



Patient and public participation in commissioning health and care:

Statutory guidance for clinical commissioning groups
and NHS England

This document is only compatible with adobe acrobat and some elements will not display/function correctly whilst using other pdf views



[Click here to download the latest version](#)

The document has been designed to be viewed electronically and may not print out correctly.
If you would like a plain text version please visit the [NHS England website](#)



Summary

This guidance is for clinical commissioning groups (CCGs) and NHS England. It supports staff to involve patients and the public in their work in a meaningful way to improve services, including giving clear advice on the legal duty to involve.

The guidance links to an extensive range of resources, good practice and advice that will support staff to involve patients and the public. It highlights key participation principles, alongside themes such as working in partnership with others, including with 'seldom heard' groups to maximise the benefits and impact of involvement.

This guidance has been developed alongside [Involving people in their own health and care: statutory guidance for clinical commissioning groups and NHS England](#).



This guidance sets out 10 key actions for CCGs and NHS England on how to embed involvement in their work. They should:

The guidance also explores some of the complexities of commissioning in a changing healthcare landscape, in relation to co-commissioning, devolution and joint arrangements, including [accountable care systems](#) (ACs).



Foreword

Effective participation comes from our mindset and culture. It moves beyond process and embraces people, carers and patients in the design, delivery and assessment of care. It should be a natural part of the way we work.

The major challenges facing health and social care cannot be addressed without diverse thinking to develop innovative and sustainable solutions. Involving people and communities in genuine co-production is part of the answer. This will allow us to make the best use of the assets of the people we work with every day and harness their energy, experience and wisdom. This guidance supports us to take participation to the next level – something that will be essential for leaders throughout the system.



Rob Webster

Chief Executive, South West Yorkshire Partnership NHS Foundation Trust

Lead Chief Executive, West Yorkshire and Harrogate Sustainability and Transformation Plan



Foreword

In Bradford, Airedale, Wharfedale and Craven we have some major health challenges, including cancer, heart disease, diabetes, respiratory problems, mental health and wellbeing. We are a district of diversity with some of the highest levels of deprivation in the country - 34% of the district's population lives in the most deprived 10% of neighbourhoods in England. We want to tackle our challenges head on, working with our whole community to achieve our vision. Our aim is to make sure that all our work is informed by the people we are here to support – people who use services, care for others or work in the district. We want to hear directly from people about their health and wellbeing needs, wishes and aspirations, their experiences of current health and care services and their ideas for improvement.

We all know that resources are being stretched further and we are going to have to make some difficult decisions to safeguard local services for people. Listening to what our communities have to say about what works and doesn't, and supporting people to make healthier choices and make their own decisions about health and care is critical to long term sustainability of health and care services. During the development of our mental wellbeing strategy we paid particular attention to the voice of children and young people, ever mindful that the services we are developing have to be fit for the future and adaptable for the longer term.

We strongly believe in working in partnership, and it has never been more important to do so. As our local sustainability and transformation plans are developed and implemented, it is imperative that all the partners come together and engage with local people, giving consistent messages and considering together what people tell us is important to them. People tend not to care about organisational boundaries, but about how services can work better for them and their families. We need to keep our focus on serving people and communities.



Helen Hirst

Chief Officer
Bradford City CCG,
Bradford Districts CCG and
Airedale, Wharfedale and
Craven CCG



Introduction

Purpose, scope and links to other resources

This guidance will help staff in clinical commissioning groups (CCGs) and NHS England to involve patients and the public in their work in a meaningful way. It shows the importance of involving people in commissioning to improve health and care services, and how CCGs and NHS England can meet their legal duties to do so.

Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs and NHS England have duties to involve the public in commissioning, (under sections 14Z2 and 13Q respectively). The wording of these duties is set out in appendix A.

This guidance is statutory and CCGs must have regard to it^{1 2}, as must NHS England staff.

Commissioning approaches are changing. The NHS does not commission services in isolation, but works closely with local authorities and other partners. In light of this, [the guidance includes information on co-commissioning and local variations in commissioning arrangements](#).

The guidance will also be of relevance/interest to:

- patients, carers and the public
- providers of health and care services
- organisations that support commissioning
- local authorities, including overview and scrutiny committees
- health and wellbeing boards
- [Healthwatch](#)
- the voluntary community and social enterprise (VCSE) sector
- sustainability and transformation plan partners and accountable care systems.

The guidance links to an extensive suite of web based resources, including bite-size guides and best practice case studies on the [NHS England website](#).



NHS England staff should also refer to the [NHS England Patient and Public Participation Policy](#) and to the participation frameworks, shown below, for each area of direct commissioning³. The frameworks set out the key partnerships and approaches to working with different groups of stakeholders for each service area. CCGs will also find the primary care and public health frameworks of relevance.

- Framework for patient and public participation in primary care commissioning
- Framework for patient and public participation in public health commissioning
- Framework for patient and public participation in armed forces commissioning
- Framework for patient and public participation in health and justice commissioning
- Framework for patient and public participation in specialised commissioning

All of the frameworks can be found on the [NHS England website](#).

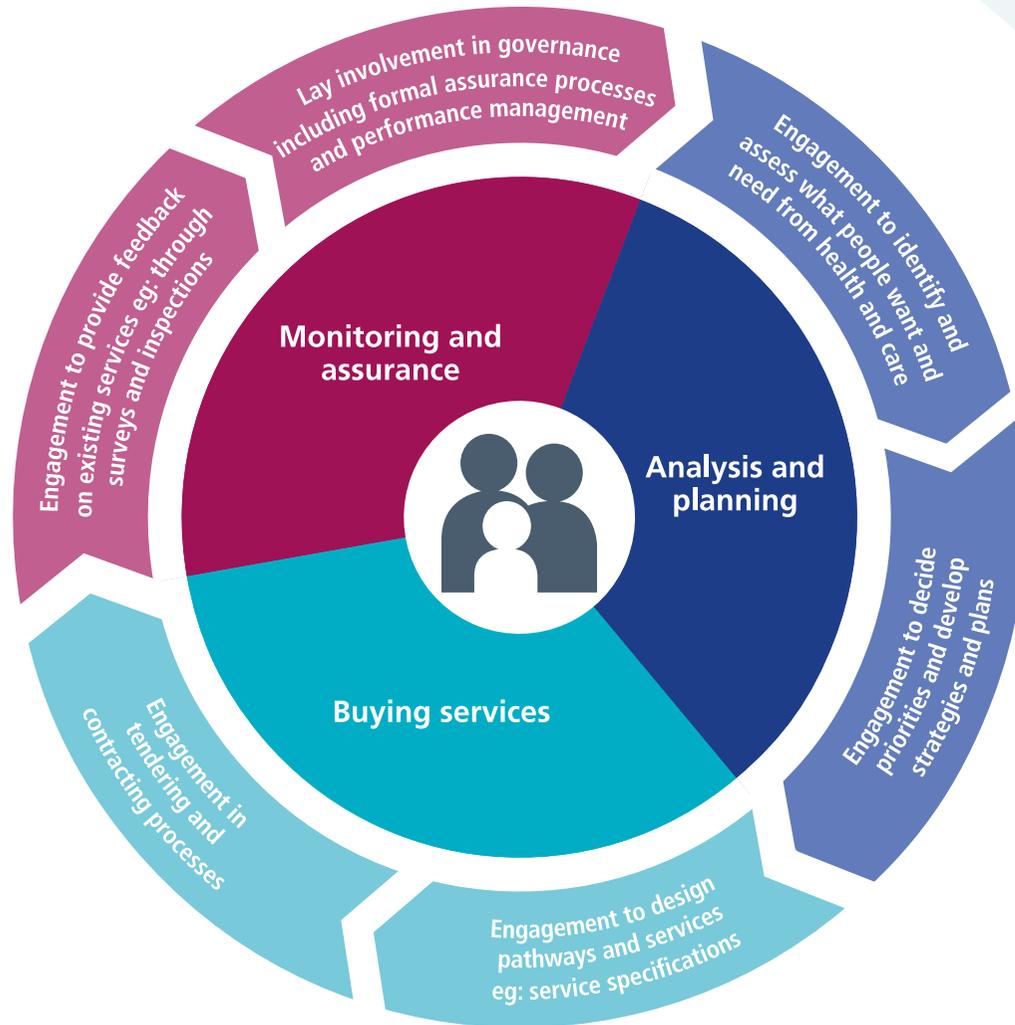
Tools to support commissioners

Those who are involved with sustainability and transformation plans should also use [Engaging local people: a guide for local areas developing sustainability and transformation plans](#).

Commissioners may also find the guidance for local authorities, [New Conversations: the Local Government Association guide to engagement](#) a useful resource. NHS Improvement has developed a [Communications and engagement toolkit for teams in service change programmes](#).



How public participation can support the commissioning cycle





Why is public involvement in commissioning important?

The [NHS Constitution](#) enshrines public ownership of the NHS as a fundamental value:

“The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill, and when we cannot fully recover, to stay as well as we can to the end of our lives.”

The NHS is accountable to the public, communities and patients that it serves and is therefore subject to public scrutiny. Building on the constitution, the [Five Year Forward View](#) sets out a vision for growing public involvement:

“One of the great strengths of this country is that we have an NHS that – at its best – is of the people, by the people and for the people...we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services.”

Staff can better understand population health needs, and respond to what matters most to people when they involve and listen to those who need, use and care about NHS services. Patients and the public can often identify innovative, effective and efficient ways of designing, delivering and joining up services.

