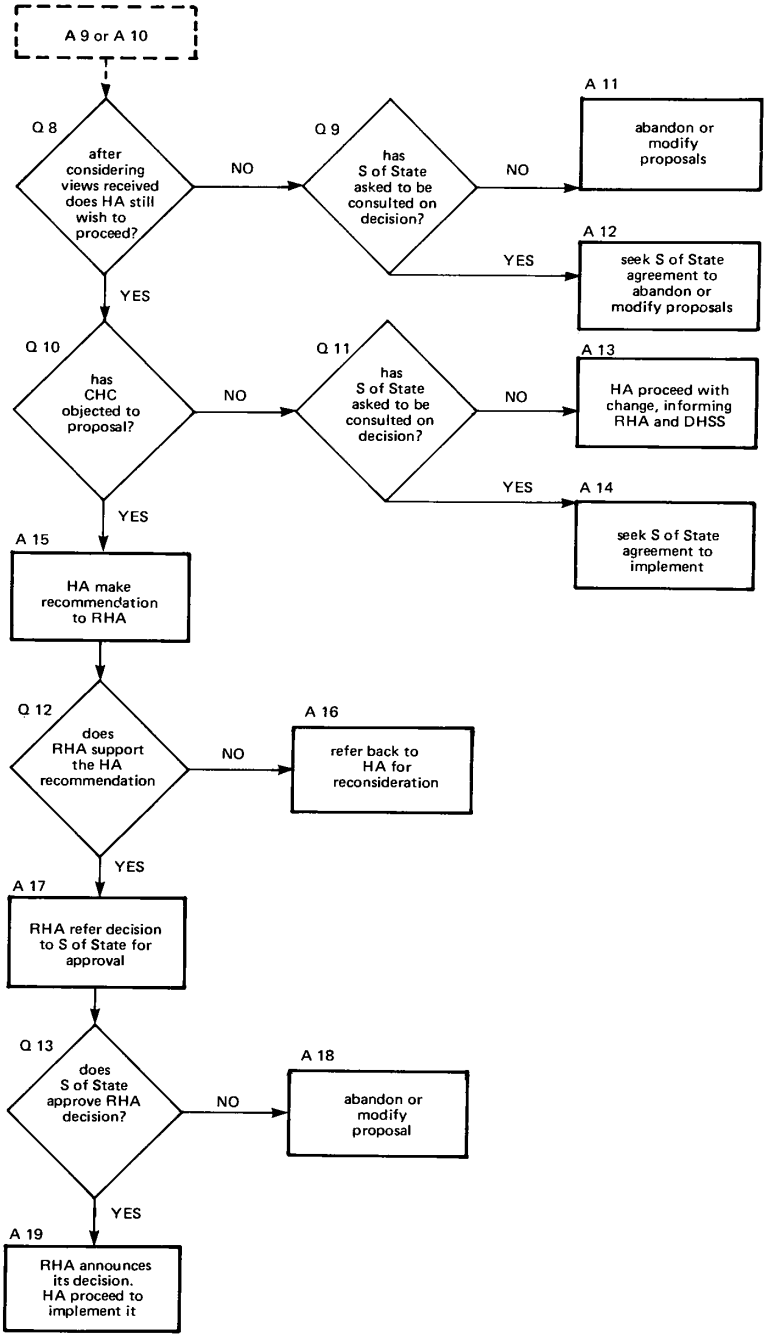
## EXAMPLE 4 -- POST HOC CONSULTATIONS ON DECISIONS ON TEMPORARY CLOSURES WHICH ARE NOT INTENDED TO BE PERMANENT

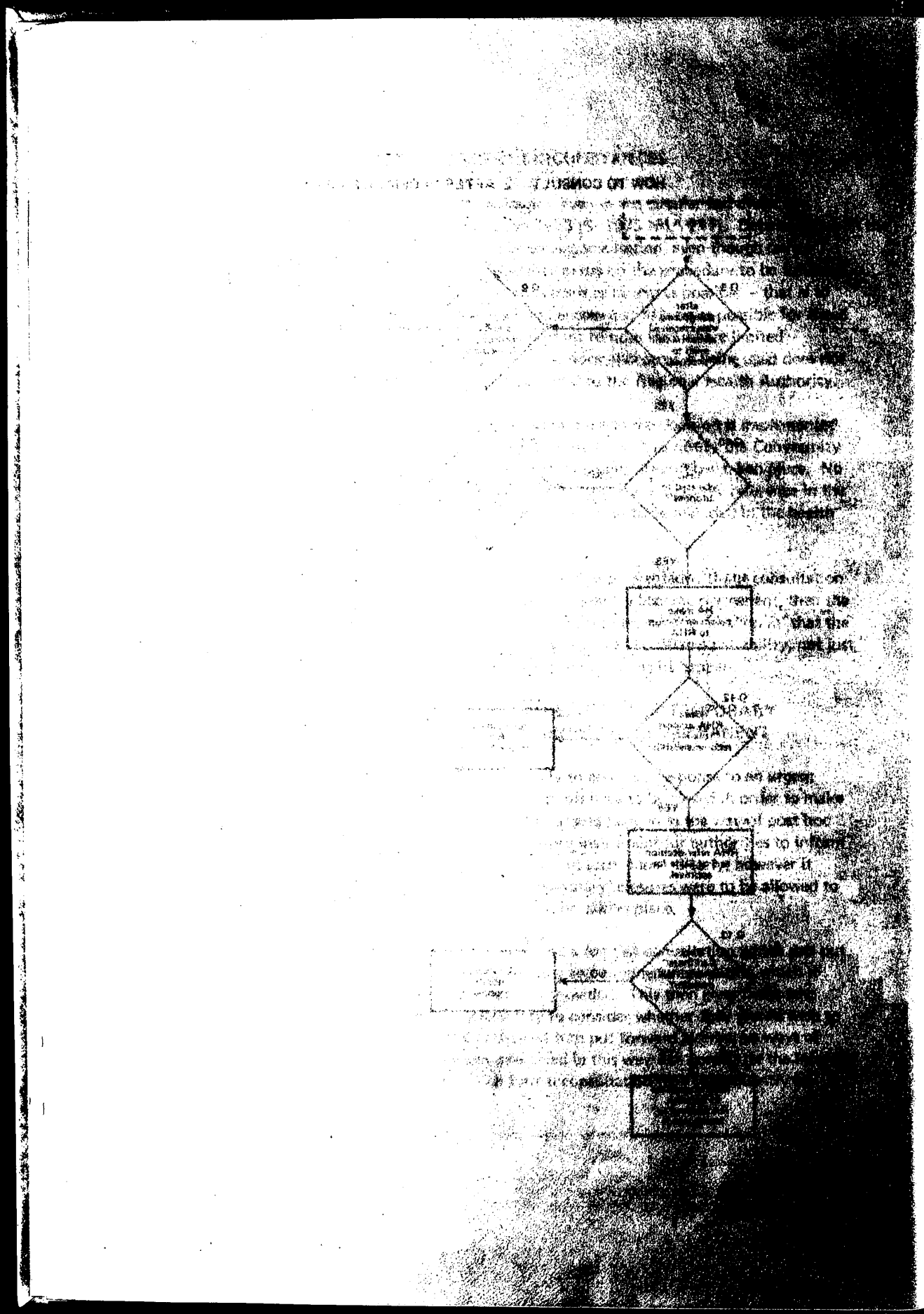
This situation is a relatively new one, and is most likely to arise as a response to an urgent financial crisis where changes have to be made or hospitals have to be closed in order to make savings at short notice. There is no guidance on what should happen in the way of post hoc consultation other than the requirement in the statutory instrument for authorities to inform Community Health Councils why it was necessary to take such steps. Clearly, however it would be against the spirit of consultation if such 'temporary' closures were to be allowed to become long-standing without some form of consultation taking place.

Authorities which have met this situation have initiated a form of consultation which sets out the reasons for the original decision and the constraints and circumstances within which it would be possible to reinstate the services previously provided. This then gives those who would normally have been consulted an opportunity to consider whether they would wish to see the original service reinstated, or whether they wish to put forward alternative ways of using the closed or changed facility. The views received in this way will constitute the informal stage of consultation for any changes on which formal consultation may subsequently be necessary.

FIGURE C

## HOW TO CONSULT - - 2 AFTER RECEIPT OF VIEWS





## 5 CONSULTATION – THE FORMAL CONSULTATION DOCUMENT

The consultation document issued by the health authority is a vital component in the consultation process. The content and presentation of the document are therefore of crucial importance. The Authority will have only one chance to put its case on paper. In preparing the document the knowledge, background and experience of the readership should be the starting point. It is likely to be a very heterogeneous group, including among others, local inhabitants, CHCs, local authorities, NHS staff, senior civil servants and ministers. The document should aim to reach the least informed of these.

CONTENT

### A Standard Front sheet

A standard beginning to every document should refer to HSC(IS)207 and set out the requirement for consultation, the decision to consult, the closing date and the person to whom comments should be sent.

### B Statement of the Proposal

A simple statement of the proposal should begin the document.

This should include the full name, address and/or siting of the unit or service. Only when this has been clearly established in the mind of the reader is it appropriate to give the reasons for, background to and details of the proposed action.

Formal consultation should relate to one specific proposal only.

### C Statement of the Present Position

Consultation documents can often be difficult to understand without a section which deals with the background and sets out the way services are organised at present (and which includes, where appropriate, bed allocations, out-patient attendances, accident and emergency department attendances, etc). A reference to the present financial position facing the authority might be included here.

### D Aims of Closure/Change of Use

1 Positive Approach

The aims of closure/change of use should be expressed in positive terms. The most obvious way in which to do this is to show the relationship of the change to the authority's strategy. The detailed justification might refer to the change:

(a) as a direct and planned consequence of capital investment in new facilities.

(b) as an indirect and possibly unforeseen consequence of capital investment.

(c) following population movements and demographic changes.

(d) as a result of changes in policy or priorities.

(e) as a result of changing patterns of delivery of health care.

Paragraph 3 of HSC(IS)207 specifically sets out the minimum points which should be covered in this section.

Elimination of waste and inefficiency is legitimate even in times of growth. It is important that the authority should not appear to be consulting on whether its revenue allocation is sufficient. That can never be the point at issue. While revenue cuts or other financial pressures provide the impetus for change the choices of what actually is changed are determined by service planning reasons. In addition it is often the case that there are a range of choices facing those who have to make economy decisions. All these are positive points which should be stressed in the document.

The expected savings should be expressed in quantifiable terms and/or details given of the services which will benefit.

2 Initial Statement of Aim

A simplified statement of the aim of closure/change of use might usefully precede the background details about policies, priorities or needs of the District.

Example Change of use of a 'partly acute' hospital to a 'non-acute' hospital. An initial statement saying that the unit is currently deemed more suitable for geriatric than acute work might precede a reference to the developing needs of modern acute medicine, changing emphasis on geriatric provision in the District, etc.

In this example the initial statement of aim may seem simplistic and assertive but it provides the thread which the less informed reader may bear in mind before embarking on the more complex background details and reasoning.

**E Detailed Justification of the Proposal**

Having stated the reason for closure in basic terms, a detailed exposition of the reasoning behind the proposal for closure or change of use should be given.

Whether this consists of a description of evolving local needs, or of policies, national guidelines, etc, the following should be observed:

1 All statements should be supported by factual evidence and statistics.

2 Details other than those strictly relevant to the argument should be omitted.

3 Headings should be useful indicators rather than general categories, eg indicating changing priorities in the authority rather than simply headed 'background'.

4 Medical, financial or other 'jargon' should be avoided or explained, eg 'childrens' beds' for 'paediatric beds'. The language used should be capable of being understood by the intelligent lay reader.

5 Tables, diagrams, maps should be clear and simple, as aids to understanding. (See examples in Appendix 5).

Without 'overselling' the proposal, this section should be rigorously argued, and scrupulously backed up with as much statistical and other data as is thought necessary bearing in mind the critical readership which the document will face. Potential areas to be covered are:

(a) Demographic, epidemiological changes.

(b) Norms, policy changes.

(c) Utilisation, occupancy statistics.

(d) Effects of the proposal on other units.

(e) Effects on the service concerned.

(f) Effects on medical teaching if relevant.

(g) Cost implications of the proposal.

Cost implications should be given in as much detail as possible for a lay readership. They should show the extent of savings, where and how they would arise, and how they would be used.

### F Rejected Alternatives

Although formal consultation should relate to one specific proposal, other options which have been rejected may be mentioned. This may occur naturally during the detailed justification of the proposal but it will also be prudent to supplement the main proposal with a separate section in which other options are briefly but comprehensively rejected. Some alternatives may have been discussed with the Community Health Council at the informal consultation stage and then rejected. These could be included here.

### G Implications for Patients

Whereas the earlier section should emphasise the service details of the proposed closure or change of use, this section covers, as fully as possible, the implications for patients. The following points should be included:

1 The medical benefits of the proposal should be clear from the preceding section but they

might be repeated.

