SOCIAL POLICY RESEARCH FOR CORNWALL

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Closing a community hospital: how consultation went wrong

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EXECUTIVE SUMMARY

The case: Deciding the future of Edward Hain Community Hospital, St Ives, Cornwall

- The issue was framed to limit debate to the future of the building, excluding consideration of the service that it had provided. There has been no public debate on how best to deliver inpatient (intermediate) care in the Penwith area.
- A *fait accompli* was created before the community was consulted.
- Information about the current and likely future impact of closure was withheld from community stakeholders and evaluators.
- When the community stakeholders did express a clear view, the structure of the decision-making process allowed experts and executive officers to ignore it.
- The scoring system used to evaluate alternatives ignored NHS England's guidance that service changes should reduce health inequalities.
- The scoring system gave weight to conjectural and subjective statements rather than to empirical evidence.
- The scoring system confused confidence levels with 'real world' criteria.
- Such quantitative data as has been put forward has been misinterpreted and this has gone unchallenged.
- General recommendations were taken as inflexible rules.
- Mixed messages were given to the public.

Improving on the Gunning Principles of public consultation

The Gunning Principles are a set of rules for public consultation. Since a Supreme Court case in 2014 they have formed a strong legal foundation from which the legitimacy of public consultations is assessed. They are frequently referred to as a legal basis for judicial review decisions.

- The first Gunning principle refers to a 'formative stage'. It should be amended to require that the public be notified when a 'formative stage' is beginning. From that point on all debate, all information gathered and all steps taken should be open to public view.
- The second Gunning principle, that a proposal must be backed up by 'sufficient reasons' to permit 'intelligent consideration' and response, presumes a smooth, rational path based on reasoning towards a conclusion. This makes no mention of disagreement and dissent but presupposes a process focused on a search for consensus and multiple endorsements. This principle should be amended to require that differences of opinion are made explicit and visible.
- The third Gunning principle, that adequate time be given for consideration and response, presupposes that it is for the body in charge to 'give' time for consultation. This principle should be amended to require that body, rather than take a unilateral decision, to provide an opportunity for challenging the timing of consultation deadlines. This would allow for proposed closing dates for a survey to be challenged if, for example, community stakeholders need time to obtain expert advice.
- The fourth Gunning principle is that the product of consultation should be conscientiously taken into account by the decision maker(s). The problem here, of course, is that it is not easy to legislate for conscientiousness. This principle should be amended to require decision makers to be open about the process of reasoning that they followed, including the reasoning behind accepting or rejecting the views of consultees.

1. The story: how a community hospital reached the point of closure

This is the story of Edward Hain Community Hospital in the Cornish coastal town of St Ives and the hospital's role in the local community. The hospital was founded after the first World War, and is named after a son of St Ives who lost his life in the War. It occupies a converted Victorian building. Today it is owned by NHS Property Services Ltd and leased to Cornwall Partnership NHS Foundation Trust. It is the last remaining community hospital in Penwith, the area at the south-west extremity of Cornwall, which includes the Land's End promontory and the towns of Penzance and St Just as well as St Ives.

The Edward Hain Hospital used to have 12 inpatient beds but because of concerns about evacuating the building in case of fire these were 'temporarily' closed to new admissions in February 2016. The last patient left in August 2016. Despite pressure to reopen the beds, and a generous offer of a contribution to the cost of doing so from the hospital's League of Friends, they have remained 'temporarily' closed ever since,[1][2] although the building has continued to house community podiatry and mental health clinics.

In the winter of 2018-19, NHS Kernow, the clinical commissioning group for Cornwall, set up the Penwith integrated community services project, together with the Edward Hain community hospital stakeholder group. Its members considered eight options for using the building and site. They recommended that just a single one be taken forward for full evaluation: it would provide for the reinstatement of 12 inpatient reablement beds in a fire safety compliant and refurbished environment.[3]

This recommendation was assessed by a group of 13 evaluators, two of them local community stakeholders, the other 11 'subject matter experts' drawn from all over Cornwall. They used 21 'pre-determined' evaluation criteria for 'scoring' the recommended option. Agreement was not reached on four of them, and these were referred to a 'super moderation' team of four NHS Kernow executives. The total of the scores that were ultimately decided is said to show that the option chosen by the community stakeholder group is not viable.