Involving people isn't always easy and can take time, but done well it provides opportunities to improve patient safety, patient experience and health outcomes, and to support people to live healthier lives. Conversely, as starkly illustrated by the [Francis Inquiry](#) into events at Mid Staffordshire Hospitals NHS Trust, when the NHS does not take account of the views of patients, carers and staff, the consequences can be very serious.

[The Marmot Review, Fair Society, Healthy Lives \(2010\)](#) clearly demonstrated the difference in life expectancy between socio-economic groups. At a local level, [joint strategic needs assessments](#) (JSNAs) tell a similar story. If we are to truly address these inequalities, activity should start from the stance of those who experience the greatest inequalities.

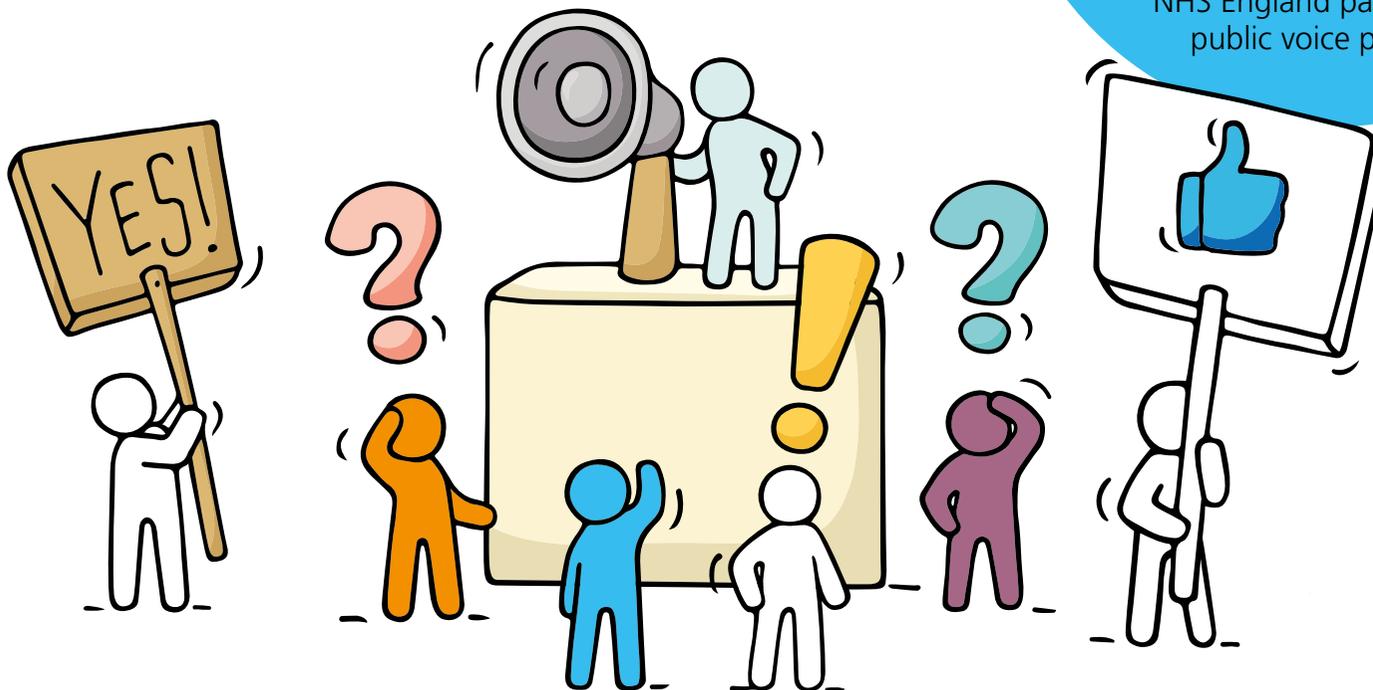
By prioritising the needs of those who experience the poorest health outcomes, CCGs and NHS England will be better able to improve access to services, reduce health inequalities in our communities and make better use of resources.



As well as the benefits to the NHS and the population as a whole, public involvement offers personal benefits for individuals. People who are involved are likely to find that their involvement increases their knowledge of services and how to use them appropriately, supporting them to be in control of their own health and care. They may also find that their involvement activity increases their skills and confidence.

“Becoming an expert by experience has helped to build my confidence and given me a taste of being the voice of patients. I have developed new skills and taken up a role as an expert by experience, working alongside the inspectors of services for the Care Quality Commission... Being involved with NHS England gave me the confidence to apply for the post.”

NHS England patient and public voice partner





The principles of participation

NHS England has developed 10 principles of participation based on a review of research, best practice reports and the views of stakeholders.

- 1 Reach out to people rather than expecting them to come to you and ask them how they want to be involved, avoiding assumptions.
- 2 Promote equality and diversity and encourage and respect different beliefs and opinions.
- 3 Proactively seek participation from people who experience health inequalities and poor health outcomes.
- 4 Value people's lived experience and use all the strengths and talents that people bring to the table, working towards shared goals and aiming for constructive and productive conversations.
- 5 Provide clear and easy to understand information and seek to facilitate involvement by all, recognising that everyone has different needs. This includes working with advocacy services and other partners where necessary.
- 6 Take time to plan and budget for participation and start involving people as early as possible.
- 7 Be open, honest and transparent in the way you work; tell people about the evidence base for decisions, and be clear about resource limitations and other relevant constraints. Where information has to be kept confidential, explain why.
- 8 Invest in partnerships, have an ongoing dialogue and avoid tokenism; provide information, support, training and the right kind of leadership so everyone can work, learn and improve together.
- 9 Review experience (positive and negative) and learn from it to continuously improve how people are involved.
- 10 Recognise, record and celebrate people's contributions and give feedback on the results of involvement; show people how they are valued.

The [People and Communities Board](#), in conjunction with the new models of care 'vanguard' sites, have also developed [six principles for engaging people and communities](#) to give practical support to services as they deliver the 'new relationship with people and communities', set out in the Five Year Forward View.



1. Involve the public in governance

The CCG constitution must describe:

- the key ways it involves the public in commissioning
- a statement of the principles it will follow in involving the public
- how the CCG will ensure transparency of decision making.

CCG governing bodies must include at least:

- one lay person who has qualifications, expertise or experience in finance and audit, and chairs the audit committee
- one lay person who has knowledge about the CCG's local area to express informed views about how the CCG is performing its functions. This person will help to ensure that, in all aspects of the CCG's business, the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the CCG⁴.

NHS England recommends a third lay member is appointed to CCG governing bodies in light of CCGs' increasing role in primary care commissioning⁵.

"As a group, we had 20 meetings over the two and half years, and maintaining motivation and momentum was really important for us - we needed to 'see' the impact of our conversations. We started meetings with 'You Said, We Did' sessions, to challenge speakers to be able to update us on how they had used our conversations to effect change. This was our real time thermometer of how meaningful our meetings were."

Chair of the Patient, (Carer) and Public Engagement Group, Dorset CCG

Good practice example:

Bristol CCG sets out a clear and comprehensive overview of the way it involves people, on page 13 of its constitution.



NHS England has a [patient and public participation policy](#) which sets out its corporate arrangements for involvement. The NHS England Board includes a Chairman and Non-Executive Directors, who all have responsibility for ensuring that the views of patients and the public are appropriately considered by the Board. [NHS England has also produced a bite-size guide to governance for participation.](#)

**Good
practice example:**

Wakefield CCG has a Public Involvement and Patient Experience Committee (PIPEC) which meets on a quarterly basis. Members are drawn from across Wakefield to provide representation of patient views and opinions and to inform commissioning arrangements, business planning and to identify possible improvements. PIPEC provides a single recognised structure to oversee the delivery of patient involvement and patient experience activity and to ensure impact and change is demonstrable both internally and externally. All PIPEC notes, detailing the discussions held, are submitted to the Integrated Governance Committee, minutes then form part of the Governing Body papers, which are available on the [Wakefield CCG website](#).



2. Explain public involvement in commissioning/ business plans

CCG commissioning plans/the NHS England business plan must explain how the public involvement duty will be met⁶. In practice, this means explaining how priorities have been influenced by engagement, and planning and budgeting for future engagement activity.

Good practice example:

NHS Rotherham CCG's commissioning plan includes a communications and engagement plan that sets out its priorities and how it will involve communities.

3. Demonstrate public involvement in annual reports

Annual reports produced by CCGs and NHS England must show how the public involvement duty has been discharged⁷. NHS England has produced a guide for CCGs and NHS England staff, [Annual reporting on the legal duty to involve patients and the public](#). This sets out the organisations' responsibilities to report on how they meet their legal duties to involve patients and the public. The guide includes useful tools, resources and good practice examples to support the development of annual reports. It also provides advice on making reports accessible and appealing.



4. Promote and publicise public involvement

Arrangements for public involvement should be promoted and publicised in a variety of ways. It is important to think about the range of different ways that people may engage and select the most appropriate method(s) of engaging with the identified audience.

Each CCG should publish at least the following information on its website:

- Involvement opportunities, including formal roles, consultations and public meetings.
- Details of how to make complaints and comments.
- A summary of key local health needs and how these are being addressed.
- Links to local Healthwatch.
- Links to other relevant local organisations.

For NHS England, the relevant information is set out on the Involvement Hub on the [NHS England website](#).

For further information on different communication channels that CCGs and NHS England can use, see page 27.



5. Assess, plan and take action to involve

CCGs and NHS England must assess the benefits of, and the legal requirement for, public involvement and plan and carry out involvement activity. Decision making and the rationale for decisions should be clearly documented at all stages.