2 Effects on access for patients and visitors. Details of the transport facilities lost and gained should be given in full. Experimental walks, bus and train journeys could perhaps be made at visiting and clinic hours, and travel times and conditions included. Clear maps of transport routes should be included. (See Appendix 5).

3 Non-medical hospital facilities lost and gained (day rooms, diversional facilities, libraries, shops, car parking, waiting rooms.)

**H Implications for Staff**

As much care should be taken to investigate the implications for staff as for patients. This should constitute a separate section.

The following points should be included:

1 Where a redundancy policy exists this should be stated absolutely clearly and categorically. Alternatively, the principles of the Authority's policy on protection of employment should be set out. This might cover:

(a) Filling of vacancies during the consultation process.

(b) Opportunities for staff affected to seek alternative employment elsewhere in the authority or in neighbouring authorities.

(c) Assurance that Whitley agreements on redundancy would apply.

2 If a reduction in staff is likely then information should be given. Present staffing levels should be shown, with information on what they will be reduced to when the change is fully implemented. The amount of detail appropriate will be a matter for judgement in each case.

3 If relevant details of transport and staff facilities under the new arrangements are available, these should also be included, as in the section on implications for patients.

**I Possibilities for Using the Redundant Facilities for Other Purposes or Disposal of the Site**

The closure of a hospital/health building for its present use should be regarded as a separate issue from the future use of the premises. If the area health authority have a proposal for future use it should be stated. If it is unclear whether the premises will be used for National Health Service purposes, it is essential to say so, rather than to imply some possible future use that is unlikely to be implemented. If there are a number of options for the future use of the building concerned these could be mentioned in brief with an indication that no firm decision has yet been made. As noted above, the cost of maintaining the site and building when empty should be mentioned.

## J Estimated Timetable of Closure or Change of Use

The consultation document should include an estimated timetable of the closure or change of use. Details of the proposed interim arrangements in the case of change of use, or closing down plans in the case of closure, should be described sufficiently to show that the main issues and problems have been considered (and costed, where appropriate).

## STYLE AND PRESENTATION

Generally speaking, the consultation document would be prepared following the order laid out above. The tone of the document should be conditional and the subjunctive tense used when referring to future proposals. It should not imply that decisions have already been made or that the result of the consultation is a foregone conclusion.

Care should be taken in the presentation and layout of the document. It will rarely be possible or justifiable to print the document, but it should be easy to read. Statistics should be well presented and not crammed together. Occasionally a photograph might help to emphasise a point. (Modern photocopiers can reproduce good black and white prints well).

## DISTRIBUTION

Copies of the document should be sent to and comments sought from:

1 Community Health Councils.

2 Local Authorities through their chief executive.

3 Joint Consultative Committees.

4 Joint Staff Committees and any other recognised staff organisations not represented on the Committee.

5 Trade Union full-time officials (where it is considered helpful to supplement 4).

6 Family Practitioner Committees.

7 Appropriate local advisory committees, including the statutory advisory committees for the authority concerned.

8 Local Medical Committees etc.

9 Other health authorities should be consulted on any proposal which may have repercussions for them. (The consultation document should make quite clear what are the implications of the proposal for other health authorities. It should not be left to neighbouring authorities to puzzle out for themselves why they have been sent the document. It might even be helpful to prepare a supplement which specifically points to the aspects of the proposal which affect them.)

10 Medical Schools, Post-graduate Institutes, Training bodies and Universities should be consulted where appropriate.

11 Any other body not covered above which the Health Authority considers should be consulted (eg voluntary organisations, Trades Councils).

12 Appropriate groups and individuals within the District:

(a) This list should normally include members of local Joint Staff Committees, the Medical Committee and heads of departments.

(b) Every individual member of staff directly affected by the proposal should be given the opportunity to see a copy of the consultation document.

13 The Regional Health Authority, the Department of Health and Social Security, local Members of Parliament, and the local press should be sent the document for information.

When other health authorities are consulted, constituent officer teams, the Family Practitioner Committee and the Community Health Council should also be included. It is for the authority issuing the consultation document to decide whether it wishes to consult extra-territorial officer teams direct or through the appropriate health authority. It is important to make clear to everyone which course has been adopted.

HSC(IS)207 allows the Health Authority almost complete freedom in extending consultation as it sees fit. The Health Service Commissioner's Report 1977/78 suggests that consultation should be 'as wide as possible' on all issues, particularly on closure and change of use which are known to arouse local feelings. Therefore, additional requests for consultation by bodies not on the above list should generally be acceeded to. Finally, a check-list such as that in Appendix 6 may be found useful as a means of checking on the content of the consultation document.

## 6 'DE-COMMISSIONING'

Once there is acceptance and authority to proceed with a closure, there is still much work to be done in managing the physical changes which are necessary. The ultimate change, and one which includes the greatest range of activities, is the hospital closure. The closure process is therefore described in this section in relation to a hospital but the principles should be applied to all changes of use. The foundations of 'de-commissioning' * are laid during the preparation of consultative documents as set out in earlier chapters. In discussing how to build on these foundations, this section takes five topics: budgets; staff; equipment, services and records; physical closure; alternative use or disposal. Some of the recommendations are illustrated by actual examples. The process is summarised by a check-list in Appendix 7.

### BUDGETS

All closures have budgetary implications which should have been stated as objectives in the early proposals. The main purpose of closure may be to achieve economies or release resources for other uses. Alternatively, if new facilities are to be opened, contributions to their budget will come from the unit that is closing. (Appendix 8(a) shows how the existing budget was shared between three new units and what additional funds were needed). The stated results will only be achieved with the help of a rigorous monitoring system. No closure is going to contribute full year savings except over a period of at least two financial years and some, where closure is planned to take place over a number of years, will need a clear statement of the budgetary effect of each partial closure.

Appendix 8(a) also illustrates, for overall financial planning, the broad changes expected over a number of financial years. However, to enable all managers to plan their contribution to the closure process by not replacing staff to posts which are going to disappear and, by eliminating unnecessary non-staff expenditure immediately before closure, a detailed statement is needed. This is also illustrated in Appendix 8(a). During the preparation of each operational plan, the detail of the following year's closures will be worked out. A prolonged closure is the most complicated budgetary exercise faced by an authority but the principles apply equally to a one-off closure. Although the emphasis will be on saving money, due allowance must be made for the cost of closing down a hospital after patients have left, heating and maintaining it on a 'mothballed' basis until disposal, and the cost of preventing an asset diminishing in value because of vandalism. The scale of these last costs can help instil urgency into those whose responsibility it is to determine the future use and to dispose of any redundant site.

### STAFF

Because the National Health Service is labour intensive, the implementation of any change of use is going to concentrate as much on the effect on staff as on services to the public. Any changes

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* Reference is made in this chapter to the 'de-commissioning' process. There are useful parallels here with the 'commissioning' process for new buildings, particularly in those changes which entail the closing of one building and opening of another. The King's Fund publication, *Commissioning Hospital Buildings,* which is currently being revised in preparation for a third edition, has obvious relevance in this respect. The check lists of 'operational systems' may be particularly useful.

will have been the subject of informal discussion as outlined earlier but their success or otherwise may well be determined by the confidence that staff have in the procedures which will be used to make the changes. The procedures for staff consultation and for staff transfer must be clear. For an authority planning a number of changes, or one which may have implications in several districts, a more formal procedural agreement is desirable. The essentials of such a document are set out in Appendix 10.

Whatever procedure is adopted, all authorities acknowledge the extent to which having an agreed, well-known and understood system is crucial to implementation. Management and staff organisations should not be negotiating procedural details when everybody should be concentrating on the move. Each manager should accept that there is one framework within which to work and not be divisive by adopting a different standard from others. Experience has shown that with clear procedures, staff can usually be absorbed quickly either to vacancies as they arise, through normal retirement, or by appropriate transfer with the patients who have been relocated. Short term vacancies which must be covered at the building to be closed can be filled by temporary appointments, or the judicious use of overtime, rest day working, etc.

There are advantages in having had detailed financial statements as part of the consultation document. Where one or more units are to be closed and staff and patients transferred to other units, detailed costings of the savings and expenditures to be incurred can be set out in the consultative document as in Appendix 8 (a and b). These have obvious advantages in encouraging full discussion and agreement on staffing implications at the consultative stage, and also provide invaluable data for use in managing the process of staff transfers once the formal decision to close has been agreed.

## EQUIPMENT, SERVICES AND RECORDS

During the process of planning a new department, equipment lists are drawn up which identify whether an item will be transferred or purchased. Whether a closure is due to the opening of a new department or other reasons, the same process must be completed for all the equipment due to be left behind. Indeed, the activities are very much the reverse of equipping a new building. The lists prepared on a room-by-room, department-by-department basis, must be capable of aggregation so that once a building is emptied, the furniture and equipment can be brought together. Equipment lists should be drawn up three to nine months in advance of closure – the earlier date if existing equipment is transferring with the patient service to its new location.

All health service buildings are subject to service contracts from swill to funerals, lift insurance to typewriter maintenance, window cleaning to grass cutting – often negotiated on a twelve month basis. These should be put on an inventory as part of the closure planning so that any renewals are considered during the consultation period, quite apart from action being taken to terminate them once the closure date is known. Additional security contracts may have to be negotiated as a result of the closure. Apart from the main purpose to which any health service building is devoted, there may be many lesser patient services affected by closure. Visiting medical or para-medical staff may have hours or possibly sessions freed for other purposes. The individual staff time is unlikely to be sufficient to be treated under a formal procedure agreement as considered in the section on staffing, but the development benefit

of this time should not be overlooked. A check should also be made of the use by others of the hospital building, even if only on an occasional basis, eg a community-based dialysis patient using a hospital incinerator for disposal.

All health service buildings are depositories of records. HC(80)7 gives the most recent Department of Health and Social Security guidance about the retention of records. Determining what should be kept and what can be destroyed or preserved on microfilm rather than in their original form should be an on-going process. The chances are, however, that in any long-established hospital, there will be records and other items which have not been sorted. Although these are obsolete, they may now be of historic interest and not only transient rubbish. Administrators should always be willing to seek the advice of their local authority archivist. A report jointly prepared by archivists and National Health Service administrators in the North Western Region is available.*

Stocks of consumable items tend to provide most departments with a generous buffer against the unexpected crisis. Managers should not only run down buffer stocks to basic levels between three to six months of closure but should aim to use up virtually all items during the last month in order to minimise the need, for example, to destroy residual drugs and perishable foods. This will also avoid the work of returning stocks of excess linen, central sterile supply department, or similar items to the producer department or stores after closure.

## PHYSICAL CLOSURE

When patients are transferred, the caring staff leave with them, thinking little about the building or part of the building that they have left behind. The first requirement is security. If only part of a building is vacated, additional locks will be needed on access doors to prevent security being overridden by the normal master keys. If a whole building is being vacated, access should be restricted to one entrance. All other entrances and ground floor windows should be permanently secured and, in some parts of the country, covered. Arrangements for patrolling the premises should be initiated from day one.

In spite of preparations taken before, it will still be necessary for catering, CSSD, linen room, pharmacy and stores staff to visit vacated departments to remove all reusable items and to dispose of the remaining consumable goods. Furniture and equipment for transfer will have been checked out on the day of the move, but checking the residual items can be done over a more prolonged period. If the closure is partial, the remaining staff may carry out the following duties over several weeks or months. For a total closure, it is better to concentrate on completing the work as quickly as possible. Some authorities have used contract services successfully. The problem of occupation by 'squatters' is a real one and a number of hospitals have been so affected.

All residual furniture and equipment should be checked against the inventory lists and categorised for renovation and re-use, disposal as surplus, or scrap. Everything should be moved to pre-determined locations according to type of item. This grouping assists decisions about the most beneficial re-use of furniture and equipment rather than allowing items to be dispersed in penny numbers.

*See bibliography.

The works officer should be consulted from the earliest stages of the closure proposals and his advice sought on all aspects of building maintenance and environmental safety until final disposal or demolition. Unless a building is scheduled for early demolition, arrangements should be made to ensure the availability of minimum heating services at short notice to reduce deterioration due to high humidity and prevent frost damage. This will require that boilers and/or calorifers and ancillary equipment remain in situ and must be maintained in a safe and operable condition until disposal or demolition.

Fire hose reel installations and the water supply service to them should be maintained in a state of readiness and, in certain circumstances on the advice of the fire officer, it may be advisable to retain fire extinguishers on the premises. Fire alarms should also be maintained and tested regularly.

Loading gates or doors of lifts should be closed and secured. Lift motor rooms must also be locked and the door keys held by a responsible officer. Unless the building is shortly to be demolished, maintenance should be continued at a minimum level consistent with safety and operational efficiency until it is ascertained that the health authority or the purchaser will not require the premises for occupation.

Lighting circuits should remain in situ but lighting fittings, shades and most lamps on flexible pendants may be removed.

Arrangements should be made to ensure that the building is weatherproof and occasional examinations are recommended to ensure that roofs are sound and the windows are closed with glazing intact. Gutters and drain pipes should also be inspected at regular intervals to ensure that blockages are cleared before unnecessary structural damage is caused.