Since that conclusion was arrived at there has been a new public engagement activity by NHS Kernow. In October 2020 the public were invited to respond to a 'Have your say' questionnaire which did not mention inpatient beds. At the time of writing a report on the questionnaire and a decision by NHS Kernow's Governing Body are awaited.

2. What went wrong in the consultation process

We can identify thirteen defects in the consultation process.

1. The issue was framed to limit debate to the future of the Edward Hain building.
We can see from the questions posed that the issue in this case was framed in terms of two decisions that needed to be taken: 'What should be done with the hospital building?' and 'Where can the clinics currently using the building be moved to?' A potential third decision – 'Should the inpatient beds at the hospital now be closed permanently?' – was omitted, although at the time of writing it officially still remains to be taken, along with the corollary: 'What needs to be done for Penwith residents who require inpatient beds?'

In a 2016 publication by the South West Clinical Senate reviewing proposed changes to community beds in Devon,[4] we read:

> There should be acknowledged *(sic)* that some current community hospitals are too small, in a poor state of repair, in inappropriate locations, or unattractive workplaces due to the scope of services delivered or the physical environment. ***In these circumstances there should be public debate to determine how best to deliver intermediate care in these locations***, recognising that not all models require a community hospital. (Author's emphasis)

No public debate on how best to replace the intermediate care provided by Edward Hain Hospital has ever taken place. This failure to follow the recommendation of the South West Clinical Senate and then to conceal that failure must be counted as a lapse on the part of NHS Kernow.

2. NHS Kernow created a *fait accompli* before consulting the community.
With the closure of the inpatient beds, teams of nursing staff and other professionals were lost to the hospital, accommodation was not maintained and equipment was removed. The bedded inpatient facility as a going concern no longer existed. The longer the closure lasted, the more money and effort it would necessarily take to restore the hospital's facilities. After more than four years, any cost-benefit analysis would have been firmly tilted in favour of closure by virtue of this.

3. Information about the impact of the Edward Hain Hospital closure on Penwith residents was withheld from community stakeholders and, it appears, evaluators.
No up-to-date evidence of the impact on patients of closing the inpatient beds at

Edward Hain Hospital has been made public. An impact assessment was submitted to Cornwall Council's Health and Adult Social Care Overview and Scrutiny Committee in September 2017, but it said only that the closure would have zero impact as 'Community beds are available in alternative locations' in Cornwall.[5]

We now have much more information, thanks to a response by NHS Kernow to a request for information submitted in September 2020 by West Cornwall HealthWatch.[6] We now know that ***since Edward Hain hospital lost its 12 inpatient beds in 2016, demand for such beds has risen significantly***: the number of Penwith residents aged 65 or over who were discharged from Cornwall's main acute hospital at Treliske and needed to go to a 'step-down' (intermediate) bed, because although medically fit to leave they weren't yet 'therapy fit' to go home, has increased: ***it was 195 in 2015-16 (the last year that Edward Hain's beds were in use) but 232 in 2019-20, a rise of almost 20%.***

We also now know that ***in 2019-20 no fewer than 75 Penwith residents aged 65+ were discharged from Treliske and found themselves in community hospitals far from home***: in Falmouth (17 patients, an average distance of 24 miles from home); Newquay (20 patients, 34 miles); St Austell (12 patients, 40 miles); Bodmin (11 patients, 47 miles); and Liskeard (15 patients, 63 miles). These are all places that had previously taken very few Penwith residents: only 8 between them in 2015-16, the last year that Edward Hain was offering inpatient beds.

Evidently closing Edward Hain has resulted in the dispersal of Penwith residents aged 65 or over to community hospitals far from their home community. This crucial information has been withheld from community stakeholders. Nor, indeed, has it been presented to NHS Kernow's Governing Body or Cornwall Council's Health and Adult Social Care Overview and Scrutiny Committee.

4. NHS Kernow structured the decision-making process in a way that allowed subject matter experts and its own executive officers to ignore the clearly expressed view of community stakeholders.