Assessing the benefits of patient and public participation and the legal duty to involve

CCGs and NHS England should always consider the benefits of involving the public in their work and seek to take account of feedback from the public about the services they commission.

In some cases the need to involve the public will be obvious. However, in other cases it may be necessary to assess more carefully whether there is a legal obligation to involve the public and, if so, what kind of public involvement is appropriate.

Examples of circumstances in which the legal duty to involve may arise

The examples (on the next page) indicate some circumstances where the legal duty to involve the public may apply and therefore where commissioners should assess this to determine the appropriate response. As it is not possible to anticipate every such situation, the list is not exhaustive.



Changes to commissioning arrangements

- The strategic planning of services, for example:
 - Plans to reconfigure or transform services or improve health.
 - Plans in response to the latest joint strategic needs assessment and health and wellbeing strategy.
- Developing and considering proposals to change commissioning arrangements, for example:
 - Changes to services, new models of care, new service specifications, local improvement schemes, etc.
 - Reconfigurations involving movement of services from one provider or location to another.

Procurement

- Considering or developing proposed models, configurations or specifications for a service.
- Commencing a procurement process.

Contracts

- Entering into a contract with a provider.
- Varying a contract, other than a variation required by law.
- Serving a notice to terminate a contract with a provider.
- Receiving a notice to terminate from a provider.

Overview and scrutiny referral

- Any instance in which a referral has been made to the local overview and scrutiny committee.

Equality

- An equality impact analysis may indicate the need for engagement, for example a lack of evidence relating to certain groups.

Circumstances in which the legal duty may arise could be identified at a number of stages throughout a single commissioning process. On each occasion this should prompt a consideration of the need for public involvement and what is already in place or should now be done. A separate public involvement exercise is not required at every step, so long as existing arrangements are sufficient to secure the necessary public involvement in the commissioning process.



A process for assessing the benefits of participation and whether the legal duty to involve applies

NHS England has developed a three step process for assessing the benefits of participation and whether the legal duty to involve applies. NHS England staff must document their assessment using the public involvement assessment and planning form available on the NHS England intranet. CCGs should ensure adequate records are kept, and may wish to adapt the example form, shown in appendix B for their own use.



Does the activity relate to commissioning responsibilities?

For example

- A decision in relation to the relocation of a podiatry service commissioned by the CCG does.
- A decision in relation to the relocation of one of the CCG's administrative offices does not.

If **yes**, go to [step 2](#).

If **no**, the legal duty to involve does not apply, but you should still consider and make a judgement about whether some form of public involvement, or staff/stakeholder engagement, would be beneficial. This is particularly important where there is likely to be significant public interest, when a promise to consult has been made, or a precedent to do so has been set.



What type of activity is it?

The duty applies to three types of commissioning activity.

1. Planning

CCGs and NHS England are required to always have arrangements in place to involve the public in the planning of commissioning arrangements, regardless of the impact these plans would have on services if they were implemented. If the activity relates to planning, go directly to page 22 for advice on planning and taking action.

2. Proposals for change

This activity includes not only the consideration of proposals to change services, but also the development of such proposals. If the activity relates to proposals for change, go to [step 3](#).

3. Operational decisions

This activity relates to decisions that change or affect the way a service operates. If the activity relates to operational decisions, go to [step 3](#).

While the legislation distinguishes between these different types of commissioning activity, as can be seen by the examples opposite they often overlap and sometimes a plan, proposal or decision can fall into more than one category.

Examples of commissioning activities

Planning

- The development of a CCG policy for the commissioning of diabetes services.
- Planning a new urgent care service to be commissioned in a particular area in response to increased patient demand in the area.

Proposals for change

- Development of options for the reconfiguration of A&E services in a particular area and the subsequent consideration of any developed options or model.

Operational decisions

- Making changes to the services or the location of services.
- The closure of a fracture clinic for operational reasons.



Would there be an impact on service delivery or the range of services?

An impact on services can arise in two ways:

1. An impact on the way services are delivered to individuals, for example the transfer of a service to another location; and/or
2. The range of health services available to individuals, for example the decommissioning of a service of limited clinical benefit to fund investment in other services.

The impact on services should be considered from the perspective of patients and not necessarily limited to the clinical services being commissioned. Accessibility, transport links and ambulance availability are all examples of matters that could be significant in considering impact.

If yes, go to page 22 for guidance on planning and taking action.

If no, the legal duty to involve does not apply, but you should still consider and make a judgement about whether some form of public involvement would be beneficial.

Examples

Impact on services

- The closure of a GP practice would mean patients having to find a new practice to seek treatment. This would impact upon the way in which services are delivered to patients. The degree of the impact will depend on how far individuals will have to travel to access another GP practice as well as any specific care that may have been provided at the practice. In such circumstances it is likely that the legal duty to involve applies.

No impact on services

- The retirement of a GP from a practice may mean that patients with a preferred choice of doctor will need to be seen by a different GP. However, this would not typically affect the range of services or the manner of their delivery, in which case the legal duty to involve is unlikely to apply.
- The termination of a GP contract and the award of a new contract to a provider, with no change in the specification of such a contract, would not ordinarily be expected to result in changes to the way that services are delivered to patients or the range of services available. In such circumstances it is unlikely the legal duty to involve will apply.



Planning and taking action

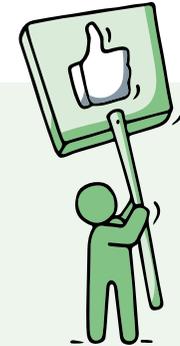
If public involvement has been identified as a requirement under the legal duty, review existing arrangements for involving the public in this activity (if any) and, where you assess that further action is required, this should be planned and undertaken.

Review existing insight and previous involvement activities as a first step – what do we already know?

Staff should consider whether there are existing sources of feedback and insight on the views and experiences of different groups of people. A review of existing information can save time and money and point staff towards gaps in insight. This helps to ensure that public involvement is focused and meaningful, rather than being generic and imposing an unnecessary burden on people.

Examples of insight and feedback sources:

- 👍 surveys
- 👍 social media
- 👍 Healthwatch reports
- 👍 [Care Quality Commission](#) (CQC) reviews
- 👍 research reports
- 👍 complaints
- 👍 [Patient Experience Library](#)
- 👍 intelligence from NHS bodies, the VCSE sector and local authorities
- 👍 staff feedback including their own views, any 'whistleblowing' concerns and intelligence they have gained through their interactions with patients and the public
- 👍 previous public involvement exercises.



[Further information on sources of insight and feedback and their use in commissioning is available on the NHS England website.](#)



There should be a review of any previous public involvement exercise that is relevant to the plans, proposals or decisions and consideration of the following questions:

- Is the new proposal the same as the one previously considered?
- Was the proposal considered previously similar to what is being considered now or have there been significant changes?
- How long ago was the public involvement? Does it remain relevant?
- Who was involved previously? Has there been a significant change to the people who are affected?
- Did previous involvement sufficiently address the diversity of patients and communities?
- Is there new information that the public needs to know before the decision is taken?
- Has there been any change, for example a population change, that may affect the proposal or the impact it will have?

Example:

A CCG is considering reducing the number of sites on which primary care services are provided in an area, to improve quality, provide extended opening hours and integrate with other services. A comprehensive review into primary care services in the area was undertaken a year ago and made a number of recommendations. The public was widely involved in this process. However, the population of the local area has changed significantly since this time and there are a number of housing developments being built and young families moving into the area. This has both increased patient lists and also changed the nature of services required. Whilst undertaking their assessment of whether the legal duty to involve the public applies, the CCG decides to consider the findings of the previous involvement activity but also to undertake new involvement activity to help them to better understand the needs and views of the current population. They also plan public involvement to support the implementation of the recommendations.



Who needs to be involved?

Staff should involve patients and those who may use services in future. This includes carers and families, where relevant.

Taking an [asset based community development approach](#) can help to identify the range of partners who may have an interest in involvement and a useful contribution to make. It may be helpful to involve members of self help and support groups, Healthwatch, faith groups, patient and carer groups, local neighbourhood or social action groups, local timebanks or charities.

CCGs and NHS England should draw on the expertise and experience of Patient Participation Groups (PPGs) which all GP practices must have. The National Association of Patient Participation (N.A.P.P.) has produced a set of [top tips for engagement with PPGs](#).

“The NHS should support and work through PPGs if they wish to reach and work with the ordinary patient.”

NHS England patient and public voice partner

Ideally, CCGs and NHS England should engage directly with the population affected by the commissioning activity, but in some circumstances, some aspects of public involvement can take place via representatives. For example, a policy or review group with appropriate expertise and representation from those affected may be sufficient.

Where involvement takes place via representatives, staff should seek assurance that the representatives offer a fair reflection of the views of others. Engagement through representatives should only be used where directly engaging with service users is not practicable or proportionate. It should complement – not substitute – opportunities for direct engagement. Patient and public representatives on working groups can help to ensure that engagement approaches are appropriate for the population in question.

The appointment of a patient/public representative or ‘expert by experience’ as the chair of a working group, where appropriate, can send an important message about how their contribution is valued.

“Are your representatives actually representing the community – or just their own personal views?”

NHS England patient and public voice partner



Decide how to involve the public

Where public involvement is required, staff will need to make their best possible judgement on what is a 'fair and proportionate' approach to the circumstances. This is not an area where definitive advice can be offered without knowledge of the specific circumstances. Where staff need to make a particularly complex or potentially contentious judgement, they may wish to consider seeking legal advice.