Mains services – eg electricity, gas, water, ventilation or air conditioning ducts, medical gases, etc, should be switched off at the main intake or blocked off at a convenient point, unless it is necessary to retain the service for essential maintenance or for reasons of safety. Care must be exercised to ensure that the curtailment of a service does not disrupt the supply to occupied parts of the building or to other areas of the hospital.

Arrangements should be made at an early stage to re-route pipework etc and install any necessary valves or switches which may be required to isolate the vacated premises or to provide alternative sources of supply to residual area being retained.

A notice should be displayed near the entrance to vacated premises stating, if appropriate, that the building is not to be occupied or used for any purpose and indicating the name, address and telephone number of an officer to whom enquiries should be directed in the event of an emergency.

Partial closure, particularly of a large hospital, creates difficulties unless complete blocks can be isolated. Small departments serving the residual unit may remain in otherwise empty blocks. The cost of re-housing has to be assessed against the marginal cost of retaining engineering and cleaning services to that area, and continued payment of rates on all partially occupied blocks. In a gradual closure those services which are used by the site as a

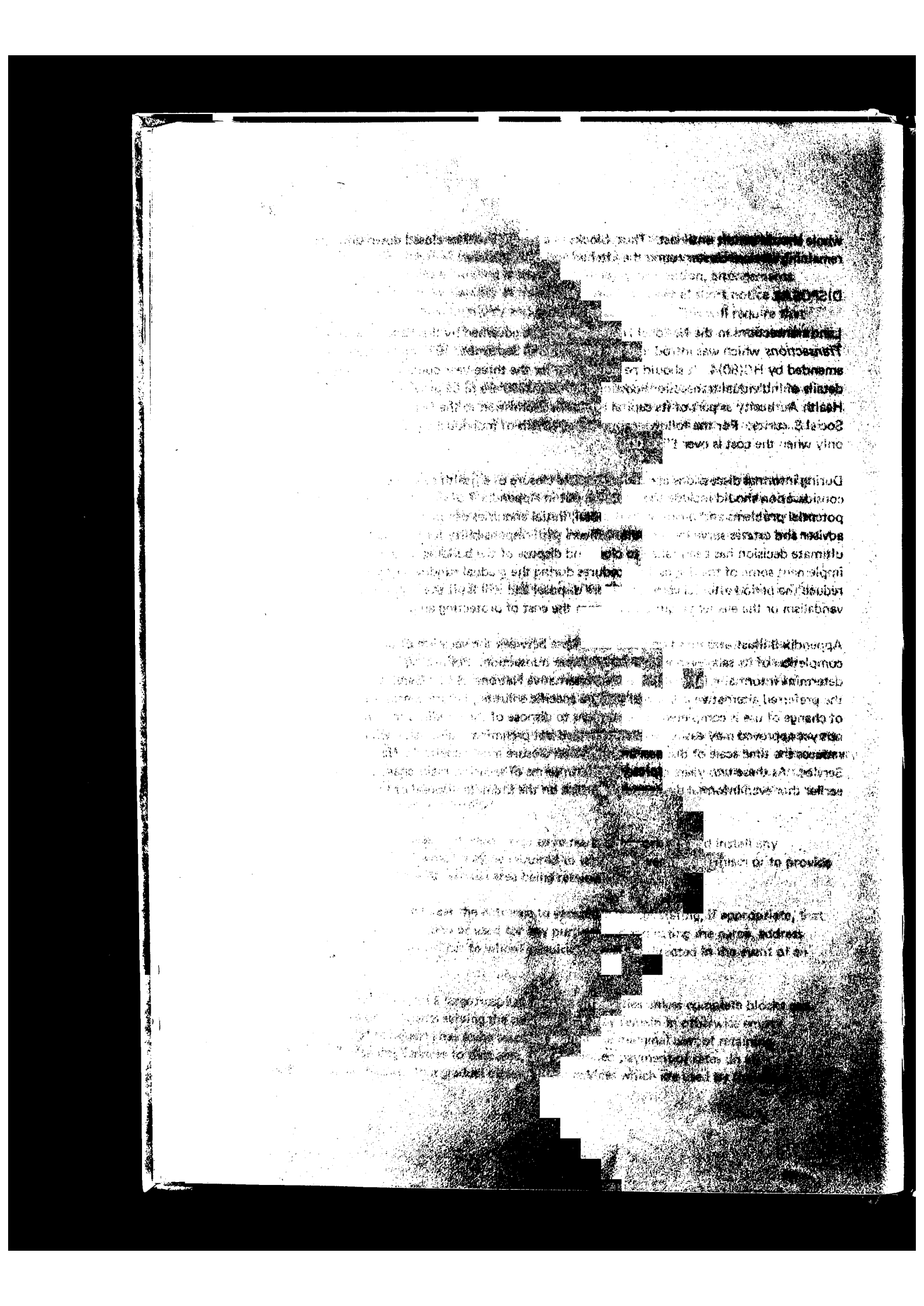
whole should be left until last. Thus, blocks in a hospital will be closed down until the remaining services cluster round the kitchen and boiler house.

## DISPOSAL

Land transactions in the National Health Service are governed by the *Handbook on Land Transactions* which was introduced by HC(77)34 in September 1977 and subsequently amended by HC(80)4. It should be noted that for the three-year operational planning period details of individual transactions costing over £250 000 are to be provided by the Regional Health Authority as part of its capital estimates submission to the Department of Health and Social Security. For the following four years, details of individual transactions are required only when the cost is over £500 000.

During informal discussions about the possible closure of a health service building, consideration should include the issues set out in Appendix 7 of the handbook. To avoid potential problems and delays with disposal, initial enquiries can be completed by the legal adviser and estates surveyor, or other officers with responsibility for land matters. Once the ultimate decision has been taken to close and dispose of the building, it will be possible to implement some of the disposal procedures during the gradual rundown of services. This will reduce the period after its vacation before disposal and will limit the likelihood of damage by vandalism or the elements, quite apart from the cost of protecting an unwanted building.

Appendix 9 illustrates that two years can elapse between the vacation of the premises and the completion of its sale, even with a fairly simple transaction. Politically, it may be difficult to determine informally (a) that there is no alternative National Health Service use, and (b) that the preferred alternative is disposal giving a specific solution, before consultation on closure of change of use is completed. Negotiations to dispose of the buildings for which closure is not yet approved may easily be misinterpreted but preliminary discussion which subsequently reduces the time scale of disposal after physical closure must benefit the National Health Service. As these two years represent costs in terms of security, maintenance and rates, the earlier that even informal discussions can start on the ultimate disposal of the site, the better.



## 7 CONCLUSION

It has been the purpose of this handbook to indicate ways in which current procedures concerned with change can best operate. As changes occur more frequently, 'case law' is being developed rapidly which affects every new situation that presents itself. Changes in procedures have been suggested which could be discussed further. For example the setting up of 'review bodies' similar to the Transport Users Consultative Committees has been proposed, so that all issues surrounding a proposed closure can be publicly debated prior to a Ministerial decision. (See the article by Nigel Weaver in the October edition of the *Hospital and Health Services Review.)*

The role and function of Community Health Councils has been discussed in connection with the consultative document *Patients First.* Some would want to question a Community Health Council's right to place obstacles in the way of a proposed closure; others the onus placed on Community Health Councils to propose alternative solutions especially when they do not have the necessary information on which to do so.

Few would disagree with the statement that every closure or substantial change of use is unique. Moreover, there are few people including the public or staff who are likely to be very enthusiastic about substantial change. There are, however, a number of important areas which have always to be borne in mind as has been outlined above. In brief they can be associated with the need to:

- Clarify the **need** for change — reasons for it, alternatives, consequences, and benefits, particularly with regard to clinical care.
- Develop a **realistic** timescale.
- Pursue the concept **energetically** and **purposefully.**
- **Consult** with all concerned frankly and maintain contact after consultation.
- **Think** and **plan** ahead — develop all stages of the operation well in advance.
- Remember that the exercise requires extra managerial effort particularly from senior management as well as whole hearted support from management generally.
- **Understand** attitudes of the public and staff.

It is certain that changes in medical technology, patterns of care, and economic climate will lead to constant evaluation of the optimum use of existing resources. Change in the service, whether it be associated with structure and management arrangements, or change in use of resources must be able to adapt to change more easily than at present. Existing consultative procedures are open to interpretation and refinement in the light of events. However, the time taken to obtain ministerial approval to closures during the period between 1974 and 1980 has, at times, been a cause for concern because of 'planning blight' and the difficulties of maintaining services and making economies during the intervening period.

It will, no doubt, be necessary to review and amend sections of this handbook from time to time. Meanwhile, it is hoped that it will help to serve as a guide to those administrators who have to tread a difficult path trod by others before them and perhaps even for other interested groups to understand better the need for change and to feel that they have been able to play their part in enabling the best possible care to be provided to the patient within the resources available.

## SELECT BIBLIOGRAPHY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Other examples of closure documents used in this book were selected from material supplied by:

The South West District of Hertfordshire AHA
Worcester District, Hereford and Worcester AHA
South Glamorgan Health Authority (Teaching)
Surrey Area Health Authority
Ealing, Hammersmith and Hounslow Area Health Authority (Teaching)
Merton, Sutton and Wandsworth Area Health Authority (Teaching)
Rochdale Area Health Authority.

APPENDIX 1

## EXTRACT FROM THE NATIONAL HEALTH SERVICE (COMMUNITY HEALTH COUNCIL) REGULATIONS 1973 (SI 1973 No. 2217)

*Consultation of Councils by relevant Area Authority*

20 (1) It shall be the duty of each relevant Area Authority to consult a Council on any proposals which the authority may have under consideration for any substantial development of the health service in the Council's district and on any such proposals to make any substantial variation in the provision of such service:

Provided that this regulation shall not apply to any proposal on which the Area Authority is satisfied that, in the interest of the health service, a decision has to be taken without allowing time for consultation; but, in any such case, the Area Authority shall notify the Council immediately of the decision taken and the reason why no consultation has taken place.

(2) An Area Authority may specify a date by which comments on any such proposals as are referred to in the foregoing paragraph of this regulation should be made by the Council to be taken into consideration by the Area Authority and in any case where a Council is not satisfied that sufficient time has been allowed or that consultation on any such proposal has been adequate, the establishing authority shall have power to require the Area Authority to carry out such further consultations with the Council as the establishing authority considers appropriate and the Area Authority shall reconsider any decision taken on the proposals having regard to such further consultations.

*Information to be furnished by relevant Area Authority*

21 (1) It shall be the duty of the relevant Area Authority to provide the Council with such information about the planning and operation of health services in the area of that Authority as the Council may reasonably require in order to carry out its duties:

Provided that confidential information about the diagnosis and treatment of individual patients or any personnel matters relating to individual patients or any personnel matters relating to individual officers employed by a health authority should not be given to any Council or member or officer of such Council and, subject to the provisions of the next following paragraph of this regulation, an Area Authority may refuse to disclose to a Council any other information which the Authority regards as confidential.

(2) In the event of a relevant Area Authority refusing to disclose to a Council information requested, the Council may appeal to the establishing authority by which the Council was established and a decision of the establishing authority as to whether the information is reasonably required by the Council in order to carry out its duties or as to whether the Area Authority may regard the information as confidential shall be final for the purpose of this regulation.

**APPENDIX 2**

## CLOSURE AND CHANGE OF USE OF HEALTH BUILDINGS – DHSS CIRCULAR HSC (IS) 127

## DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities
Area Health Authorities
Boards of Governors
Family Practitioner Committees

October 1975

### CLOSURE OR CHANGE OF USE OF HEALTH BUILDINGS

**Summary**

This Circular and Appendices set out the procedures which Health Authorities should follow in relation to the closure or change of use of Health Buildings.

**Introduction**

1. Following NHS reorganisation and the introduction of new procedures for planning in the NHS, the procedures for closures and changes of use of health buildings have been reviewed. The aim of the revised procedures is to enable resources to be redeployed with the maximum speed and simplicity consistent with adequate local (and, where relevant, national) consultations. Especially at a time of economic constraints it is essential that no unnecessary barriers should impede cost-effective use of the resources available to the NHS. Because local circumstances vary, the procedures should be worked out for each case in the light of individual circumstances at the time and reviewed if those circumstances change.

**General**

2. In general, responsibility for determining the closure or change of use of health buildings rests with the Area Health Authority, subject to the formal agreement of the Community Health Council. Where sufficient local agreement exists, it should be possible to move from a proposal to close (or change use) to actual closure or change of use within a period of six months.

3. A closure or change of use must be justified for one of the following reasons:-

a. the service provided can more efficiently be undertaken elsewhere;

b. the facility is no longer required because of new developments;

c. redeployment of services is essential having regard to the resources of manpower and finance available;

d. it is necessitated by developments outside the NHS, eg road proposals.