The community stakeholder group members 'co-developed' and appraised eight long-listed options. Having done so, the group recommended taking just one option forward to full evaluation:

> Re-provision of 12 inpatient reablement beds and continuation of existing ... community clinics in a fire safety compliant and refurbished environment.

This statement, coupled with the rejection of all alternatives, makes it very clear that restoring inpatient beds was the prime concern in the minds of many local people.

Theirs was not the last word, however. The decision-making process prescribed that the next step should be an 'evaluation', to be undertaken by 13 evaluators, comprising eleven Cornwall-based subject matter experts and two local community stakeholders. We now know that they used 21 'pre-determined' criteria and a highly unorthodox scoring system (see below). The scores on four criteria were not agreed, and these were escalated to a 'super moderation' stage, carried out by four NHS Kernow executive officers. The upshot was that the community stakeholder group's favoured option was determined to be not viable.

It is very apparent from the criteria employed that the experts and executive officers made no attempt to understand why community stakeholders were so concerned about the loss of inpatient beds from Edward Hain Hospital. Nor did they attempt to understand the role of community hospitals in accommodating patients discharged from Treliske, or to enquire into the consequences of the non-availability of intermediate beds in St Ives. It is hard to see any reason for this neglect other than that the decision makers were not qualified to undertake the task they were set.

In short, the message from community stakeholders, that there was a need for inpatient beds, was not listened to. We can see now that that message was justified by the information that has recently come to light regarding elderly Penwith residents who were discharged from Treliske only to be moved further from home, but, as we see, those in charge of the process, if they were aware of this information, were reluctant to release it.

5. The scoring system employed by evaluators did not include equality as between local areas, despite NHS England's guidance that service changes should reduce health inequalities.

NHS England's guidance on planning, assuring and delivering service change for patients sets out 'key' tests that proposed service changes must meet and – crucially – reminds commissioners of their duty to reduce health inequalities.[7] Since the closure of inpatient beds at Edward Hain there has been inequality of community hospital provision as between St Ives and other places in Cornwall. For example, the Camborne-Redruth area has its own community hospital, and the Cornwall Partnership Foundation Trust's (CPFT) website specifically says: 'Camborne Redruth Community Hospital provides physical and mental health care ... services for people in the local area.'[8] By no stretch

of the imagination can Penwith be considered to be in the 'local area' of Camborne-Redruth, which is some 25 miles from St Just in Penwith (with no direct bus service connecting them). Penwith is its own local area and deserves at least the same community hospital service as other parts of Cornwall, especially given the relative isolation of the promontory on which it sits.

But the scoring system used by the evaluators took no account of this.

6. The scoring system employed by evaluators did not include equality as between different groups in the population, despite NHS England's guidance that service changes should reduce health inequalities.

In particular, the scoring system incorporated in the evaluation stage paid no heed to the problems of special groups, such as older people living with frailty and people with mental health needs, and did not identify any need to put them on an equal footing with people outside those groups. 'Frailty' does not get a mention, other than in the statement that Edward Hain Hospital is not suitable for 'those with frailty'. Mental health too got only a single passing mention. This is not acceptable.

7. The scoring system employed by evaluators gave weight to conjectural and subjective statements rather than to empirical evidence.

The evaluation document as published takes the form of a compilation of 82 short (mostly of one- or two lines) statements, as would fit comfortably on a Post-It Note.[9] The conjectural and subjective nature of many of them is demonstrated by the language used: the words 'may', 'could', 'if', 'but', 'likely' and 'unlikely' appear numerous times. For example, we find 'It is unlikely that GP and other services could be provided 24 hours' and 'It may be a "false choice" as local people may still need to have inpatient care elsewhere'.

These statements appear to have been included not because they derive from evidence but because of the deference accorded to the people who utter them. Statements of this kind are not untypical products of so-called co-production and consultation procedures but they do not constitute evidence from which extrapolations into the future may be made. Such empirical evidence is notably absent from the scoring system used here.

8. The scoring system employed by evaluators confused confidence levels with 'real world' criteria

The scoring system ran from 0 to 4 as follows: 0 = No evidence; 1 = Limited evidence; 2 = Adequate evidence; 3 = Good evidence; 4 = Exceptional evidence. While these can

be used as criteria for gauging the *confidence* that we might have in assigning a particular score, they are not substantive scores, i.e. scores on criteria to do with providing healthcare services in the 'real world'.