Fair

Acting fairly is an important duty which applies to all public bodies. The courts have established guiding principles for what constitutes a fair consultation exercise, known as the 'Gunning' principles. These four principles relate to formal consultation and will not apply to every type of public involvement activity. However, they will still be informative when making arrangements to involve the public, whatever form these arrangements take.

1. Consultation must take place when the proposal is still at a formative stage

Meaningful consultation cannot take place on a decision that has already been made. Decision makers can consult on a single proposal or 'preferred option' (of which those being consulted should be informed) so long as they are genuinely open to influence. There is no requirement, and it would be misleading, to consult on adopting options which are not genuinely under consideration, or are unrealistic or unviable – but it may be necessary to provide some information about arguable alternatives.

2. Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response

Those being consulted should be provided with sufficient information to enable them to understand what the proposal is, the reasons for it and why it is being considered. They should be made aware of the basis on which a proposal for consultation has been considered and will be considered thereafter, including any criteria to be applied or factors to be considered. This may involve providing information about (or at least making reference to) arguable alternatives and the reasons why they are not also being considered. The level of detail provided will depend on the circumstances.

3. Adequate time must be given for consideration and response

People must have enough time to properly consider and respond to the consultation. There is no automatically required timeframe within which the consultation must take place.

4. The product of consultation must be conscientiously taken into account

Decision makers must properly consider what they have heard during the consultation when the ultimate decision is taken.

The Cabinet Office published revised [Consultation Principles](#) in February 2016, which provide additional guidance.



Proportionate

CCGs and NHS England need to consider their duty to involve the public alongside their duty to act effectively, efficiently and economically. Staff will need to consider the impact of proposals on people who may be affected. As a general rule, the greater the extent of changes and number of people affected, the greater the level of activity that is likely to be necessary. However, the nature and extent of public involvement required will always depend on the specific circumstances of an individual commissioning process.

Staff should also consider the potential impact on other services which they may not commission, and issues for patients beyond the clinical services themselves, such as accessibility, transport links and ambulance availability.

“I just need someone to walk through the door with me.”

NHS England patient and public voice partner

People may need to be encouraged to give honest feedback and opinions, and sometimes reassurance that any negative views will not have any adverse consequences for them, e.g. in relation to future treatment, where people are critical of services they are using. Advocacy and support may be needed to help people express themselves.

Location, access and demographic issues need to be taken into account, for example, considering how a population in a rural area or how children and young people may be particularly affected by a change to services. These issues also need to be considered when planning participation itself. For example, in a small market town it may be best to carry out surveys on a market day when there are more people around than on other days.

The NHS Youth Forum has a set of [top tips to involve young people in healthcare planning](#).

“Young people make up a big part of the population; we are the NHS users and staff of the future. By listening to our experiences of services you can better understand our health and care needs and what they might look like in years to come. If you’re going to develop a service for young people it’s important that we are involved in the design. If our input is valued we will feel comfortable sharing our experiences and will be more likely to use the service that’s being developed.”

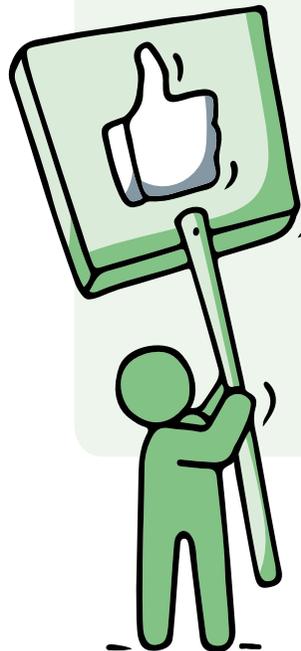
NHS Youth Forum member



Examples of ways to involve patients and the public

- 👍 Through their elected representatives (MPs and councillors).
- 👍 Letters or emails to affected individuals.
- 👍 Newsletters.
- 👍 Information on notice boards in local community facilities such as GP surgeries, libraries, leisure centres and supermarkets.

- 👍 Suggestion boxes.
- 👍 Boards on the street for people to write their thoughts on a particular question, for others to see and contribute to the discussion.
- 👍 Leaflet drops.
- 👍 Dedicated events to enable discussion.
- 👍 Focus groups and interviews - telephone interviews are particularly useful for people who may find travel difficult or who may feel uncomfortable having a face to face conversation.



- 👍 Surveys and feedback forms.
- 👍 Seek views at local events or venues such as faith centres, community celebrations, festivals, markets, schools, leisure centres, libraries, shopping centres, neighbourhood gatherings, etc.
- 👍 Work with local VCSE organisations, local Healthwatch and the PPG at GP practices.
- 👍 Provide opportunities for the public to meet staff (not just during office hours, which could exclude people who work and children and young people who are at school).
- 👍 Formal public consultations.
- 👍 Social media, for example Twitter, Facebook.
- 👍 Public and patient advisory or reference groups.
- 👍 Patient and public representatives who provide regular input to committees/groups/boards.
- 👍 [Co-production](#) with experts by experience.

“We helped the CCG have different levels of detail on the proposals, so people could access the information that matched their interest, time and understanding.”

Chair of the Patient, (Carer) and Public Engagement Group, Dorset CCG



Example:

Working with the homeless community to improve health and wellbeing

St George's Crypt is a charity that works with homeless people in Leeds to improve many aspects of their lives, including health and wellbeing. Clients come to the crypt and tell staff about the services they are having problems accessing or the things they would like to be involved in. The crypt works in partnership with other organisations including Leeds Beckett University, NHS organisations and the city council to bring in the services needed. They have produced a film that highlights some of the successes of their joint work, including making physiotherapy and exercise classes available to homeless people.

Working with the voluntary community and social enterprise (VCSE) sector

The VCSE sector makes an invaluable contribution to health and care in England. It has a long history of developing innovative and creative approaches to improving health and wellbeing and delivering health and care services. The sector includes organisations such as charities, not for profit organisations, community groups, social enterprises, civil society organisations and non-governmental organisations.

There are many benefits to working in partnership with VCSE organisations, especially in reaching 'seldom heard' groups and communities.

VCSE organisations are often trusted, accessible and skilled at outreach and engagement. They work

with some of the most disadvantaged communities and have an excellent understanding of the health and care issues their beneficiaries face, both at a local and national level. The VCSE sector is well placed to provide expertise to directly engage patients and the public in the commissioning process and to advise/ support staff. CCGs and NHS England can provide grant funding to VCSE organisations to carry out engagement activity. More information about how to do this can be found in NHS England's [bite-size guides to grants for the voluntary sector](#) and [working with partners](#).

Locally, the best way to link with the VCSE sector is through councils for voluntary services (CVS), which are sometimes called local development and support agencies. These organisations can help staff to reach large numbers of VCSE organisations in their area. They typically know how best to engage with their communities and often support a network of organisations working in health and social care, which can be useful for staff and policy makers to work with and is a good starting point in developing a suitable approach to local engagement.

A database of local support and development organisations is available from [NAVCA](#), the national voice of local support and development organisations.

NHS England staff can also access support through the VCSE Health and Wellbeing Alliance, run by NHS England, the Department of Health and Public Health England.



Example:

Healthwatch Norfolk – working with veterans to understand mental health needs

Healthwatch Norfolk conducted targeted engagement with 30 military veterans living with mental health conditions in Norfolk and Suffolk. The aim was to understand what it was like for them to experience NHS mental healthcare and to find ways of improving local services for a group of ‘seldom heard’ service users. The project involved a wide variety of stakeholders, bringing together local veterans and their families with NHS England staff and working with Health Education England and the Ministry of Defence to provide veteran specific training to 272 GP students across the east of England. You can find out more by [watching a short film about the project](#).

Working with Healthwatch

The [Healthwatch](#) network was set up to understand the needs, experiences and concerns of patients and the public and to ensure people’s views are put at the heart of health and social care. They listen to what people like about services, and what could be improved, and share this insight with a range of commissioners, providers and regulators. At a national level Healthwatch England has statutory powers to provide NHS England with information and advice about the views of people who use services. At a local level there are 152 local Healthwatch which have the same statutory power to advise and inform CCGs. Local Healthwatch also have a statutory seat on local health and wellbeing boards.

Local Healthwatch are well placed to carry out engagement activity because of their links with patients and the public and local networks, including the VCSE sector and local authority health overview and scrutiny committees. These links also enable local Healthwatch to engage with harder to reach groups and those who have problems accessing services. Local Healthwatch provide a good source of existing patient and public insight into how

services are being used at a local level. Healthwatch England compiles insight from across the network and can be a useful broader source of intelligence on how people are experiencing services.

Working with communities

Commissioners should consider how they can help to build stronger communities and have a positive impact on people’s lives in everything they do. This includes developing partnerships and having a continuous dialogue with local people, promoting their ownership of their own health and wellbeing and their capacity to manage this themselves. [Social value approaches](#) can help commissioners to understand and maximise the wider social benefits of their work. Community building and development approaches can improve health and wellbeing, reduce health inequalities and improve the responsiveness of NHS and care organisations to the needs of the communities they serve. [A review of the evidence in relation to community development and health is available online](#).

There may be existing community development workers in the local authority, VCSE sector and/or CCGs may want to commission their own. [The Health Empowerment Leverage Project has developed a handbook to help organisations commission community development](#).

NHS England has developed a [bite-size guide to engaging with communities](#).



When should public involvement take place?