**Links with planning procedures**

4. The draft "Guide to Planning in the NHS" emphasises the need for early, informal consultations, especially on points of possible difficulty, between Districts, Areas and Regions, and describes the consultations on planning proposals that will need to be undertaken with a wide range of interests. Any foreseeable closure or change of use will clearly need to be dealt with in the exchanges and consultations described in the Guide. The attention of Community Health Councils, Local Authorities (including District Councils) through the Joint Consultative Committees, Family Practitioner Committees, Local Advisory Committees, Local Medical Committees, Joint Staff Consultative Committees and other bodies, as appropriate, should be drawn particularly to any closures or changes of use required by plans, and their general reaction to the proposals sought. A final commitment is not normally required at this stage since the plan as a whole will still be subject to review.

APPENDIX 2
(Continued)
(HSC (IS) 207)

5. The integration of tentative proposals for closures and changes of use in the planning system as in Paragraph 4 above obviates the need for a separate process of informal consultation on these issues. Exceptionally, however, where a proposal has not been covered in plans because it arose from sudden and unexpected reasons, the AHA may, with the prior approval of the Regional Health Authority and the Department, proceed directly to formal consultations as in paragraph 6, without preliminary informal consultations.

**Total closure or change of use**

6. When the AHA considers that sufficient informal agreement has been reached on plans which include a proposed closure or change of use (but see paragraph 5 above) and a firm decision is required, formal consultation should be undertaken in accordance with the detailed procedures in Appendix 'A' to this Circular. If, despite disagreement, the AHA decides that the position is such as to justify moving to formal consultation they should inform the RHA that they are proposing to do so.

**Other arrangements**

7. Appendix 'B' to this Circular outlines some special circumstances in which it may be appropriate to vary the arrangements described in paragraph 8 below and in Appendix 'A'.

**Transitional arrangements**

8. There are at present a number of proposals for closure or change of use at varying stages of the procedures. It will be for the AHA to operate the above mentioned consultation process at the most appropriate point; and in particular to ensure that the proposal has been put to the bodies listed in paragraph 4, and any other relevant bodies, for their comments.

**Guidance Superseded**

9. This Circular supersedes the following documents -

a. DS 111/74

b. DS 168/72

c. Secretary of State's letter to Hospital Board Chairmen dated 17 November 1969.

**From:** **Regional & Planning Division (RPD3)**
**Euston Tower**
**286 Euston Road**
**London NW1 3DN**
**Tel: 01-388 1188, Ext 688**

J/H 109/01

**Further copies of this circular may be obtained (by written request wherever possible please) from: Central Store DHSS Depot Primrose Mill Clitheroe Lancashire BB7 1BP**

APPENDIX 2
(Continued)
(HSC (IS) 207
– Appendix A)

## PROCEDURES FOR CLOSURE OR CHANGE OF USE OF HEALTH BUILDINGS: FORMAL CONSULTATION PROCEDURE

1. Except where otherwise provided in Appendix B, a consultation document should be prepared. This should cover such matters as:-

i. the reasons for the proposed closure or change of use;

ii. evaluation of the possibilities of using the redundant facilities for other purposes, or disposal of the site;

iii. proposals for alternative employment of staff;

iv. the relationship between the closure or change of use and other developments in the plans - and

v. implications for patients, eg travelling and transport.

2. The AHA should require comments, *within a period of three months*, from:

- Community Health Councils †
- Local Authorities through the appropriate Joint Consultative Committees.
- Joint Staff Consultative Committees and any other recognised Staff Organisation not represented on the committee.
- Family Practitioner Committees (which will wish to consider the position of the tenancy agreements of general practitioners and others in proposals for closure or change of use of a health centre).
- Appropriate Local Advisory Committees, including the statutory Medical Advisory Committee for the Area concerned.
- Local Medical Committees etc.
- Any other body or person not covered by the above which the AHA considers should be consulted. (eg voluntary organisations).

At the same time local MPs, the RHA and the Department should be informed, and a press statement issued. If the Secretary of State's approval is required before the final decision is taken, in view of the national importance of the proposal or for any other reason, the AHA and RHA will be so informed by the Department.

3. The AHA should seek the CHC's views on the comments received and the AHA's own observations on those comments. The AHA should then reconsider the proposed closure or change of use in the light of all the comments received, particularly those of the CHCs in view of their special responsibility in relation to closures referred to in paragraph 23(e) of the Consultative Paper 'Democracy in the National Health Service'. If the CHC agrees, and the Secretary of State has not asked to be consulted further before approval, the AHA can proceed with the closure or change of use, notifying the RHA and the Department of such decision. The aim should be to reach this point *no later than 6 months* from the issue of the consultation document as in paragraph 2.

4. If the CHC wishes to object to a closure or change of use, it should submit to the AHA a constructive and detailed counter-proposal; paying full regard to the factors, including restraints on resources, which have led the AHA to make the original proposal. The AHA should extend to the CHC all reasonable information and help they may require in formulating a counter-proposal. The AHA should consider the counter-proposal and refer the matter with recommendations to the RHA. If the RHA is unable to accept the views of the CHC and proposes to proceed with the closure or change of use, it should seek the Secretary of State's approval before announcing its decisions.

† **When more than one CHC is involved, possibly in different areas, consultations should take place between the relevant CHCs and AHAs concerned, or their agreed representatives, and their views fully discussed before final agreement is reached.**

APPENDIX 2
(Continued)
(HSC (IS) 207
– Appendix B)

## PROCEDURES FOR CLOSURE OR CHANGE OF USE OF HEALTH BUILDINGS: VARIATION OF PROCEDURES IN CERTAIN SPECIAL CASES

### PARTIAL CLOSURES OR CHANGES OF USE

1. Proposals for partial closure or change of use which amount to 'any substantial variation in the provision' of the health service within the meaning of Regulation 20(1) of the CHC Regulations should be discussed with the CHCs, LAs (through JCCs), FPCs, appropriate LACs, LMCs, the Joint Staff Consultative Committees and any other recognised staff organisation not represented on the Committees. In most cases it should be possible for local agreement to be reached on restricted consultation but, if not, the procedures in Appendix A should be followed.

### TEMPORARY CLOSURE OR CHANGES OF USE

2. Temporary closure or changes of use should continue to be part of day to day management of the resources within the health district and will generally lie outside the procedures in Appendix A. The CHC should however be informed of substantial temporary closures as soon as possible. If it is necessary to translate temporary closure or changes of use into permanent closure or changes of use, the detailed procedures in Appendix A should be applied.

### BUILDINGS USED FOR NHS PURPOSES UNDER CONTRACT

3. In the case of buildings used for NHS purposes under contract the procedures in Appendix A apply only to proposals for withdrawing from substantial and long-standing contractual arrangements with private hospitals etc for the provision of services to NHS patients.

### SPECIAL ARRANGEMENTS FOR BUILDINGS SERVING NO GIVEN AREA

4. Special arrangements are necessary for closures or changes of use affecting health buildings which do not draw their patients from any given area (usually hospitals managed by Boards of Governors of Post Graduate Hospitals). In such cases consultation on proposals for closure or change of use will be on an ad hoc basis - including, and subject to the approval of, the Secretary of State. The consultations will take account of the national as well as the local interests concerned and will have regard to the possibility of alternative use for health purposes.

### CLOSURE OR CHANGE OF USE INITIATED BY THE DEPARTMENT

5. Consultation on closures or changes of use initiated by the Department should follow the pattern appropriate to the actual proposals, but reference need be made to the Department only if there is substantial disagreement with the proposal.

### HEALTH CENTRES

6. Where it is proposed to close or change the use of a health centre, the AHA must obtain the full agreement of the general practitioners and provide suitable alternative accommodation before including the proposal in its plans.

**APPENDIX 3**

## LETTER FROM DHSS TO REGIONAL ADMINISTRATORS 7 DEC 1979

Dear Regional Administrator

CLOSURE PROCEDURES

1 You will be aware that legal proceedings were taken against the Commissioners for the Lambeth, Southwark and Lewisham HA over the consultation procedures involved in temporarily closing a hospital in that area. It is possible that decisions to close hospitals elsewhere in the country may be challenged in the Courts, and the Department is therefore anxious that health authorities should be fully conscious of the need to follow the consultation procedures on closures laid down in the relevant circular and regulations (HSC(IS)207 Closure or Change of Use of Health Buildings, and the National Health Service (Community Health Councils) Regulations 1973, SI 1973 No 2217).

2 Although the circular only prescribed formal consultation on substantial permanent closures and changes of use, its spirit is that consultation should be undertaken on all closures whenever practicable. Where circumstances do not permit the full period of consultation or procedures prescribed, the health authority should nonetheless give as much time, and provide as much information, as possible to CHC, staff, and other interests. Staff can be consulted urgently through the Joint Staff Consultative Committee or equivalent arrangements. The rest of this letter deals with some points of difficulty that have arisen on arrangements for the temporary closure or change of use of health facilities.

SUBSTANTIAL VARIATIONS IN SERVICE

3 The CHC Regulations (SI 1973 No 2217) require an area health authority to consult the relevant CHC on any proposal "to make any substantial variation" in the provision of a district's health services (Regulation 20(1)). They do not distinguish between temporary and permanent closure. It is for the authority to decide whether a particular temporary closure constitutes a "substantial variation" for the purposes of the regulations, but its decision can be challenged in the courts. A temporary closure will often be no more than a short term measure of limited scope with minimal repercussions on health services in the district, for example when a hospital ward is closed for redecoration. This kind of insubstantial temporary closure was in mind when the advice was given in HSC(IS)207. Appendix B, Paragraph 2 that "temporary closure or change of use . . . . . will generally lie outside the procedures . . . . .". A temporary closure could however have a considerable effect on district services, for example if it involved the temporary cessation of the only service of its kind in the district, or the removal of such a service to another centre elsewhere in the area. Such a temporary closure might well constitute a substantial variation in service and so fall within the scope of Regulation 20(1). Thus authorities should not assume that because a closure or change of use is only temporary it can for that reason alone be regarded as not being a "substantial variation" for the purposes of the regulations.

APPENDIX 3
(continued)

URGENT CLOSURES

4 The regulations provide that a health authority need not consult the CHC(s) on temporary closures if **the authority** "is satisfied that, in the interest of the health service, a decision has to be taken without allowing time for consultation" (Regulation 20(1)). The authority is, however, required to notify the CHC "immediately" of the decision taken and why no consultation has taken place. It is not difficult to think of examples of situations in which closure of a building is urgently required – an outbreak of infection or inadequate staffing levels are obvious ones, but the need to make immediate savings so as to avoid overspending may also make closure a matter of urgency. The urgency of the situation will not always rule out the possibility of consultation, and while the full procedures set out in the HSC may not be practicable, a health authority should do what it can in the time available.

5 Authorities are reminded that the Secretary of State expects there to be full consultation on all proposals for permanent closure or change of use. Further, if a substantial temporary closure has to be implemented without any prior consultation and if there is a possibility that the authority might eventually wish – or be forced to make the closure permanent, he expects authorities to undertake consultation immediately the temporary closure has been made.

DOCUMENTATION

6 Where the full consultation procedure is not followed, a health authority should ensure that its decisions on the relevant questions are properly documented: its reasons for not consulting should be embodied in a formal resolution, duly recorded in the minutes of the authority's meeting. The wording should be consistent with that of the CHC regulations, ie that the authority has concluded that the proposal would not result in a substantial variation in the provision of a district's health service or that the authority is satisfied that, in the interest of the health service, a decision has to be taken without allowing time for consultation. Where both grounds are invoked for departing from normal consultation procedures, both should be recorded.