In the case of Edward Hain Hospital, as the slides for the final workshop show,[9] of 21 so-called criteria, eight scored 0 and thirteen scored 1. Thus, for eight of the 'criteria' we are told there was 'No evidence' and for thirteen there was only 'Limited evidence' There is no other word than 'bizarre' to describe this misconceived scoring system.

It is extremely disturbing that mistakenly using confidence scores instead of substantive scores should have been accepted by the group of evaluators. (It is evident that there was dissent among them but details have not been published.)

9. Such quantitative data as have been put forward have been misinterpreted, and this has gone unchallenged.

The figures provided by NHS Kernow in response to the request for information from West Cornwall HealthWatch allow us to check a calculation presented in the recent *Edward Hain Community Hospital engagement report*. This says:

> We have looked at data to understand if Penwith residents need to travel further to access a hospital bed. Recent data shows that in the recent 12 months compared with the 12 months when the Edward Hain Community Hospital beds were open, Penwith residents were admitted to hospitals on average 5.36 miles further away than residents outside Penwith who were discharged from [Treliske]. [10]

This figure is as low as it is purely because of the method of calculation. Averaging the distances travelled by Penwith residents means offsetting the long distances travelled by some (e.g. 63 miles to Liskeard) against the short distances travelled by others (e.g. 3.3 miles to West Cornwall Hospital). Averages obtained in this way have no meaning for patients in the real world. The calculation should be repeated using 'out of local area' journeys only.

Taking that average figure hides the fact that in 2019-20 no fewer than 75 Penwith residents aged 65+ were transferred to a community hospital 24, 34, 40, 47 or 63 miles from their home. They were parted from their local community at an extremely vulnerable point in their lives. There is no suggestion by NHS Kernow that large numbers of elderly residents of other parts of Cornwall have been sent so far from home.

We don't know why it took a request from West Cornwall HealthWatch to uncover these figures.

10. Other important features of community hospitals, such as their closeness to home, their role as places of safety and the part they play as important community assets, were not considered as part of the evaluation.

A major study carried out as part of the Health Services and Delivery Research (HS&DR) programme, under the National Institute for Health Research, and published in January 2019[11] found that 'key to patients' and carers' experiences of community hospitals was their closeness to "home" through their physical location, environment and atmosphere and the relationships that they support; their provision of personalised, holistic care; and their role in supporting patients through difficult psychological transitions'. The Edward Hain evaluation took no account of these roles that community hospitals equipped with inpatient beds play in their local community. ignoring this research confirms that that evaluation was superficial at best.

There is a need in the hospital system for places of safety. Acute hospitals are not places of safety, as the Embrace Care project emphasized,[12] and the current Covid-19 'rulebook', which is dominated by the attitudes and preconceptions of clinicians,[13] will make this even more the case. This need has not been recognized in the Edward Hain evaluation, but it adds to the case that a replacement for Edward Hain Hospital should include inpatient beds.

The NIHR study referred to above emphasises the benefit of recognising community hospitals as 'important community assets, representing direct and indirect value: instrumental (e.g. health care), economic (e.g. employment), human (e.g. skills development), social (e.g. networks), cultural (e.g. identity and belonging) and symbolic (e.g. vitality and security)'. It follows that these benefits to the community should be taken into account when taking decisions about the distribution of community hospitals in Cornwall. Again, the Edward Hain evaluation process failed to do that.

11. General recommendations were taken as inflexible rules.

One of NHS Kernow's justifications for rejecting the retention of Edward Hain Hospital was that it provided only 12 beds, whereas the South West Clinical Senate recommended 'that the minimum number of beds in any single location should be 16 for safe, reliable and efficient staffing'. (In fact the recommendation says, on p.13: 'The minimum effective size of unit is 16 beds to ensure safe staffing levels.'[14]) Besides

'talking up' the recommendation, NHS Kernow is taking the 16-bed minimum specification as a hard-and-fast inflexible rule rather than a general guideline. For example there was no attempt to explore the potential of a 12-bed unit for particular categories of patient, or of using it for specialized training, or of linking the hospital to the West Cornwall Hospital in Penzance. Nor are we told whether Edward Hain Hospital was considered to be over-staffed prior to the closure of its inpatient beds.