Staff should decide on the best timing for public involvement, bearing in mind the need for fairness, as set out in the 'Gunning' principles in page 25. The public does not necessarily need to be involved at the earliest possible stage, especially if there is insufficient information for them to consider. It will sometimes be appropriate to first develop a proposal, a shortlist of options or a preferred option. However, involvement should never be left to a time when the views obtained could not make a meaningful difference to the approach being taken.

Involvement should not typically be a standalone exercise such as a formal consultation. It will generally be part of an ongoing dialogue or take place in stages. A phased approach can often maximise involvement. It is good practice to develop a communications and engagement plan (in appendix C) to set out objectives and methods, and to provide regular communications to stakeholders throughout the commissioning activity. Publishing the timeline for engagement is an effective way of demonstrating that patient and public views have been adequately factored into a commissioning process.

The public may be involved in different ways, for example in:

- designing the approach to engagement
- developing options
- refining options
- formal consultation on a limited range of options
- being informed about the outcome of the consultation and the decision taken.

Staff should continually assess the effectiveness of public involvement throughout the commissioning process. The following are examples of potential issues that may warrant further consideration:

- Where feedback suggests that the needs of a particular group (possibly with a shared protected characteristic) have not been adequately considered as part of the proposal.
- Where there is an unexpectedly small response from a group that staff anticipated would be significantly affected by the proposal.
- Where a lot of feedback queries the same point, suggesting that it has not been clearly conveyed or there was insufficient information.
- If the response to a consultation or attendance at public events has been poor.

If such issues arise, staff should try to understand why this is the case and how the issues could be addressed. This could include attempting different engagement methods or approaching partners for advice on how to reach certain groups.



Good
practice
example:

'Meeting the Challenge' – Clinical Commissioning Strategy for the Mid Yorkshire Health and Social Care Transformation Partnership

This project involved the centralisation of specialist services for A&E, paediatrics, midwifery and complex surgery onto a single large acute hospital site. Inevitably the proposals were seen as controversial as people in some areas felt they were 'losing' services at their local hospital and campaigned against the proposed changes. A strategy of diverse and imaginative engagement and communications was used to reach out to all stakeholders.

- Development of an identifiable brand for all activity – 'Meeting the Challenge'.
- Development of key messages and approach developed with patient/public feedback. Consistently presented information based on:
 - What happens now?
 - What are we proposing?
 - Why would this be better?
- Set up a patient and public advisory group.
- Senior clinicians fronted public meetings.
- As well as a full/formal consultation document a tabloid style summary document was distributed, containing a feedback questionnaire to over 241,000 homes.
- Dedicated and interactive website – kept up to date with all documents, meeting records, presentations and evidence material.
- Easy read, other language and large print documents were produced.
- Eight large public meetings (300+ attendees) – all independently/professionally chaired. All meetings were recorded, transcribed and on the website within 48 hours.
- A series of 'talking heads' films was created with clinicians explaining the proposals.
- 40 mobile roadshows – including two with drop in sessions with senior clinicians/Trust Chief Executive.
- Attended meetings with community and local interest groups, reaching out to those groups with 'protected characteristics' under the Equalities Act 2010.
- Did a live phone in on mosque radio.
- Tweeted several times every day throughout the consultation – as well as monitoring social media activity.
- Briefed journalists, gaining balanced coverage wherever possible, supported by some advertising.



Good
practice
example:

'Meeting the Challenge' – Clinical Commissioning Strategy for the Mid Yorkshire Health and Social Care Transformation Partnership

- Engaged with patients/visitors in hospital wards and departments.
- Held nine focus groups – including two in schools.
- Webchats and online polling.
- Telephone survey of over 1,000 participants.
- Close involvement with the Joint Health Scrutiny Committee including nine detailed evidence gathering sessions and site visits.
- Engagement with local MPs and other elected representatives including local authority health and wellbeing boards.
- Meetings with ward councillors including some from neighbouring districts.

Wherever opportunities arose, such as overview and scrutiny committee evidence sessions, patient representatives and independent experts also took part. Serious challenges to the clinical case were referred to the National Clinical Advisory Team for an independent expert view. All information obtained – regardless of whether it was positive, negative or neutral – was posted onto the supporting website. This included responses to individual questions and comments received from groups and individuals throughout the consultation.

The website was a key tool, used as a repository for evidence/information and as a means to engage in the consultation and/or find out about the proposals and the wider local health system. This included an interactive travel tool to help visualise how changes would affect a journey to access health and care services.

A key characteristic was the flexible approach taken. The plan was regularly reviewed and updated and new activity rolled out in response to need/gaps identified.

The decision making process was planned as extensively as the consultation, with meetings including key stakeholders, culminating in a deliberative event to agree and take forward recommendations on the proposals to both of the CCG boards.



Good
practice
example:

'Meeting the Challenge' – Clinical Commissioning Strategy for the Mid Yorkshire Health and Social Care Transformation Partnership

Project outcomes

The engagement and consultation activity had a profound impact on the proposals. In response to concerns expressed in one part of the area covered, significant enhancements to hospital and community based services were agreed between the CCG and the acute trust. They included agreement to develop specialist assessment for children with complex needs, increasing the availability of specialist consultants in a range of services and enhancements to post-operative, emergency day care and assessment services. Measures were also agreed to provide various forms of assistance to patients facing difficulties with transport and travel.

A series of recommendations was also approved by the commissioners to develop and deliver strong ongoing communications and engagement activity to engage people in implementation of the proposals over the next five years. It will also be used to help people understand the changes proposed, see how they affect them, and how best to use the services available within the wider transformation programme of integrated health and social care services.

Positive engagement led to some people who began the consultation in a position of entrenched opposition changing their views, with some agreeing to remain engaged in the coming months and years to influence the implementation process.



What if a decision needs to be taken urgently?

In an urgent situation, it may be necessary to consider the duty to involve the public alongside the public interest in maintaining continuity of care and protecting the health, safety or welfare of patients or staff.

It will only be reasonable to justify carrying out a limited (or no) public involvement exercise on grounds of urgency when the lack of time was genuinely caused by an urgent development or where there is a genuine risk to the health, safety or welfare of patients or staff. It does not permit CCGs and NHS England to leave public involvement until the last moment without enough time to carry out a fair and proportionate exercise, when the public could and should have been involved earlier or to a greater extent.

Example:

NHS England has the contractual right to terminate a general dental services contract on patient safety grounds. Unless a new provider is immediately available and able to use the premises, it is inevitable that patients will have to go to another location for consultations and treatment, at least for a temporary period. NHS England's public involvement duty would be engaged in this scenario, but carrying out a detailed public involvement exercise before closing the practice could place patients at risk. It would therefore be sufficient for NHS England to notify all patients by letter of the situation in this case, even though a more detailed level of public involvement would usually be required for the closure of a dental practice.



“Carers can bring an alternative voice and evidence to the table and offer a different perspective, but often they are not mentioned or included in discussions. If you listen to carers it’s possible to gather lots of information about patients/service users that will help with their recovery and make their treatment quicker and more effective.”

Carer/NHS England patient and public voice partner

Managing the outputs of public involvement

CCGs and NHS England should be prepared to manage the outputs of public involvement activity, including documenting and processing feedback.

This can be time consuming and complex, and this should be factored into planning and budgeting. It is good practice to keep records of who was involved,

when, how (what was the scope of the exercise; were specific questions asked?), what they said and how their views were considered. There may well be differences between the views of different groups, for example, young people may want one thing and their parents/carers something very different. Staff need to be able to analyse these differences of opinion and to identify the most appropriate course of action, considering factors such as the representativeness of views expressed.

NHS England has produced a [bite-size guide to involving carers](#).

Good practice example:

Improving carers’ health and wellbeing in Ealing

The Carers’ Centre was commissioned to run a carer friendly GP project across Ealing. This involved carers in the community, young carers, Carers’ Centre staff, carers’ forum members, local authority partners delivering services for carers, and GP practice staff.

This led to an improvement in:

- identification of carers by practice staff
- highlighting services available to carers (statutory services and in the VCSE sector)
- carers being offered appointments alongside those they care for
- increased referral to the Carers’ Centre for information, advice and support
- practices having noticeboards with key information for carers and having a carers’ champion
- practice staff attending training sessions to learn more about the needs of carers and the issues they face
- practice staff understanding how to refer residents to undergo a carers’ assessment and carers having an emergency card which outlines what should happen when a carer is admitted in an emergency.

[NHS England has produced bite-size guides](#) to planning participation; running focus groups; online participation and event planning and delivery.



6. Feed back and evaluate

Feeding back on the results of participation is a critical step in the process. It can help people to feel valued and encourage them to be involved. Feedback should show how views have been considered and how they have impacted (or not) on commissioning decisions. If public participation has indicated support for a proposal which is not taken, the reasons should be explained. It is recognised that commissioning decisions are highly complex, and the views of patients and the public are one of a number of factors for CCGs and NHS England to take into consideration. Feedback to patients and the public should generally be themed, and individuals' identifiable information should not be released. Feedback should be shared with other partners where appropriate, to maximise joint intelligence and avoid the risk of people being asked the same/similar questions more than once.

Feedback should be given in an appropriate way, taking into account the needs and wishes of the population group.