7 I am copying this letter to area administrators and, for information, to the local authority associations and the Association of Community Health Councils. Enquiries from CHCs or other interested parties about the procedures for temporary closure may be answered by reference to this letter: it may prove simplest in many cases to give them a copy. Further advice on closure procedures may be obtained from the Department ( Mr R Venning 01-388 1188 Ext 836 or Mr K McDowell 01-388 1188 Ext 760). *

Yours sincerely

D de Peyer

*Editorial Note: The Officials now concerned are:
Mr D S Fanning 01-407 5522 Ext 6562 and
Mr M T Skinner 01-407 5522 Ext 6823

## THE NORMAL CONSULTATIVE PROCESS

| ref on figures | ref in HSC(IS) 207 | Activity | Related Administrative Work | Notes | Likely timescale |
|---|---|---|---|---|---|
| – | – | Officers decide time is is right to move to formal consultation. This may involve discussions between officer teams, and preparation of outline case for new or complicated issues. | Prepare any necessary papers.<br>Identify officer(s) who will take the lead in subsequent stages. | It is important to identify both a 'lead' officer and contact officers at other levels to ensure continuity and consistency of approach. | 1 month where issue has previously been considered.<br><br>2–3 months where new proposals are involved. |
| | | Put proposal to health authority and seek agreement to issue consultative document. | | The health authority may wish to take this in the closed part of the agenda to avoid unnecessary public and staff concern over a proposal which may not be accepted. | |
| Q4– A6 | para 5 | if there has been no previous consultation, obtain agreement of RHA and DHSS before proceeding | Send papers to RHA and DHSS and arrange any further consideration necessary. | Approval required | 1 month minimum |
| Q5/A6–A8 | para 6 | if previous informal consultation resulted in lack of agreement, check AHA still wishes to proceed and inform RHA | Send papers to RHA for information and discuss with regional officers as required | Approval not required | Could be 2–3 months |
| A10 | App A para 2 | Finalise consultation document and agree closing date for response | As well as final document the following should be drafted and agreed ready for issue when the document is cleared –<br><br>• covering letter inviting comments (over signature of Health Authority Administrator. Separate similar letter may go from other administrators for internal District consultation)<br><br>• Press release, in consultation with regional PRO, and staff notice if appropriate.<br><br>• distribution list with names and addresses.<br><br>• assess number of copies of all documents; plan arrangements for reproduction, collation and despatch.<br><br>• agree contact name for follow-up enquiries (and tel. no.) to be included in Press or staff notices.<br><br>• give CHC(s) involved advance warning of likely timetable so they may plan their own arrangements to consider proposals. | May involve a further reference to AHA. No standard procedure. Some authorities may delegate final drafting to officers, having already seen and approved outline case; others may wish to see and agree the document itself.<br><br>The time needed for this essential back-up work should not be under-estimated. A simple local issue can involve about 300 copies of the consultation paper. A more complicated one involving hospitals with a supra-District role may go up to 1,000.<br><br>The date set for the return of comments should take account of the authority's meeting timetable and allow time for Officers to analyse and respond to views received during consultation.<br><br>RHA, DHSS and local MPs should be informed when document is issued. It is usual to send copies to them, although circular does not specifically say so.<br><br>Total time required up to issue of consultative document | The aim should be to do as much of substantive work as possible in parallel with the previous activities.<br><br>Allow about a week for final editing, reproduction, collation and despatch<br><br>3–6 months depending on circumstances |

APPENDIX 4
(Continued)

| ref on figures | ref in HSC(IS) 207 | Activity | Related Administrative Work | Notes | Likely timescale |
|---|---|---|---|---|---|
| Q 8 | App A para 3 | health authority reconsiders proposals in light of all comments received, including the CHC's views on the comments received and the HA's own observation on those comments. | A comprehensive report should be prepared which will include:<br>• a summary of all the comments received.<br>• full copies of the CHC response and any others which contain major arguments.<br>• an analysis of the points made during consultation; officers' comments as appropriate; and recommendations for further action.<br>• the CHC's further views (if any) on the comments received and the Authority's response. | It will not normally be necessary to circulate all replies in full – for example those limited to straightforward agreement or objection without much in the way of qualification or argument. But members of the HA and CHC should always be offered the opportunity to see all the papers.<br>The CHC should be given an advance copy of the report in sufficient time for them to consider before decisions are taken by the Health Authority. | Time needed depends o on how much anticipatory work was done in previous stage and whether CHC has counter proposals. The aim should be to report back to the first HA meeting following the end of the consultative period.<br>1 – 2 months |
| Q 8 – A 15 | App A para 4 | health authority decides it wishes to proceed with proposal despite CHC objections, and agrees to recommend to RHA accordingly.<br>(If the CHC has not objected, and provided the Sec. of State had said he did not wish to be consulted, the HA's decision could be implemented and formal consultations would end at this point). | Assemble dossier for RHA to include all papers put to the AHA plus AHA minute recording its decision.<br>Provide any further briefing for RHA officers and members. | Ensure work is ready in time for the first RHA meeting following the HA decision. | 1 month max. (may be less if RHA meeting date is close to HA meeting. |
| Q 12 – A 17 | App A para 4 | RHA considers all papers and decides to support AHA recommendation. Before announcing this decision it must seek Sec. of State's approval to do so.<br>(This example assumes RHA endorses HA recommendation.) | RHA officers send papers to DHSS for Ministers to consider. | | 1 week |
| Q 13 – A 18 or A 19 | App A para 4 | Secretary of State decides whether or not to approve the health authority's decision.<br>Health Authorities take the necessary action. | RHA and local officers may be involved in further briefing for Ministers. | | No fixed time – depends on nature of the proposal.<br>2 months minimum is a reasonable assumption but some have taken over 12 months. |

| ref on figures | ref in HSC(IS) 207 | Activity | Related Administrative Work | Notes | Likely timescale |
|---|---|---|---|---|---|
| – | App A para 2 | Allow up to three months for comments to be received | Administrative action during this period should be aimed at (i) helping those being consulted to achieve a thorough understanding of the issue, and (ii) achieving the minimum delay between the end of the consultation period and report back to the HA. It will include:<br>• create a file/or comments, acknowledge all letters received and inform respondents their views will be reported to AHA.<br>• answer substantive points, in particular clear up any misunderstanding and offer further information.<br>• inform appropriate officers (and Authority) Chairman if appropriate) of contentious issues which are emerging and start work on a response.<br>• offer all help and information to CHC(s) to enable them (a) to consider proposals and (b) to prepare a counter-proposal where they intend to object to the proposal.<br>• confirm whether or not Sec. of State approval will be required before final decisions are taken<br>• make proper arrangements to receive any petitions and delegations.<br>• arrange for officers to attend public meetings or meetings of local groups where proposals are to be discussed.<br>• deal with Press enquiries | A meeting with CHC officers and members to go through the issue can be very helpful at this stage.<br>Regional Liaison section of DHSS should be asked to advise at the time they receive their copy of the consultation document.<br>Identify officer(s) preferably only one, who are familiar with both the detailed issue and the technical consultation process. | 3 months |
| | | | **Total time required from issue of consultative document to final decision by Secretary of State** | | 7 months at best (may be much longer) |
| | | | **TOTAL FOR WHOLE PROCESS**<br>(non-controversial changes which are not opposed by CHC, and where the Health Authority may take the decision itself, can be completed in 4–5 months after consultative document is issued.) | | **10 months at best** |

APPENDIX 5

## THE CONSULTATION DOCUMENT

### SOME EXAMPLES OF CONTENT

The following information and diagrams have been taken from actual consultation documents. They show some of the information which needs to be provided in a consultation document and are examples of some of the different ways of presenting it.

#### (a) EXAMPLE OF INFORMATION ON TRANSPORT IMPLICATIONS

It has already been mentioned elsewhere that the travelling distance from West London Hospital to Queen Charlotte's Hospital is relatively short, approximately 1 mile. Plans showing the relationship of the 3 hospitals are given in section 10, where underground and bus routes are also clearly indicated.

Below is a list of the London Transport underground and bus services serving Charing Cross Hospital, West London Hospital and Queen Charlotte's Hospital.

**a) Charing Cross Hospital**

| Bus/Underground | Route/Line | Distance to Hospital from alighting point |
|---|---|---|
| Bus 9 | Mortlake/Dalston | 10 minutes walk |
| 11 | Hammersmith/Liverpool St | At the entrance |
| 27 | Highgate/Teddington | 10 minutes walk |
| 30 | Roehampton/Hackney | 5 minutes walk |
| | – – – – etc – – – – | |

**b) West London Hospital**

All the bus services which serve Charing Cross Hospital, with the exception of route No 30 pass Hammersmith Broadway (Butterwick Bus Station) which is directly opposite West London Hospital. Similarly, the Metropolitan Line terminates at Hammersmith which is also served by the Piccadilly and District Lines. Both stations are almost adjacent to the hospital.

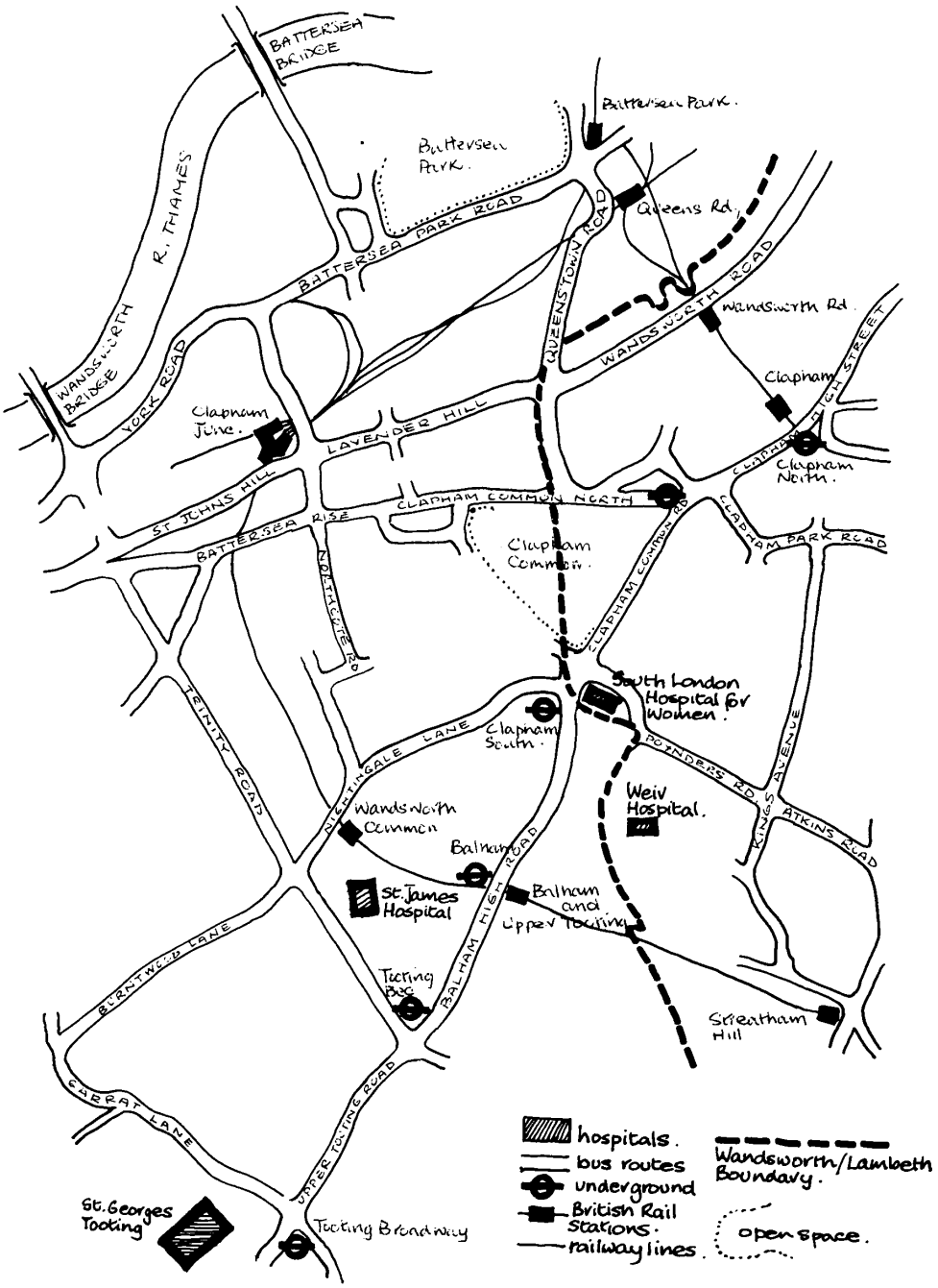
**c) Queen Charlotte's Hospital**

| Bus/Underground | Route/Line | Distance to Hospital from alighting point |
|---|---|---|
| Bus 27 | Highgate/Teddington | 5 minutes walk |
| 88 | Acton Green/Mitcham | 5 minutes walk |
| 91 | Hounslow/Wandsworth | 5 minutes walk |
| 237 | Shepherds Bush/Staines | Main gate |
| 266 | Hammersmith/Colindale | 5 minutes walk |
| | – – – – etc – – – – | |

It is appreciated that the additional journey to Queen Charlotte's Hospital for the residents in the southern-most part of the district may be a little more inconvenient and the district are, therefore, actively exploring with the Division of Obstetrics the possibility of providing a limited out-patient service in other health premises.