12. There are grounds for thinking that within the NHS it is being taken for granted that inpatient beds in community hospitals should be reduced in number.

A recent innovation in Cornwall has been the setting up of Community Assessment and Treatment Centres for older people living with frailty. While this is a welcome innovation, when it was presented at the July meeting of the Cornwall Partnership Foundation Trust Board it was received purely as a narrow 'business case', one 'which will soon be evidenced to show the opportunity to reduce the community bed stock', as the presenter put it.[15]

Reducing the community bed stock has not been put forward as a motive for closing Edward Hain's inpatient beds, but community stakeholders are understandably suspicious that it has played a part in forming attitudes among professional 'experts' and executive officers and contributed to dismissing their views about bed closures.

13. Mixed messages do not inspire public confidence.

For the final stage of consultation over Edward Hain Hospital, NHS Kernow published online a 27-page 'Engagement Report'.[16] That report said:

> The work to consider the role of Edward Hain hospital has concluded [and it] has told us the hospital is no longer able to provide health and care.

The Engagement Report also contained the repeated message 'no decision without you' and the last two pages (Appendix 3) comprised an invitation to 'have your say' by answering four questions. None of those questions mentioned inpatient beds.

So local people were being encouraged by NHS Kernow to have their say about the closure of Edward Hain and told there would be no decision without them while also being told, in the very same publication, that the hospital had no future.

Such mixed messages do not inspire public confidence.

3: Assessing the quality of consultation

The October 2020 report to NHS Kernow's Governing Body cited a testimonial provided by the Consultation Institute, a not-for-profit institute 'promoting high-quality public and stakeholder consultation in the public, private and voluntary sectors'. The testimonial says: 'The Institute provided the following statement regarding the process of co-development and evaluation of options with the stakeholders and the outcomes produced to date:

> *The work that has been undertaken to engage the local stakeholders and communities appears to be comprehensive and thorough, particularly the work undertaken to involve stakeholders in options development, criteria development, shortlisting and then ultimately options appraisal of potential solutions for your community hospitals.*

Comment: This judgment ignores the fact that only two community stakeholders were involved in the appraisal of options, and that disagreement among the evaluators was resolved only by passing the decision to experts and officers, while the message from community stakeholders regarding the importance of inpatient beds was disregarded.

The Consultation Institute said: The four Gunning Principles provide the framework against which the robustness of engagement can be tested – these principles are:

> ***Gunning 1 – Consultation must be at a time when proposals are still at a formative stage.*** *The work that you have done is good evidence that you have engaged the public at an early stage and before any final decision on the hospitals* (sic) *has been taken.*

Comment: The 'early stage' began in February 2016 when the first inpatient beds were closed. Since then engagement of the public has been inhibited by framing the issue as being about the building and the site, by the lack of any public debate to determine how best to deliver intermediate care as the South West Clinical Senate recommended, by the creation of a *fait accompli*, by a failure to provide information about the impact of the closure on elderly Penwith residents, and by NHS Kernow structuring the decision-making process in a way that allowed subject matter experts and its own executive officers to ignore the clearly expressed view of community stakeholders.

> ***Gunning 2 – Sufficient reasons must be put forward for any proposal to permit 'intelligent consideration' and response.*** *Considerable information has*

> *been provided to local stakeholders to enable them to contribute to, and assess, options for the future of the sites* (sic) *and provide their view to the CCG.*

Comment: As noted above, crucial information about the 'shipping out' of elderly Penwith residents from Treliske to Liskeard, Bodmin etc. has been withheld from local stakeholders despite being of central concern to them.

> ***Gunning 3 – Adequate time is given for consideration and response.*** *The process has been undertaken over a period of time that enables local people to engage in the work and put forward their views.*

Comment: As is apparent, time is immaterial if there is no engagement, and in this case no attempt was made to explore and understand the facts and experiences that lay behind local concern about inpatient (intermediate) beds. Genuine engagement would have required NHS Kernow officers to make such an attempt. They did not do so.