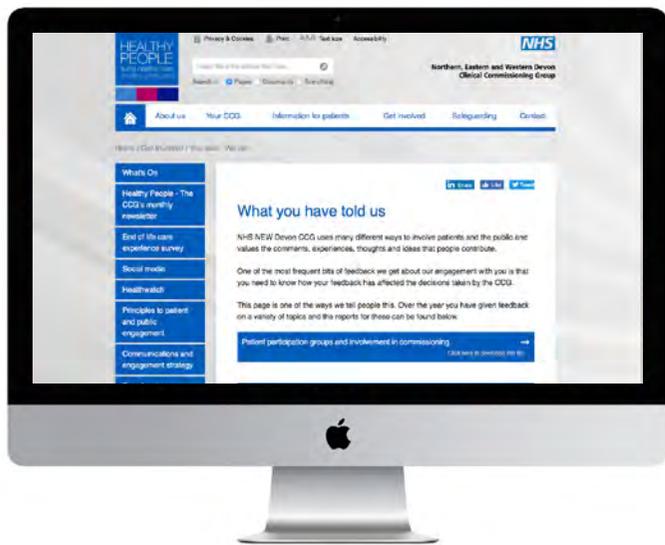
Possible ways of feeding back include:

- Letters/emails with direct feedback on particular questions/issues.
- Inviting all those who have been involved in developing a service specification and procurement, to meet the new service provider and hear about their plans.
- Producing a regular 'You said, we did' feature, which may be online or in newsletter form.
- Attending a meeting of the group that provided their views to tell them how those views were considered.
- Through social media, for example Twitter, Facebook.
- Publishing a formal consultation report.

Evaluation of the whole process of patient and public involvement is necessary in order to learn the lessons for the future and continuously improve performance. Evaluation should cover every aspect, from planning to delivery and feedback.



Good practice examples of CCGs showing their responses to patient and public feedback



[New Devon CCG](#)



[Wolverhampton CCG](#)

Sharing and learning

The learning points (positive and negative) from evaluation of public involvement exercises should be documented for future reference and shared with others as appropriate.

Anonymised feedback from patients and the public should be shared with partners who would find it helpful, and to minimise the chances of similar questions being asked of the same group again.

Developing a healthy weight service, Southwark CCG

“One of the key learning points was that it was really important to have a clinical lead with expert knowledge of the subject, who led the workshops and a lot of the outreach sessions. One user became very emotional during a session and the GP, who was the clinical lead, spoke to them privately and provided clinical advice and support. They followed up a few days later and encouraged the person to go and see their own GP.”

Head of Membership, Engagement and Equalities, Southwark CCG



7. Implement assurance and improvement systems

CCGs and NHS England must have systems to assure themselves that they are meeting their legal duty to involve the public, in order to fulfil the requirement to report on this in their annual reports. In addition, in year evaluation and assurance of activity and impact is necessary for continuous improvement.

CCGs

The [CCG Improvement and Assessment Framework](#) includes a series of key lines of enquiry (KLOE) for patient and public participation, as follows:

- The CCG has governance processes which embed participation throughout the organisation and across the commissioning cycle. It can evidence how decisions taken by the governing body (and any relevant subcommittees) are informed by engagement with – and the views of – patients and the public.
- The CCG has built, and continues to build, robust relationships with its local communities. It supports strong partnerships with VCSE organisations, local Healthwatch, and patient groups.
- The CCG can demonstrate how it has identified and engaged with ‘seldom heard’ groups and the full diversity of the local population.

- Prior to starting engagement activity, the CCG considers and uses existing sources of insight about patient and public views and experiences.
- The CCG holds its providers to account for how they involve patients in their own governance, decision making and quality improvement activities.
- The CCG ‘closes the loop’ whenever it seeks the views of patients and the public by feeding back the results of consultation and engagement activities and explaining how views have been considered and had an impact on decisions.

It is expected that CCGs are able to demonstrate, including through the annual reporting process (see page 15), how they have met the requirements set out in this guidance.



NHS England

Alongside its statutory duty to carry out an annual assessment of each CCG, NHS England aims to support CCGs to be the best they can be by providing a range of tools, resources and training opportunities, as well as offering bespoke support according to local need.

[NHS England's patient and public participation policy](#) sets out its internal reporting and assurance arrangements.

Reconfiguration: planning, assuring and delivering service change for patients

NHS England has a role in supporting its staff, those working in CCGs and their local partners to develop clear, evidence based proposals for service reconfiguration, and to undertake assurance of these.

There are four tests that proposals are assessed against, one of which is ensuring the effective involvement of patients and the public throughout the development, planning and decision making of proposals for service reconfiguration.

Information about the [planning and assurance processes for delivering service change](#) can be found on the NHS England website.

Local authority overview and scrutiny

Local authority overview and scrutiny committees have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area.

CCGs and NHS England must consult the local authority when considering any proposal for a substantial development or variation of the health service in the area. The local authority may scrutinise such proposals and make reports and recommendations to the NHS commissioning body (CCG or NHS England) or referrals to the Secretary of State for Health.

As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from local Healthwatch. The overview and scrutiny process can therefore enhance public involvement in the commissioning process.

The threshold for reporting proposals to the local authority under the overview and scrutiny process is higher than that for the duty to involve the public under sections 14Z2 and 13Q of the NHS Act 2006 (as amended). Frequently, both duties may apply, particularly where significant changes to the configuration of local health services are under consideration.

For further information, see part four of the [Local Authority \(Public Health, Health and Wellbeing Boards and Health Scrutiny\) Regulations 2013](#).



8. Advance equality and reduce health inequalities

CCGs and NHS England should be able to demonstrate how they have tried to ensure:

- Participation activity reaches diverse communities and groups with distinct health needs and those who experience difficulties accessing health services, including inclusion health groups.
- People who have characteristics that are protected under the Equality Act 2010 are involved.
- People who lack capacity are protected and empowered and that the provisions of the Mental Capacity Act 2005 are met.

Carrying out an equality and health inequality analysis can help identify people who experience the greatest health needs, those who face barriers to accessing services and to participation, and those groups of people with protected characteristics under the Equality Act 2010 who may be affected by a particular plan, proposal or decision (see legal duties in appendix A). NHS England has produced guidance for staff on equality and health inequality legal duties.

To reach into and develop relationships with diverse communities, especially with 'seldom heard' groups, staff should plan involvement proactively, identifying resources and sources of support. They should connect with existing patient, service user and VCSE organisations (see page 28).

Activities should be planned and adapted to ensure that they are fair and equitable regardless of a person's cultural, linguistic, religious background, communication and accessibility needs.

Auditing and monitoring participation of equalities protected groups, for example in events and formal governance roles, supports staff to promote the involvement of people who are more reflective of the population in question.

"Involving marginalised groups is a way to identify problem areas and potential impact. Be sure to manage people's expectations and be realistic about what they can change. People won't come back and get involved again if you haven't delivered what they expected. When you're working with people who are marginalised it can be even more damaging if you get it wrong, leading to a lack of trust, people feeling unvalued and indifferent."

NHS England patient and public voice partner



CCGs and NHS England are required to comply with the public sector equality duty of the Equality Act 2010. Without effective engagement with local stakeholders, including patients, carers, local community groups and other members of the public, CCGs and NHS England will not be able to respond to the duty in a meaningful way. They should use the [Equality Delivery System](#) for the NHS (EDS2), a framework to help deliver better outcomes for patients and communities and working environments which are personalised, fair and diverse. Both NHS England and CCGs can access the [NHS England Equality and Health Inequalities Hub](#) for more information and resources.

NHS England has produced [Patient and public participation equality and health inequalities - full analysis and associated resources](#), which relates to this guidance. NHS England has published [bite-size guides to diverse and inclusive participation](#) and [improving deafblind patient and carer public voice](#) in the NHS.

Good practice example:

Engaging 'seldom heard' groups in Brighton and Hove

In Brighton and Hove there is a very diverse population, and the need to ensure its voice is heard to make local services accessible and responsive. The CCG was able to identify dedicated funds for three years to commission 10 community and voluntary sector groups to reach and engage with:

- black, Asian and minority ethnic (BAME) groups
- carers

- older people who are housebound, living in senior housing or residential accommodation
- adults with a learning disability
- Gypsies and Travellers
- young men (aged 16-25)
- parent carers
- lesbian, gay, bisexual and transgender people
- disabled people, including deaf people
- people living with mental health conditions.

To engage with local Gypsies and Travellers, the CCG worked with Friends, Families and Travellers (FFT). This organisation keeps the health needs of the community on the local health agenda and provides community insight for the CCG. FFT involves the community in a range of ways, such as assertive outreach, drop in sessions, social media, focus groups and workshops. The work that has been carried out has produced excellent results and highlighted important information about the barriers to health services for the community. [FFT has produced a short film](#) that shows how it engages members of the Traveller communities across Brighton.

Other examples of the impact of the CCG's work in engaging 'seldom heard' groups include:

- health checks for carers provided at the carers' centre
- a leaflet on testicular cancer awareness produced by and for young men
- an information leaflet on good nutrition and ageing, produced in partnership by Age UK and Brighton and Hove Food Partnership.



9. Provide support to enable effective involvement

CCGs and NHS England staff must be provided with appropriate information, training and support to effectively and confidently engage patients and the public in their commissioning activities. This may include training on chairing/facilitating meetings that involve patients and the public. In addition, all staff should be encouraged and supported to get involved and share their personal experiences and their own views as users of NHS services and members of communities.

Information should be provided to all staff (including through induction processes) to raise awareness of the benefits of involving patients and the public in the NHS. Involving patients and the public in the delivery of staff training can help staff to better understand the benefits of involvement.

Induction information, training, further development and support should be provided as appropriate to patients and the public who are involved in the work of CCGs and NHS England. The NHS England [Involvement Hub](#) provides information and resources, including details of training opportunities relevant to patients and the public and NHS staff. Information about training for NHS England staff is available on the intranet.