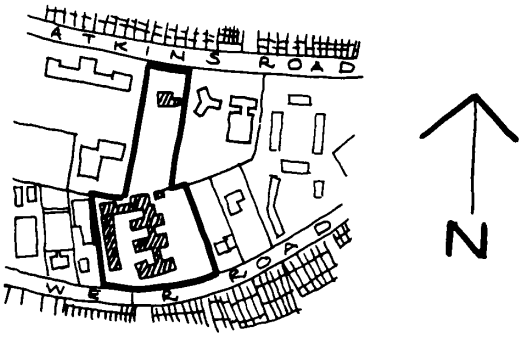
(b) Example of Information on Transport and Travel

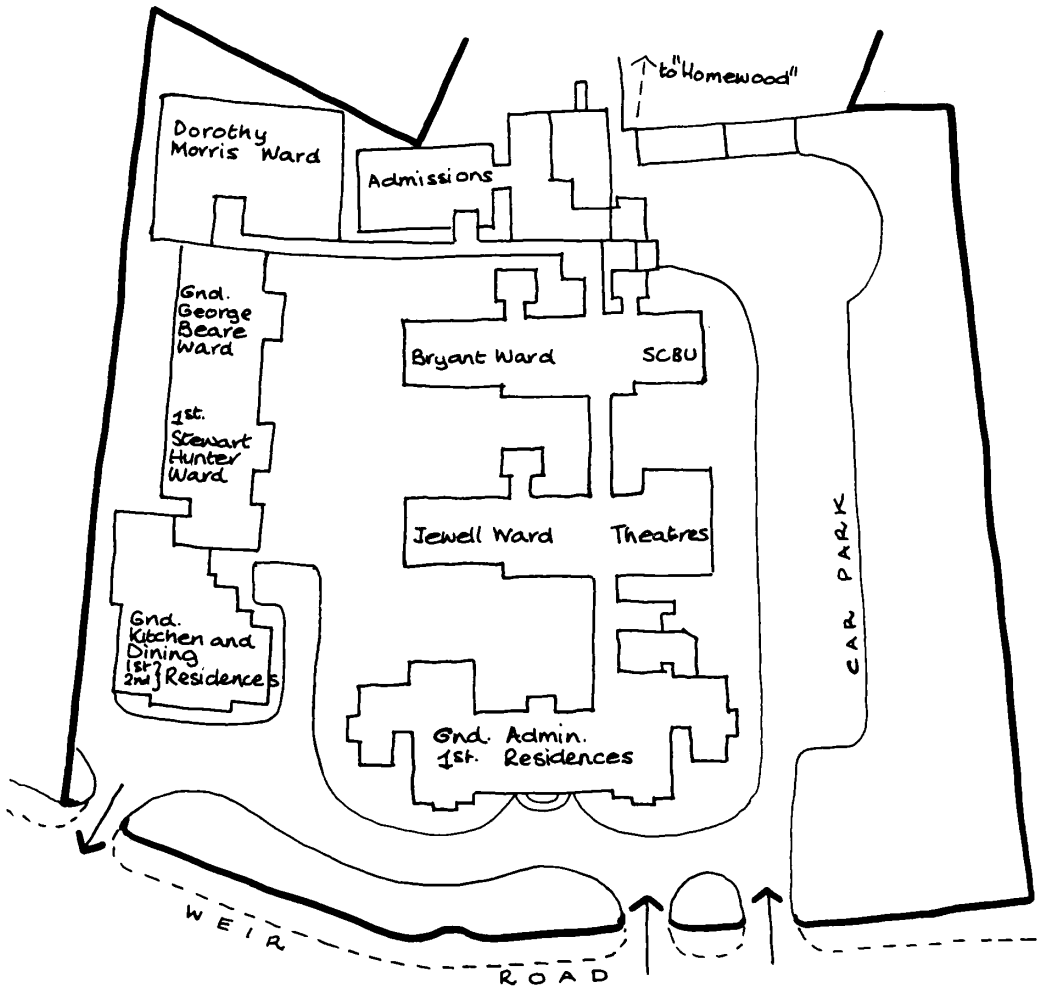
**APPENDIX 5**
**(Continued)**



APPENDIX 5
(Continued)

(c) Example of Information about Location and Site

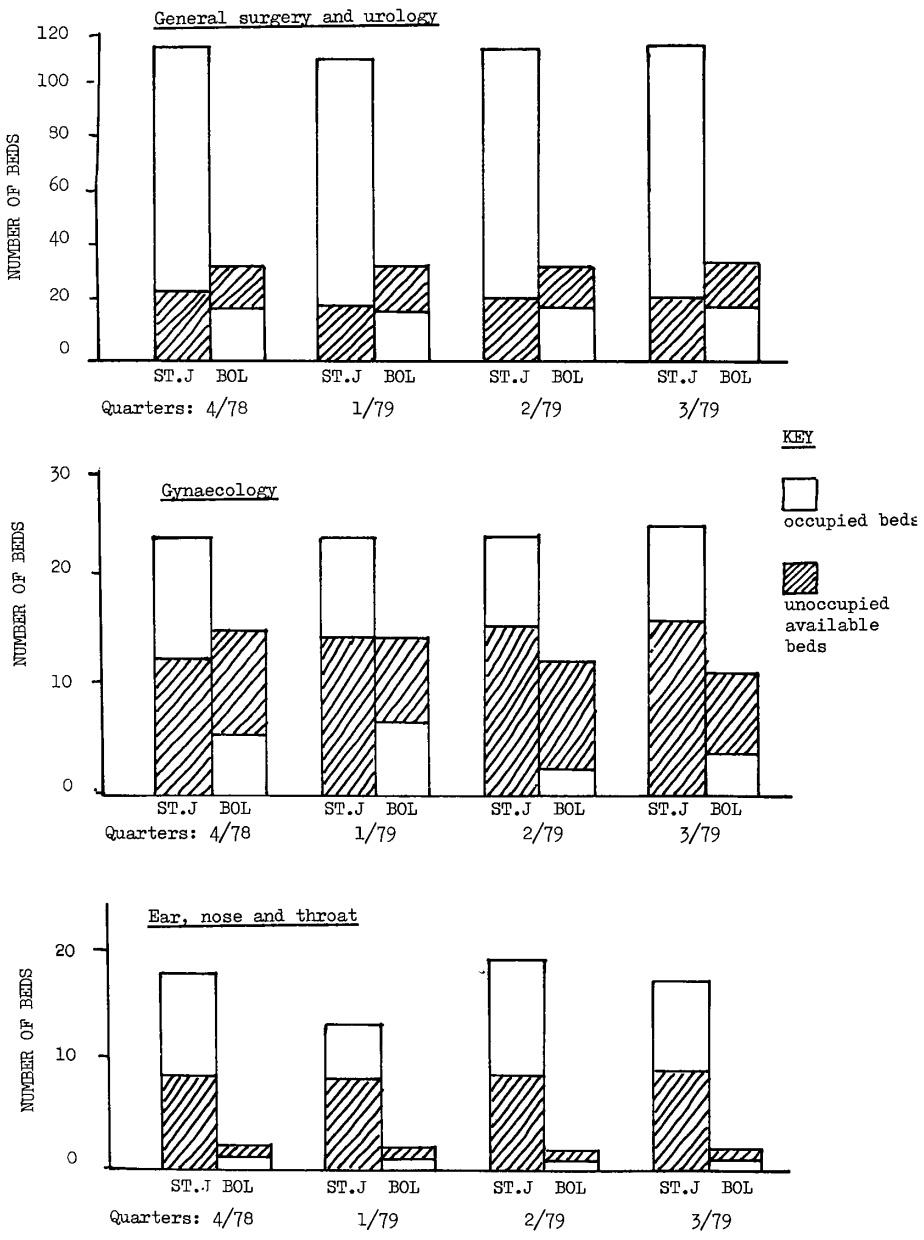


**APPENDIX 5**
**(Continued)**

## (d) Example of Information on Current Bed Usage

AVERAGE BED OCCUPANCY - ST. JAMES' AND BOLINGBROKE HOSPITALS 1.10.78 - 1.10.79




Note: different scales used for different specialties

APPENDIX 6

## CHECKLIST ON THE CONTENT OF THE CONSULTATION DOCUMENT

1 Have you thought about the **content** of the document?

- who will read the document?
- is there one specific proposal?
- is the proposal clearly stated at the outset?
- is the service planning and financial background set out?
- is the aim set out simply at the outset?
- is there detailed supporting argument?
- is it supported by factual evidence?

  ie data on occupancy?
  utilisation?
  cost implications?
- is it supported by clear tables, maps, etc?
- has jargon and unnecessary data been eliminated?
- have rejected alternatives been mentioned and convincingly rejected?

2 Are the implications for patients spelt out?

- in service terms?
- in travel distances?
- in relation to any other facilities?

3 Are the implications for staff explained?

- filling of vacancies during consultation/closure process?
- redundancy policy statement?
- redeployment arrangements?
- staff reduction figures?
- have alternative uses of the building site been covered?

4 Is the document in a **logical** order?

5 Is the **style** of the document open and conditional?

6 Is the **presentation** of the document neat, clear and readable?

7 Is the **consultation list** comprehensive?

8 Is the procedure for **consulting other AHAs** clear to everyone?

9 Has a **covering letter** been prepared?

- with a **clear deadline**?
- with a designated **point of contact** for queries?

## 'DECOMMISSIONING' : A CHECK LIST

### THE MANAGEMENT OF THE EXERCISE

1 Will the closure/transfer of service be a single event or phased over a period of time?

2 Have the consequences of closure/transfer decision for staff, current patients and future patients been fully evaluated?

3 Have the financial implications, in terms of both costs and savings, been determined? Have these been documented in such a way as to provide a basis for monitoring the change?

4 Has a network been devised for the transfer?

5 Is the critical path clear and agreed?

6 Is there one administrator who has been given clear responsibility for co-ordinating the transfer exercise and the closure exercise?

### PREPARATION FOR CHANGE

7 If the AHA has no use for the vacated premises, have these details been passed to the RHA in order to initiate the procedures in accordance with the *Handbook on Land Transactions,* and arrangements made to monitor the progress of disposal?

8 Have the area health authority and regional health authority been formally notified of the date of the change in service?

9 Have all other authorities been informed of the proposed change and its date? For example:

Community Health Council
Family Practitioner Committee
Neighbouring health authorities
Local authorities, including fire and police, Registrar of Births and Deaths
Local GPs
Ambulance service
Local press
District officials of trades unions
All district managers
Appropriate medical committees

10 Have all accounts, including imprest, been closed and a final audit carried out?

11 Has a final inventory been completed, and are arrangements in hand to complete a drug check on the date of transfer?

12 Has all equipment been assessed from the inventory for transfer or disposal?

APPENDIX 7
(Continued)

HARMONISATION OF SYSTEMS

13 Will the transfer bring together different systems of any sort, eg medical records, pharmacy, linen/laundry, CSSD, accounting (including patients' moneys), nursing etc.

14 Have the managers concerned arranged for the harmonisation of systems and identified any costs?

15 Have the medical records to be moved been extracted?

16 Have arrangements for paying salaries and wages, and dealing with pay-roll preparation, for transferring staff been organised?

17 Are there changes needed in the requisitioning procedure, new authorised signatories to be identified?

18 Is the administrative office ready to be transferred with all its procedures? Have the filing systems been integrated?

19 Have arrangements been made to amalgamate the leagues of friends?

TRANSFER OF SERVICES

20 Is building work required at the new location?

21 What changes to signposting are needed to accommodate transferred services?

22 Are there further transfers of service or decanting subsequent to and dependent upon this main change? If so, what physical implications are there?

23 In drawing up the equipment lists, have the transferred items as well as new purchased items been identified?

24 Once building alterations have been completed, has sufficient time been allowed for cleaning and equipping. Are the arrangements for transferring equipment made?

25 Are there incidental services provided by the closing hospital for which an alternative provider will have to be found?

MOVEMENT OF PATIENTS

26 When will admissions/attendances at the old unit cease?

27 Will there be a gap between that and admissions/attendances starting at the new location?

APPENDIX 7
(Continued)

MOVEMENT OF PATIENTS (cont'd)

28 Has forward booking taken account of this? (eg reduced numbers over transfer period; alternative arrangements in interim elsewhere.)

29 Have the patients been told what will happen?

30 Have their relatives been informed?

31 Will the move involve any change from single sex wards to male/female wards or vice versa?

32 What arrangements have been made to welcome the patients on arrival at their new location?

33 Has everything possible been done to minimise the psychological difficulties of the move for the patients?

34 Are there plans for medical assessment of the patients before and after transfer?

35 Will the patients' medical records go with them or separately?

36 Will a temporary supply of drugs go with the patient on transfer?

37 Will escorts be required for the patients on transfer?

38 Will the transfer occur in winter, and how will this affect the risks involved?

39 Are the patients bringing with them new special needs to the new location? (eg for piped oxygen; control of infection procedures; special apparatus or fixtures; requirements for storage space; patient call system; fire precautions).

40 How many patients for transfer are ambulant?

41 What special ambulance arrangements will be required for the transfer?

42 Have these special arrangements been discussed/prepared and booked well in advance with the ambulance authority?

43 What arrangements have been made to safeguard the personal property of patients during the transfer? (also to record before departure and check on arrival)

TRANSFER OF STAFF

44 Have staff meetings been held on a regular basis to keep everyone informed?

45 Have the establishments for thenew locations been determined?

APPENDIX 7
(Continued)

TRANSFER OF STAFF (cont'd)

46 Have new rotas been devised taking account both of rosters and schedules in receiving hospital if service is being transferred, or the needs of the new hospital if a complete change is occurring? Consider effects on bonus schemes.

47 What is the authority's policy on redundancy and natural wastage?

48 Will the excess establishment be carried until natural wastage reduces the numbers? Have the consequences of this been thought through?

49 Has recruitment been stopped or slowed down in advance of the transfer?

50 Have staff all been interviewed about their intentions in respect of transfer of service? eg

Transfer with service to comparable post
Retire
Transfer to vacancy elsewhere
Remain to close hospital and then transfer elesewhere
Request redundancy

51 Have staff been identified for particular posts? If limited competition rules apply, have these been applied? Have staff all been seen by personnel staff and managers concerned in respect of posts to be offered?

52 Have the staff agreed to transfer, and had their contracts amended?

53 Are there posts remaining unfilled and staff who remain unmatched by posts? Have decisions been made in respect of these staff?