> ***Gunning 4 – The product of consultation is conscientiously taken into account by the decision maker(s).*** *A full report of engagement activity is being submitted to the CCG Governing Body to inform the decision making process. This will include any additional comments and observations that the community stakeholders and public make following the release of the evaluation outcomes via the media, stakeholder workshop and publishing on the website.*

Comment: There is no evidence that the product of consultation is being or will be conscientiously taken into account by decision makers: indeed the evidence is that the decision makers simply do not comprehend what lies behind local people's concern regarding inpatient (intermediate) beds. It is noteworthy that the issue of those beds is not mentioned in the most recent 'Have your say' questionnaire. Finally, it is surprising to read an assessment based on what supposedly will happen rather than on what has happened.

4: What NHS Kernow needs to do now

Things are changing in Cornwall. Moves are afoot to create an integrated care system, and already there are joint positions bridging NHS Kernow and Cornwall Council, which provides adult care social services. The two hospital trusts, currently separately responsible for acute and community hospitals in the county, are on the verge of amalgamating. The COVID-19 pandemic has prompted a great deal of rethinking about

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and innovation in the kinds of health and care service that are needed in Cornwall, and these seem very positive. But there is a historical legacy of mistrust between local people and the clinical commissioning group which badly needs healing.

Here are some steps that NHS Kernow should take:

1. It should start to publish every month figures for the number of Penwith residents of all ages discharged from Treliske to each community hospital in Cornwall, so the public can see how many are being sent far from home. It should make every effort to encourage the hospital trusts to bring those figures down, and assist them in publicizing their efforts.

2. It should start to publish every month figures for the number of Penwith residents of all ages discharged from Treliske to private nursing homes in Cornwall, again so the public can see how many are being sent far from home. It should provide details of the rehabilitation/reablement facilities at those nursing homes.

3. It should bear in mind that with the system in considerable flux, as it is at the moment, it is imperative to keep options for new development open, not shut them off. With this in mind, it should resist pressures from NHS Property Services or elsewhere to relinquish any claim to property (land or buildings) currently in use by health or social care facilities or within their grounds. For example, land adjoining West Cornwall Hospital in Penzance may offer potential for a new bedded intermediate facility (the Edward Hain wing, perhaps). Again, if this is seen to be being done it will give the public confidence that the NHS is in safe hands.

4. It should enlist the support of the local member of Parliament (Derek Thomas MP) to make the case for funding for community hospital facilities in Penwith, equipped with inpatient beds and rehabilitation gym and staffed appropriately, to replace the beds lost at Edward Hain, and enlist the support of local members of Cornwall Council to the same end.

5. As for the current tangle over the Edward Hain Hospital, NHS Kernow should

> (a) acknowledge that the elapse of more than four years since inpatient beds were closed has contributed to the costs of reopening them;
>
> (b) acknowledge that the concern of the community and community stakeholders in Penwith regarding the failure of decision makers to take notice of their concern about inpatient beds is justified;

(c) acknowledge that persisting with labelling the closure 'temporary' has contributed to public anger and disquiet. This labelling exercise has allowed NHS Kernow to postpone securing approval for the closure from NHS England, but has certainly fostered scepticism as to whether the organization has the welfare of patients at heart.

(d) make use of a fact-checking outside body competent in the application of statistical methods to examine the use made of data. The misleading statement that 'Penwith residents were admitted to hospitals on average 5.36 miles further away than residents outside Penwith who were discharged from [Treliske]' is evidence of the need for this.

Standing back from the heat generated by the Edward Hain case, we can see that NHS Kernow's Governing Body has a difficult balancing job: to balance their accountability to the NHS and the government for the money they spend, against their accountability to the public in Cornwall for apportioning resources and funding services that will meet the public's needs now and in the future. But if, in particular, they focus on key issues, obtain relevant evidence and avoid giving out mixed messages they will be helped, not hindered, in balancing the accountability pressures upon them.