Other ways that CCGs and NHS England should support participation include ensuring that information is accessible and timely, and that they implement a transparent expenses policy. To facilitate participation, NHS England has a [patient and public voice partners expenses policy](#) and an [accessible communications policy](#).



10. Hold providers to account on patient and public involvement

CCGs and NHS England must use the [Standard Contract](#) for all provider service contracts, other than for primary care which is covered by separate contracting arrangements. This includes service condition 12, which outlines contractual requirements in relation to communicating with and involving service users, the public and staff.

NHS trusts and NHS foundation trusts have their own legal duty to involve the public (section 242 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012).



Local variations in commissioning arrangements

Under the Five Year Forward View, the traditional divisions between primary care, community services and hospitals are being broken down and the roles of CCGs and NHS England and providers are being integrated to better meet the needs of patients. There is not a 'one size fits all' approach, and the plans to achieve this, including sustainability and transformation partnerships and emerging accountable care systems, are place based and built around the needs of local populations.

Existing flexibilities under the National Health Service Act 2006

There are flexibilities within the National Health Service Act 2006 to enable one NHS body's functions to be exercised by or jointly with another NHS body or bodies. In particular, the Act enables:

- NHS England to arrange for its functions to be exercised by or jointly with CCGs (section 13Z).
- A CCG to arrange its functions to be exercised by or jointly with another CCG (section 14Z3).

For example, under NHS England's primary care co-commissioning programme, in many areas NHS England has arranged for CCGs to commission primary medical services on its behalf or established joint committees with CCGs to commission such services jointly.

More information about co-commissioning can be found on the [NHS England website](#).

New options under the Cities and Local Government Devolution Act 2016

The Cities and Local Government Devolution Act 2016 enables the transfer of powers and funds from central government to local government and strengthens integration of public service functions in local areas. In particular, the Act enables:

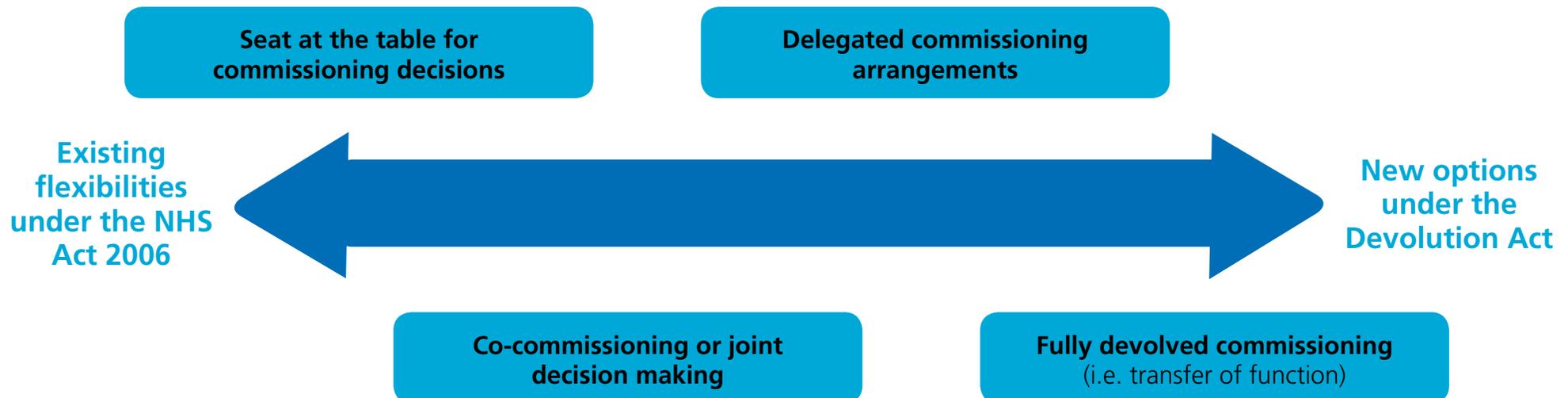
- A complete transfer of functions from one organisation to another.
- A transfer so both organisations perform the functions jointly.
- A transfer so both organisations perform the functions at the same time but independently.
- A transfer so both organisations perform the functions jointly but the original organisation also retains the ability to perform the function independently.



The Act therefore expands the range of possibilities for CCGs to work together with other public bodies, whether NHS bodies or not, which extend beyond the existing flexibilities under the National Health Service Act 2006.

Overarching models

In light of the developments in the legislative framework for commissioning health services, and the degree of flexibility in the arrangements that can be made, there are now four overarching models which sit on a spectrum of devolution. [More information about devolution can be found on the NHS England website.](#)





Overarching Model

NHS England definition

1

**'Seat at the table'
for commissioning
decisions**

- No legal change or material organisational impact across the parties involved.
- Decisions about a function are taken by the function holder but with input from another body.

- Accountability and responsibility for function remains with original function holder (including budgetary responsibility for funding for overspends).

2

**Co-commissioning for
joint decision making**

- Two or more bodies with separate functions that come together to make decisions together on each other's functions (e.g. S.75 partnership arrangements).

- Accountability and responsibility for function remains with original function holder (including budgetary responsibility for funding for overspends).

3

**Delegated
commissioning
arrangements**

- Exercise of the function is delegated to another body (or bodies).
- Decision making and budget rest with the delegate(s).

- Ultimate accountability and responsibility for function remains with original function holder (including budgetary responsibility for funding for overspends).

4

**Fully devolved
commissioning (i.e.
transfer of functions)**

- Function is taken away and given to another legal body on a permanent basis (meaning responsibility, liability, decision making, budgets and everything else to do with that function) by a transfer instrument under the Devolution Act.

- Accountability and responsibility for those functions transfers to the new 'owner' (including budgetary responsibility and funding for overspends) who will be accountable to the relevant national body for the function in question.



Guiding principles for joint public involvement exercises

- Regardless of the nature or extent of integration and devolution in a local area, where plans, proposals or decisions involve more than one organisation, it will almost always be desirable to establish joint arrangements for public involvement.
- Joint arrangements for public involvement facilitate a joined up, one stop shop for the public to be involved.
- Failure to make joint arrangements, where it is appropriate to do so, can lead to organisations not meeting their statutory duties or the public being asked about the same plans, proposals or decisions more than once or by different organisations.
- Multiple public involvement exercises can place an unnecessary burden on public bodies and the public and lead to confusion, mixed messages or inconsistent proposals.
- Joint arrangements for public involvement must comply with all the legal requirements and good practice set out elsewhere in this guidance. CCGs and NHS England should act effectively, efficiently and economically and cooperate with other NHS bodies and local authorities.

Where formal arrangements are being or have been made for functions to be exercised by another body, exercised jointly or transferred

- Day to day responsibility for public involvement generally sits with the organisation that has responsibility for commissioning. Separating decisions about commissioning from public involvement may risk the two not being properly joined up.
- As a principle of good governance, day to day responsibility for making arrangements to involve the public should be formally documented. For example, in the terms of reference for a joint committee, the relevant delegation agreement or transfer order under the Cities and Local Government Devolution Act 2016. CCGs and NHS England should not be in any doubt as to who has day to day responsibility for the public involvement arrangements that are necessary to meet their legal duties.
- With the sole exception of the fully devolved commissioning model, under current legislation, the commissioning organisation (CCG or NHS England) is liable for the exercise of its functions, including the duty to involve the public, even if in practice the activity is delegated to, or carried out jointly with, another body. CCGs and NHS England should seek assurance that the arrangements for public involvement are adequate.



Example

As an illustration of how public involvement works under different local arrangements, the typical arrangements under the primary care co-commissioning programme are set out below.

Form of primary care co-commissioning	Equivalent overarching model on devolution spectrum	NHS England involvement duty engaged (section 13Q)	CCG involvement duty engaged (section 14Z2)	Arrangements for commissioning and public involvement
1. Greater involvement in primary care decision making	1. 'Seat at the table' for commissioning decisions	Y	N	NHS England and CCGs work together on an informal basis. NHS England retains accountability and day to day responsibility for commissioning services and making arrangements to involve the public. NHS England's involvement duty applies and NHS England staff must complete a patient and public participation assessment and planning form available on the intranet. The CCG's involvement duty does not apply.
2. Joint commissioning arrangements	2. Joint decision making	Y	Y	NHS England and CCGs establish a joint committee to make decisions about services. Both NHS England and the CCGs, acting through the joint committee, have day to day responsibility for commissioning services and making arrangements to involve the public. Both NHS England's and the CCGs' involvement duties apply. NHS England staff must complete a patient and public participation assessment and planning form available on the intranet.



Form of primary care co-commissioning	Equivalent overarching model on devolution spectrum	NHS England involvement duty engaged (section 13Q)	CCG involvement duty engaged (section 14Z2)	Arrangements for commissioning and public involvement
3. Delegated commissioning arrangements	3. Delegated commissioning arrangements	Y	Y	NHS England arranges for the primary care commissioning committee, established by the CCG, to exercise its commissioning function on its behalf. The CCG, through the primary care commissioning committee, has day to day responsibility for commissioning services and making arrangements to involve the public. Both NHS England's and the CCG's involvement duties apply. However, NHS England relies on the CCG to make the necessary arrangements to involve the public. There is no need for NHS England staff to complete a patient and public participation assessment and planning form, or request such a form from the CCG. CCGs should document their assessment and plan as appropriate. They could use the example form in appendix B.