54 Are the arrangements for extra travel allowances (as per Whitley agreements) clear to all staff concerned?

55 Is adequate residential accommodation available at the new location? Or will staff remain in accommodation at the old location or elsewhere?

56 Have all personnel documents been transferred to the appropriate site?

OPERATION MOTHBALL

57 Are there any plans for the future of the buildings and within what timescale?

58 Can any use be made of the land/grounds in the interim? (eg income from grazing)

59 If no immediate alternative use requiring alterations, plan mothballing.

APPENDIX 7
(Continued)

OPERATION MOTHBALL (cont'd)

60 Have all regular contracts for the unit been terminated?

61 What arrangements are there to shut down the heating system?

62 What will the maintenance needs of the buildings be? eg

regular testing of the wiring
use of central heating occasionally
regular maintenance check
pest control visits
some grounds maintenance
lifts maintenance

63 Have the maintenance needs been costed and budgeted for?

64 Has the insurance on the boilers and lifts been ceased?

65 What security arrangements will be required? eg

boarding up all windows
caretaker facility
private security patrols
dog patrols

66 Have the security arrangements been costed and budgeted for?

67 Have the Post Office been asked to take out or disconnect all telephones?

68 Have arrangements been made to remove all consumable goods, eg drugs, CSSD items, provisions, linen, hardware and crockery, cleaning materials, either for re-use or disposal?

69 Have arrangements been made to collect together and sort all equipment not being transferred?

70 Has suitable storage been found for old medical records and have those fit for destruction (according to the Authority's policy on the destruction of records) been destroyed?

71 Has the supplies officer arranged for the disposal of unwanted items according to established practice?

APPENDIX 7
(Continued)

SIT-INS AND OCCUPATIONS

72 Is there a risk of action by staff to prevent the transfer/closure taking place?

73 Can the individual/group threatening the sit-in be identified, and have discussions with them been initiated?

74 Do contingency plans exist in case of an occupation?

75 Have the staff involved in the occupation been warned of their contractual and legal position?

76 Are the patients under the care of a consultant member of the medical staff who has access to them?

77 Have all admissions to the unit been stopped and general practitioners informed?

78 Are there problems in discharging patients from the unit once they are fit?

79 In this difficult situation are efforts being made to get the authority's point of view and objectives across to the media?

## 'DE-COMMISSIONING'

Some examples of the processes involved and the documentation required.

The following documents were produced as part of the process of closing actual hospitals. They illustrate some of the detailed work which needs to be done. Some of this information may be included in the consultation document.

(a) **Hereford and Worcester Area Health Authority: Worcester District**

(i) Worcester Development Project:
Planned Expenditure: Worcester Royal Infirmary (Newtown branch)

(ii) Worcester Development Project:
Reductions in Costs.

(iii) Worcester Development Project: Transfer of Staff Expenditure.

(b) **Hertfordshire Area Health Authority: South West Health District**

Services for the Elderly

(i) Closure of Ward 5 and transfer of 12 patients to Bushey Hospital.

(ii) Closure of Ward 6 and transfer to Abbots Langley Hospital.

(iii) Intensification of use of Day Unit at Shrodells Hospital and Development of Domiciliary Nursing Services.

(i) **Hereford and Worcester Area Health Authority Worcester District**
**Worcester Development Project Planned Expenditure Worcester Royal Infirmary (Newtown Branch)**
**Plus Day Hospitals -- Powick Hospital**

| | 1978/79 £000's | 1979/80 £000's | 1980/81 £000's | 1981/82 £000's | 1982/83 £000's | 1983/84 £000's | 1984/85 £000's |
|---|---|---|---|---|---|---|---|
| **Planned revenue exp expenditure** | | | | | | | |
| 1 Powick Residuum | 2 226 | 1 951 | 1 883 | 1 791 | 1 697 | 1 594 | 1 499 |
| Worcester Development Project | | | | | | | |
| WRI Newtown—MI Unit/ Day Unit | 915 | 1 510 | 1 510 | 1 510 | 1 534 | 1 534 | 1 534 |
| — ESMI Unit | — | — | — | — | 330 | 330 | 330 |
| — Malvern/Evesham Day Unit | 33 | 94 | 94 | 94 | 94 | 94 | 94 |
| 2 Pay and Prices 1978/79 | 948 | 1 604 | 1 604 | 1 604 | 1 958 | 1 958 | 1 958 |
| 3 TOTALS | 3 174 | 3 555 | 3 487 | 3 395 | 3 655 | 3 552 | 3 457 |

APPENDIX 8(a)
(Continued)

Hereford and Worcester AHA
Worcester District

(ii)

| FUNCTION | REDUCTIONS IN COSTS | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Location | | | | | | | | | |
| | 1980/81 (235) M4 20 beds | | 1981/82 (205) F4 30 beds | | 1982/83 (177) F15 30 beds | | 1983/84 (153) M14 30 beds | | 1984/85 (133) M12 20 beds | |
| | WTE | COST | WTE | COST | WTE | COST | WTE | COST | WTE | COST |
| Medical | | | | | | | | | | |
| Nursing | 6.25 | 30 000 | 11.25 | 54 000 | 12.50 | 60 000 | 12.50 | 60 000 | 15.00 | 72 000 |
| MSSE | | 200 | | 300 | | 300 | | 300 | | 200 |
| Pharmacy | | 2 600 | | 3 900 | | 3 900 | | 3 900 | | 2 600 |
| Radiography | | | | | | | | | | |
| Pathology | | 500 | | 750 | | 750 | | 750 | | 500 |
| EEG | | | | | | | | | | |
| ECG | | | | | | | | | | |
| Physiotherapy | | | | | | | | | | |
| Dental Surgery | | | | | | | | | | |
| Occupational Therapy | | | 1.00 | 3 400 | 1.00 | 3 400 | | | 1.00 | 3 400 |
| Industrial Therapy | | | 1.00 | 3 400 | 1.00 | 3 400 | | | 1.00 | 3 400 |
| Chiropody | | | | | | | | | | |
| Medical Records | | | | | | | | | | |
| Administration | 1.00 | 4 000 | 1.00 | 4 000 | 1.00 | 4 000 | | | | |
| Catering — Provisions | | 3 700 | | 5 500 | | 5 500 | | 5 500 | | 3 700 |
| — Staff | 3.00 | 13 400 | 1.50 | 6 700 | 1.00 | 4 450 | 2.00 | 9 900 | 1.00 | 4 450 |
| Domestic | 3.86 | 14 700 | 4.76 | 18 100 | 6.10 | 23 200 | 6.65 | 25 300 | 3.93 | 15 000 |
| Portering | 1.00 | 4 000 | | | 1.00 | 4 000 | | | | |
| Laundry | | 3 900 | | 5 900 | | 5 900 | | 5 900 | | 3 900 |
| Linen | | 2 600 | | 4 000 | | 4 000 | | 4 000 | | 2 600 |
| Transport | | | | | | | | | | |
| Engineering | | | | | | | 1.00 | 5 500 | | |
| Energy and Utility | | 1 100 | | 1 800 | | 1 350 | | 1 250 | | 1 500 |
| Building | | | | | | | | | | |
| Gardens | | | | | | | | | | |
| Miscellaneous | | 400 | | 600 | | 600 | | 600 | | 400 |
| TOTAL ANNUAL SAVINGS | | 81 100 | | 112 350 | | 124 750 | | 122 900 | | 113 650 |

APPENDIX 8(a)
(Continued)

(iii)

| SUMMARY | Powick Residuum | | | | Newtown | | | | Malvern Day Hospital | | | | Evesham Day Hospital | | | | TOTAL | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Existing | | Additional | | Existing | | Additional | | Existing | | Additional | | Existing | | Additional | | Existing | | Additional | |
| | WTE | COST | WTE | COST | WTE | COST | WTE | COST | WTE | COST | WTE | COST | WTE | COST | WTE | COST | WTE | COST | WTE | COST |
| Medical | | | | | 12.30 | 106400 | 5.00 | 25800 | | | | | | | | | 12.30 | 106400 | 5.00 | 25800 |
| Nursing | 237.00 | 800000 | | | 66.00 | 220000 | 94.00 | 313000 | | | | | | | | | 303.00 | 1020000 | 94.00 | 313000 |
| Pharmacy | 1.50 | 6900 | | | | | 1.50 | 6300 | | | | | | | | | 1.50 | 6900 | 1.50 | 6300 |
| Pathology | | | | | | | 0.50 | 1500 | | | | | | | | | | | 0.50 | 1500 |
| ECG | 0.50 | 1000 | | | | | | | | | | | | | | | 0.50 | 1000 | | |
| EEG | 2.50 | 10300 | | | | | | | | | | | | | | | 2.50 | 10300 | | |
| Physiotherapy | 2.00 | 6600 | | | | | 0.50 | 3400 | | | | | | | | | 2.00 | 6600 | 0.50 | 3400 |
| Radiography | | | | | 0.50 | 2600 | | | | | | | | | | | 0.50 | 2600 | | |
| Psychology | | | | | 4.00 | 22500 | | | | | | | | | | | 4.00 | 22500 | | |
| Occupational Therapy | 11.00 | 29600 | | | 13.00 | 38500 | 3.00 | 7300 | | | 2.00 | 6500 | | | 2.00 | 6500 | 24.00 | 68100 | 7.00 | 20300 |
| Chiropody | 0.30 | 1600 | | | | | 0.10 | 400 | | | | | | | | | 0.30 | 1600 | 0.1 | 400 |
| Medical Records | 1.50 | 3300 | | | 1.00 | 2300 | | | | | | | | | | | 2.50 | 5600 | | |
| Admin and Clerical | 22.85 | 76200 | 1.00 | 2300 | 6.50 | 19700 | 12.75 | 35200 | | | 0.50 | 1500 | | | 0.50 | 1500 | 29.35 | 95900 | 14.75 | 40500 |
| Catering Services | 20.50 | 71600 | | | 1.00 | 3400 | 22.10 | 74300 | | | 0.75 | 2700 | | | | | 21.50 | 75000 | 22.85 | 77000 |
| Cleaning Services | 84.30 | 206700 | | | 13.70 | 33300 | 19.00 | 46100 | | | 2.50 | 6000 | | | 2.50 | 6000 | 98.00 | 240000 | 24.00 | 58100 |
| Portering | 23.00 | 57500 | | | 2.00 | 5000 | 6.00 | 15000 | | | | | | | 0.50 | 1300 | 25.00 | 62500 | 6.50 | 16300 |
| Laundry and Linen | 4.50 | 11300 | | | 1.00 | 2400 | 1.00 | 2400 | | | | | | | | | 5.50 | 13700 | 1.00 | 2400 |
| Estate Management Engineering Maintenance | 6.00 | 26700 | | | 0.50 | 2200 | 4.00 | 18700 | | | | | | | | | 6.50 | 28900 | 4.00 | 18700 |
| Energy | 10.00 | 40000 | | | | | 2.00 | 9100 | | | | | | | | | 10.00 | 40000 | 2.00 | 9100 |
| Building Maintenance | 10.00 | 54300 | | | 0.50 | 1900 | 3.50 | 15500 | | | | | | | | | 10.50 | 56200 | 3.50 | 15500 |
| Grounds and Gardens | 6.00 | 17800 | | | | | 0.50 | 1400 | | | 0.40 | 1100 | | | | | 6.00 | 17800 | 0.90 | 2500 |
| Gen Est Expenses Miscellaneous | 6.00 | 14700 | | | | | | | | | | | | | | | 6.00 | 14700 | | |
| HSSU | | | | | | | 1.00 | 2500 | | | | | | | | | | | 1.00 | 2500 |
| Ambulance | | | | | | | 2.00 | 7000 | | | | | | | | | | | 2.00 | 7000 |
| TOTAL | 449.45 | 1436100 | 1.00 | 2300 | 122.00 | 460200 | 178.45 | 584900 | | | 6.15 | 17800 | | | 5.50 | 15300 | 571.45 | 1896300 | 191.10 | 620300 |

**NOTE**: This table was prepared as a commissioning document to identify the transferred staff expenditure from the existing service to the new service. Using this for the purpose of closures, the document identifies the immediate savings that will be achieved as a result of the change in use of a large psychiatric hospital. The Powick Residuum column also provides base-line staffing levels against which future changes can be measured as the patient numbers reduce and further parts of the Hospital are closed.

This is one table which underlines the essential link between commissioning new buildings and de-commissioning existing premises.

APPENDIX 8(b)
(Continued)

## (b) HERTFORDSHIRE AREA HEALTH AUTHORITY – SOUTH WEST HEALTH DISTRICT

SERVICES FOR THE ELDERLY – closure of wards 5 and 6 Holywell, and consequential measures affecting Bushey Hospital, Abbots Langley Hospital, Shrodells Day Unit and Community Services.