Appendix: An update to the Gunning principles

The Gunning Principles are a set of rules for public consultation. They were originally proposed in 1985 by Stephen Sedley QC and accepted by the Judge in the case of R v Borough of Brent *ex parte* Gunning. These principles were reinforced in 2001 in the Coughlan Case (R v North and East Devon Health Authority *ex parte* Coughlan), which involved closing a nursing home. That judgment confirmed that those principles applied to all consultations by public bodies. More recently a Supreme Court case in 2014 (R *ex parte* Moseley v LB Haringey) endorsed the legal standing of the four principles. 'Since then they have formed a strong legal foundation from which the legitimacy of public consultations is assessed, and are frequently referred to as a legal basis for judicial review decisions.'[17]

The Edward Hain case provides a test for the Gunning principles today.

Gunning 1: Consultation must be at a time when proposals are still at a formative stage. NHS Kernow is effectively but not explicitly claiming that proposals are at a

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formative stage by labelling the closure of inpatient beds as 'temporary' and maintaining this over a period of years, while deferring the procedure for gaining official approval. Meanwhile, as we have seen, the issue was framed to limit debate, a *fait accompli* was created, and crucial information was withheld.

What is needed: How do we know when a formative stage has begun? There needs to be a specified point in time at which it is declared that a formative stage is beginning. From this point on openness should be the rule: all debate, all information gathered, all processes and all steps taken should be open to public view.

Gunning 2: Sufficient reasons must be put forward for any proposal to permit 'intelligent consideration' and response. The problematic term here is 'reasons'. Reasons always have a number of ingredients: in particular we can distinguish between information and value judgments. Information may be partial, inaccurate or misleading, especially if factual evidence is in short supply: inferences drawn from it may be illogical or otherwise invalid. Value judgments – 'ought statements' – may reflect personal and professional predispositions, possibly taken for granted and only held more doggedly when they are challenged. In the field of public policy we often see attempts to resolve disagreements by appealing to authority rather than evidence.

What is needed: More is needed to resolve on a course of action than 'intelligent consideration' and response. How can and should dissent be handled and disagreement resolved? Underlying the comments by the Consultation Institute cited in Section 3 above ('Assessing the quality of consultation') there seems to be an assumption that the aim should be consensus, that differences can be smoothed over, and that through consultation we can follow a smooth, rational path to agreement. In effect, consultation is seen as a process of securing endorsement for a single, preferred outcome. Dissent and differences of opinion are played down, as happened in the Edward Hain case.

But sometimes agreement is not possible. The principle should be that effective consultation requires visibility not only of the reasoning behind the proposal but also of the reasoning behind the rejection of alternatives, with sufficient evidence and argument put forward to make differences of opinion explicit and visible. This would seem to be a prerequisite for reaching a decision that in a democratic society even people who disagree with it will accept.

Gunning 3: Adequate time [must be] given for consideration and response. The question here is: 'Adequate' in whose judgment?
What is needed: This principle presupposes that it is for the body in charge to 'give' time for consultation. Rather than this body taking a unilateral decision, it should be required to provide an opportunity for challenging the timing of consultation deadlines. So the principle could usefully be modified to allow for proposed closing dates for a survey to be challenged if, for example, community stakeholders need time to obtain an independent analysis from outside experts.

Gunning 4: The product of consultation [must be] conscientiously taken into account by the decision maker(s). The problem here, of course, is that it is not easy to legislate for conscientiousness. In the Edward Hain case the Consultation Institute took the mere proposal to submit in the future 'a full report of engagement activity' which would include 'any additional comments and observations' that the community stakeholders and public have made as satisfying this requirement, but such a report could well be fashioned to justify decisions already reached.
What is needed: It should be legitimate for those consulted to ask how decisions were arrived at. How were the views of consultees taken into account? On what basis were they accepted or rejected? In the Edward Hain case, for example, the fact that the final 'Have your say' consultation failed to mention the issue of inpatient beds strongly suggests that the evaluators' concern about them, which had been expressed very clearly, was disregarded. We have no evidence that all relevant information was put forward and considered, that pros and cons were discussed, that any kind of cost-benefit analysis was carried out, that arguments were tested, that anyone acted as a devil's advocate. The evaluators' views were clearly *not* conscientiously taken into account by those who took decisions.

So there needs to be openness about the process of reasoning that has been followed by decision makers, including the reasoning behind accepting or rejecting the views of consultees, and this should be made clear by writing it into the fourth Gunning principle.