Note: the above is based on the template delegation agreement and terms of reference published on the [NHS England website](#). Local arrangements may vary.



Appendix A: Legal duties

Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012 - public involvement and consultation by CCGs

- (1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ('commissioning arrangements').
- (2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):
 - (a) in the planning of the commissioning arrangements by the group
 - (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them and
 - (c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.
- (3) The clinical commissioning group must include in its constitution:
 - (a) a description of the arrangements made by it under subsection (2) and
 - (b) a statement of the principles which it will follow in implementing those arrangements.
- (4) The [NHS Commissioning] Board [NHS England] may publish guidance for clinical commissioning groups on the discharge of their functions under this section.
- (5) A clinical commissioning group must have regard to any guidance published by the Board [NHS England] under subsection (4).
- (6) The reference in subsection (2)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.
- (7) This section does not require a clinical commissioning group to make arrangements in relation to matters to which a trust special administrator's report or draft report under section 65F or 65I relates before the Secretary of State is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be).



Section 13Q of the Act – Public involvement and consultation by NHS England

- (1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by the Board [NHS England] in the exercise of its functions ('commissioning arrangements').
- (2) The Board [NHS England] must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) :
 - (a) in the planning of the commissioning arrangements by the Board [NHS England]
 - (b) in the development and consideration of proposals by the Board [NHS England] for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and
- (c) in decisions of the Board [NHS England] affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.
- (3) The reference in subsection (2)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.
- (4) This section does not require the Board [NHS England] to make arrangements in relation to matters to which a trust special administrator's report or draft report under section 65F or 65I relates before the Secretary of State is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be).



The Equality Act 2010

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the ground of 'protected characteristics', these are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex and sexual orientation.

As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires CCGs to have 'due regard' to the need to:

- eliminate discrimination that is unlawful under the Equality Act 2010
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

This is known as the 'public sector equality duty' (section 149 of the Equality Act 2010).

NHS England and CCGs are also under a separate statutory duty to have regard to the need to reduce health inequalities between patients in access to health services and the outcomes achieved (sections 13G and 14T of the NHS Act, as amended by the Health and Social Care Act 2012, respectively).



Appendix B:

Patient and public participation assessment and planning form

This is an illustrative example that CCGs may wish to use or adapt.

Introduction

NHS commissioners have a legal duty to 'make arrangements' to involve the public in commissioning.

- Additionally, they have a duty to promote equality under the Equality Act 2010 and seek to reduce health inequalities under the NHS Act 2006.
- This form is a tool to help staff identify whether there is a need for patient and public participation in their commissioning activity and if required help them plan for a level of participation which is 'fair and proportionate' to the circumstances.
- The form must be completed at the start of the planning process for any commissioning activity and before operational commissioning decisions are taken which may impact on the range of commissioned services and/or the way in which they are provided.
- Patient and public participation forms will be monitored to ensure that patients and the public are appropriately involved in commissioning.
- Completed forms may be used as evidence in the event of a legal challenge.



Section 1

Title of the plan/proposal/project/commissioning activity and a brief description (including key objectives where appropriate).

Possible examples - procurement of a new service, proposals for service change, national policy development or an operational commissioning decision which affects services, e.g. closure of a GP practice.

Location: e.g. town, CCG, area

Title and brief description of proposed activity:

Key objectives of the proposed activity:

EXAMPLE





Section 2

Is there likely to be an impact on patients and the public?

To assess impact you should consider the overall population and groups/individuals within that population who are likely to be affected. This can be done by completing the equality and health inequalities analysis screening tool and then, if necessary, a full equality and health inequalities analysis.

If the plans, proposals or decisions are implemented, do you think there will be:

(a) An impact on how services are delivered?

Yes No

Please explain your answer and provide further details:

EXAMPLE

[Text input area for answer to (a)]

(b) An impact on the range of health services available?

Yes No

Please explain your answer and provide further details:

[Text input area for answer to (b)]

(c) Any other impact that you can envisage at this point in time? Please describe.

If you have answered yes to (a), (b) or (c), it is highly likely that the legal duty applies. Note: the duty always applies to planning of commissioning arrangements (regardless of impact).

Does the legal duty apply to the activity? Yes No

Please explain briefly why you have answered yes or no to the above:

[Text input area for explanation]

Please note that if you have determined that the legal duty does not apply to this particular activity you are still required to retain a copy of the form as a record of your decision making. You must also consider, even if the legal duty does not apply, whether participation would be beneficial in the circumstances and complete section 3, 4 and 5 of this form.





Section 3

Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight.

Examples could include patient and public views by patient and public voice (PPV) partners; surveys; intelligence on patient and public views from partners including CCGs; Healthwatch and voluntary and community organisations.

Please briefly complete each question below:

- (a) What arrangements/mechanisms are already in place to involve the public which are relevant to this activity (these may be national/regional or local)?

Light blue rectangular box for answer (a).

- (b) How will the insight available to you help to inform your decision?

Light blue rectangular box for answer (b).

Please note that consideration of existing arrangements and patient and public insight will help inform any additional arrangements required under section 4.

EXAMPLIFIED





Section 4

Are additional arrangements for patient and public involvement required for this activity? In particular how will you ensure that 'seldom heard' groups, those with 'protected characteristics' under the Equality Act, and those experiencing health inequalities are involved?

- a) If yes, provide a brief outline of your approach and objectives for any additional patient and public participation, including consideration of 'seldom heard' groups, the nine protected characteristics and health inequalities. In due course it may be appropriate to develop a full communications and engagement plan (see appendix C).

- b) Briefly describe how your proposed participation will be 'fair and proportionate' in relation to your commissioning activity.

EXAMPLE





Section 5

Planning for impact and feedback

- (a) Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity.

Light blue rectangular box for response (a).

- (b) How will the outcomes of participation be reported back to those involved (refer to your communications and engagement plan, if appropriate)?

Light blue rectangular box for response (b).

- (c) How will you assess the ongoing impact of the change on patients and the public after it has been completed?

Light blue rectangular box for response (c).

Name of person completing the form:

Job Title:

Email address:

Team:

Date:

Where senior sign off arrangements apply.

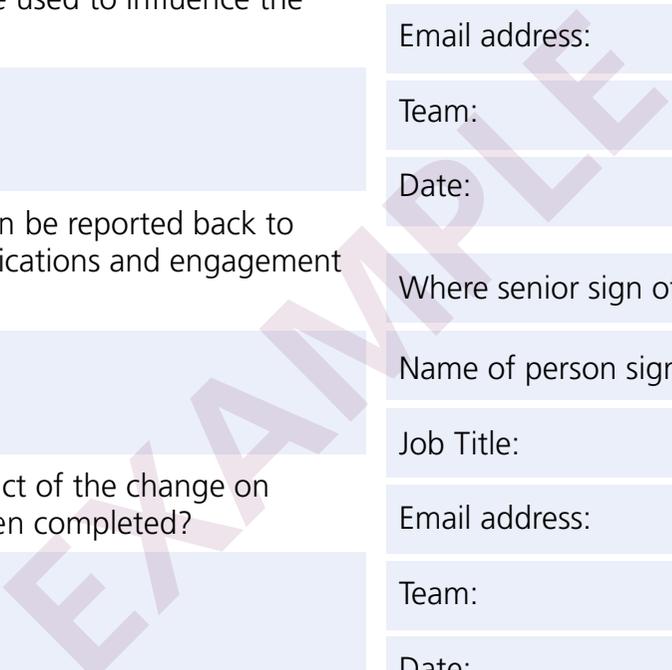
Name of person signing off the form:

Job Title:

Email address:

Team:

Date:





Appendix C:

Communications and engagement plan

Date produced

Project lead

Background

Proposal/project information

Provide details about the proposals being made. What impact will it have and what reaction do you expect?

Key messages

Remember the need to manage expectations. What can people influence/not influence?

Target audiences

For example: patients, carers, the media, MPs, etc.

Objective of communications

What are the measures of success?

Budget

Methods of engagement/communications

What activity are you planning to carry out? Is it fair and proportionate?



Timescales

Include milestones and deadlines.

Risks and mitigating actions

Risks

Actions

Equality and accessibility

Are there any specific considerations for groups with protected characteristics or those who are 'seldom heard'?

Evaluation

Report back on the success/impact of the communications plan.

Partner organisations

For example: Healthwatch, local authorities, patient groups.

Feed back to those involved

Close the loop and describe how you plan to feed back to people who have been involved.

Key contacts

For example: project leads, patient representatives who are involved, budget holders.

EXAMPLE



References and notes

- ¹ NHS England has the power to publish guidance for CCGs on the discharge of their functions under section 14Z2 of the National Health Service Act 2006. CCGs must have regard to any such guidance published by NHS England. See section 14Z2(4)-(5).
- ² Having 'regard' means that the guidance should be considered and taken account of. Where the guidance is not followed, this should be justified and the reasons clearly documented.
- ³ By 'direct commissioning', we mean the commissioning of health services by NHS England, as opposed to the commissioning of health services by CCGs.
- ⁴ [NHS England guidance on CCG governing body members: Role outlines, attributes and skills.](#)
- ⁵ [Managing conflicts of interest: Revised Statutory Guidance for CCGs, NHS England, June 2016.](#)
- ⁶ See sections 14Z(3)(a) and 13T(2)(a) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) respectively.
- ⁷ See sections 14Z15(2)(a) and 13U(2)(c) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) respectively.



Publications gateway reference: 06663

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact the Public Participation Team on 0113 825 0861.