(i) Closure of Ward 5 and transfer of 12 patients to Bushey Hospital

| | WTE | £ | £ |
|---|---|---|---|
| Savings | | | |
| Nursing Staff – Sisters | 1.0 | 6 605 | |
| Staff Nurses and SENs | 2.5 | 14 184 | |
| Auxiliaries | 6.1 | 27 030 | |
| Pool | 2.0 | 10 000 | |
| | 11.6 | 57 819 | 57 819 |
| Domestic Staff – 77 hours | 1.93 | | 8 281 |
| Building and Engineering annualised | | | 500 |
| Energy (if separate controls fitted) | | | 2 000 |
| Recurring revenue saving | | | £68 600 |
| **Expenditure** | | | |
| Medical Staff – | | | |
| 2 Clinical Assistant Sessions | | 2 055 | |
| GPs Bed Fund | | 1 051 | |
| Physiotherapy Staff – | | | |
| 20 hours, Senior II | | 3 194 | |
| 17½ hours, Helper | | 1 728 | |
| Occupational Therapy Staff – | | | |
| 20 hours, Senior II | | 3 194 | |
| 17½ hours, Helper | | 1 728 | |
| Physiotherapy and Occupational Therapy Equipment | | 1 000 | |
| Recurring revenue expenditure | | 13 950 | 13 950 |
| Net recurring revenue saving | | | £54 750 |

There are Building and Engineering adaptations required at Bushey Hospital and these non-recurring costs are estimated at £5 000.

APPENDIX 8(b)
(Continued)

(ii) Closure of Ward 6 and transfer to Abbots Langley Hospital

| | W T E | £ |
|---|---|---|
| **Expenditure** | | |
| Consultants — one Session | | 1 388 |
| Physiotherapy Staff — Basic Grade | 1.0 | 4 789 |
| Helper | 1.0 | 3 503 |
| Occupational Therapy Staff — Basic Grade | 1.0 | 4 789 |
| Helper | 1.0 | 3 503 |
| | 4.0 | |
| Physiotherapy and Occupational Equipment | | 1 000 |
| Recurring revenue expenditure | | £17 990 |

Additional non-recurring revenue expenditure will be required to bring Ward 16 Abbots Langley Hospital to an acceptable standard. This is estimated to cost £15 000. There is also an accepted requirement of a locum SHO for a period of six months at a cost of £3 300.

(iii) Intensification of use of Day Unit at Shrodells Hospital and development of Domicillary Nursing Services

| | £ |
|---|---|
| **Expenditure** | |
| Development of transport to Day Unit | 12 000 |
| Additional staffing etc to be determined, say | 10 000 |
| Domicillary Nurses — 4 W T E | 23 400 |
| Travelling expenses | 2 000 |
| Recurring revenue expenditure | £47 400 |

## DISPOSAL OF A HEALTH SERVICE BUILDING : A TYPICAL TIMETABLE

**Disposal of Wolstenholme Hospital**
**Rochdale Area Health Authority**

| Time-table of Activities | | Comment |
|---|---|---|
| 1 | Regional Architect's and Legal Adviser's reports sought in response to closure proposals — September 1977. | Procedures that should ideally be carried out during the consultation period. |
| 2 | Clinical use of hospital ceased — October 1977. | Arrangements made for proper care and maintenance of the premises pending completion of the disposal. |
| 3 | Regional Architect's report to to District Valuer — February 1978. | A detailed survey and report on the land and premises is necessary. |
| 4 | Legal Adviser's report - April 1978. | It is vitally important to allow time for the Legal Adviser to examine the title deeds and ensure that there are no restrictive covenants or other legal impediments to disposal. |
| 5 | District Valuer's report — April 1978. | In addition to assessing the market value of the land, the District Valuer will advise on the appropriate method of disposal.<br><br>Note — The time-scale for this activity may vary greatly from transaction to transaction. |
| 6 | Agents appointed to dispose — June 1978. | The District Valuer will recommend a firm of surveyors and also indicate any action which should be taken to clarify the planning position. |
| 7 | Offers received and considered — up to January 1979. | Property offered for sale by private treaty — District Valuer sometimes recommends sale by auction. |
| 8 | Original offer withdrawn and alternative offer accepted — up to June 1979. | Offers reported to the District Valuer who advised that highest offer represented current market value and recommended acceptance. |
| 9 | Sale approved by RHA — July 1979. | |
| 10 | Transaction completed — October 1979. | |

APPENDIX 10

## ELEMENTS TO BE INCLUDED IN POLICY/PROCEDURE DOCUMENT FOR STAFF CONSULTATION AND FOR STAFF TRANSFER MACHINERY

1 Involvement at informal consultation stage as well as formal consultation through existing or specially constituted meetings

joint staff consultative committees
open meetings for staff
more detailed discussion with recognised representatives
staff visits to new locations.

2 Categoric statement concerning redundancy policy, including agreements on protection.

3 Provision for individual interview of all staff affected to establish:

present working arrangements
broad future preferences
identify personal considerations, eg age, length of service, domestic circumstances
management presentation of appropriate opportunities.

4 Identify assistance available to transferring staff —

interpretation of Whitley Council Conditions of Service
locally provided assistance, eg transport, staff facilities, housing assistance (either NHS or District Council), removal arrangements.

5 Procedure for filling vacancies:

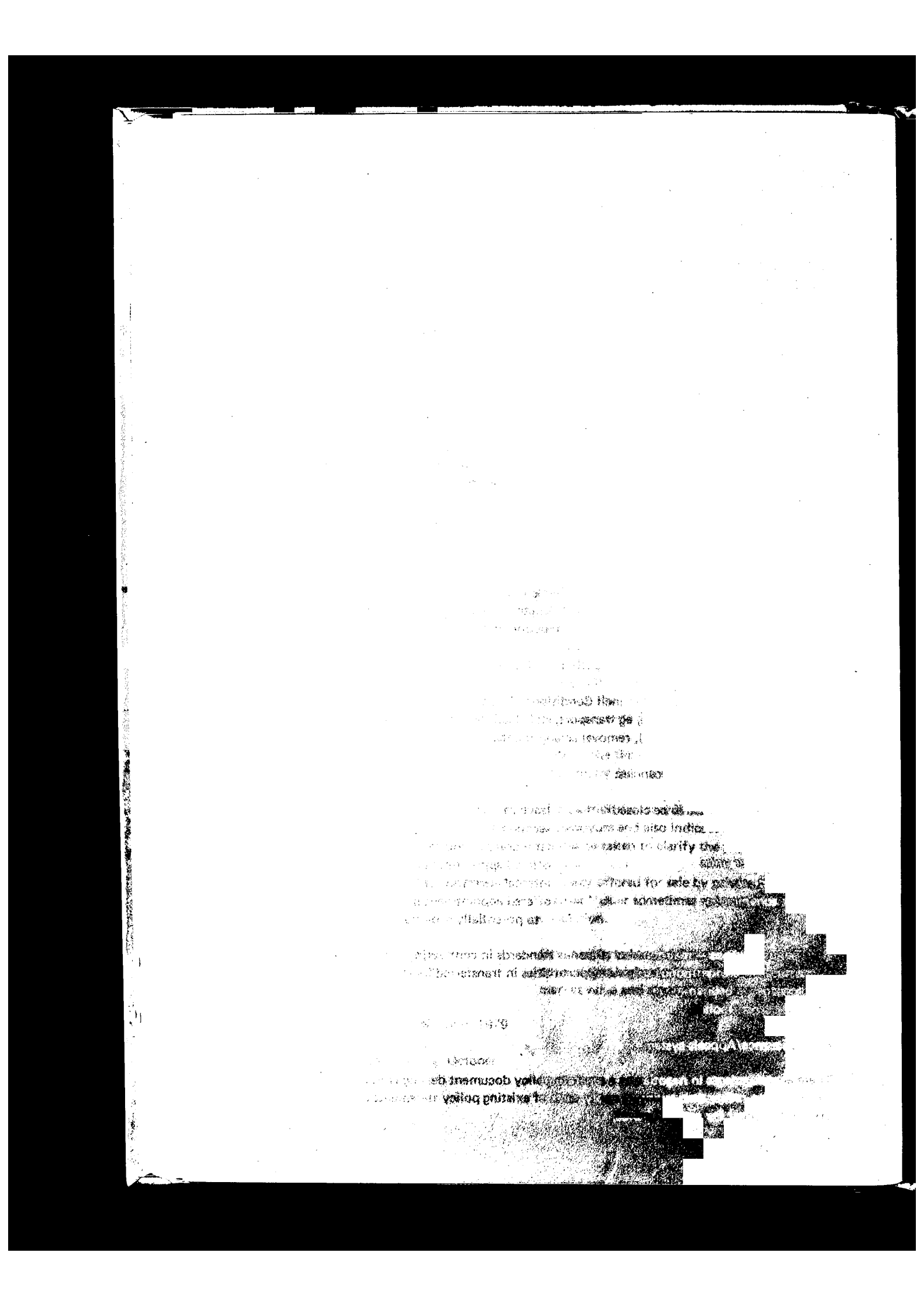
| | | |
|---|---|---|
| 5.1 In unit about to be closed | — | leave vacant |
| | — | secondment |
| | — | temporary appointment |
| 5.2 Other units | — | offered appointment on basis of comparability |
| | — | internal advertisement and limited competition |
| | — | offered appointment not strictly comparable to potentially supernumerary (redundant) staff. |

6 Bonus schemes — maintenance of bonus standards in contracting units; bonus scheme opportunities in transferred location.

7 Retirement policy.

8 Grievance/Appeals system.

There are advantages in negotiating a separate policy document dealing with closures and change of use rather than trying to apply parts of existing policy statements and having no one overall document for easy reference.



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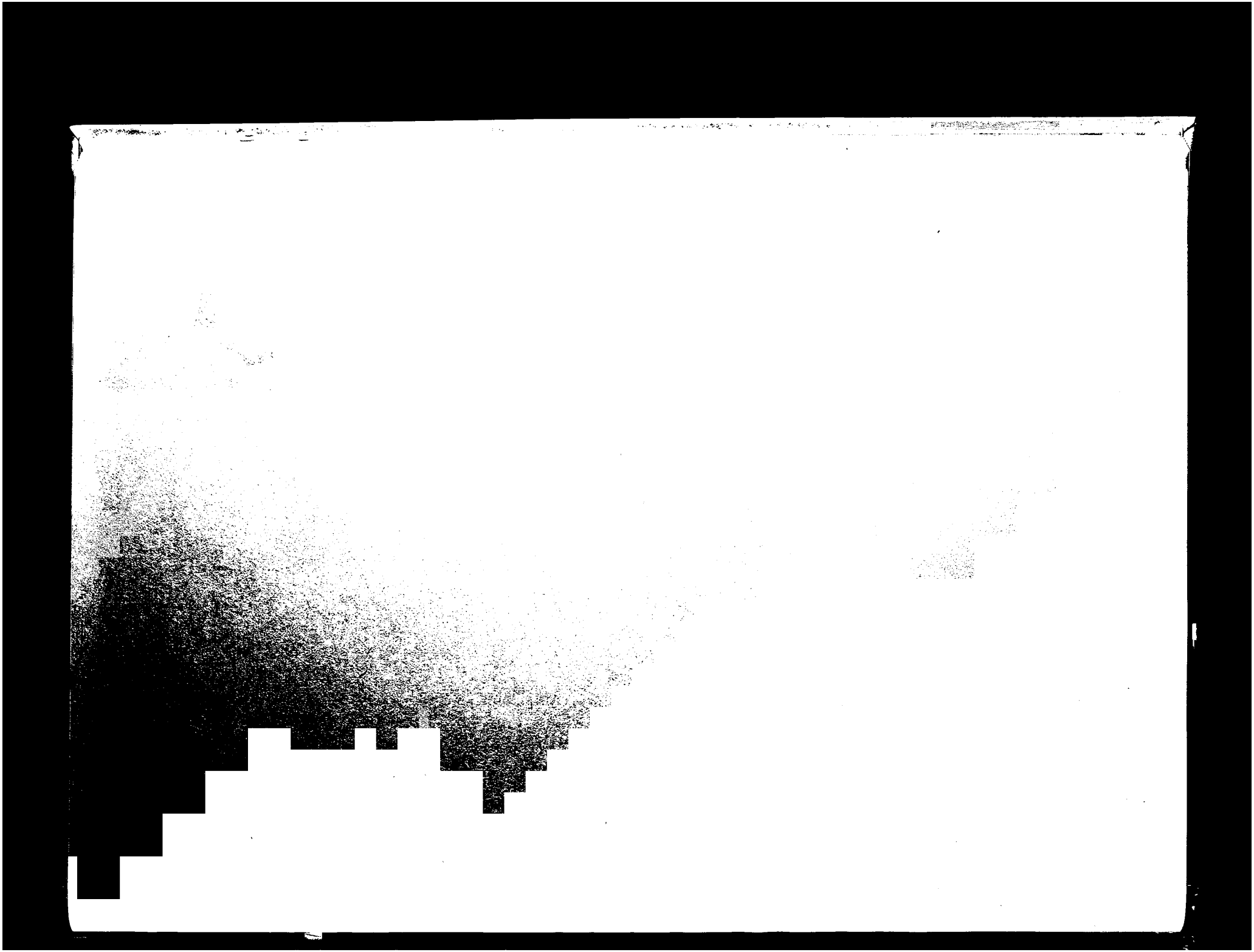

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