PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

Public Involvement Handbook
Legislation, Regulations and Duties
NHS AND LOCAL GOVERNMENT

November 2019

PATIENTS' FORUM'S ADVICE FOR THE LONDON AMBULANCE SERVICE

STATUTORY DUTIES

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With special thanks to:

- Solicitors: Mills and Reeve
- Solicitors: Swarb & Co
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- Healthwatch England

CONTENTS

This publication is designed to provide a comprehensive understanding of the statutory duties of NHS providers and Commissioners, in relation to the provision of health care.

It deals with the duties to involve, engage and consult the public in the development of services, and clarifies the rights of the public to be involved at every level when significant changes are planned for services. In particular, the document makes it clear that it is unlawful for NHS bodies to disregard the public's views when NHS services and systems are being redesigned.

Patients must always be in the centre of NHS planning, organisation and services provision, wherever and whenever changes are planned for our services.

Public Involvement in the NHS: Legislation, Regulations and Duties

"We must put every citizen and patient voice absolutely at the heart of every decision we take in purchasing, commissioning and providing services".

National Director of Patients and Information at NHS England

"Users must be involved not only in the consideration of proposals to change services, but also in the development of any proposal that will change the manner in which a health service is provided, or the range of services offered... Consultations should begin when proposals are still at a formative stage. Remember. NHS Act requires health bodies to involve the public in "the development and consideration of proposals". **Real Involvement (DH 2008)**

1. NHS CONSTITUTION (2013) PLEDGES AND PROMISES

3a. Patients and the public – your rights and NHS pledges to you:

"You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services. The NHS also commits: to provide you with the information and support your need to influence and scrutinise the planning and delivery of NHS services (pledge)"

(DH 2015)

2. DUTY TO INVOLVE SERVICE USERS - THE NHS ACT 2006 SECTION 242

NHS statutory duties - S242 applies to all NHS Trusts and Foundation Trusts:

"Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services are, whether directly or through representatives, involved (whether by being consulted or provided with information, or in other ways) in – (a) the planning of the provision of those services (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation of those services. The duty applies if implementation of the proposal, or a decision (if made), would have impact on – (a) the manner in which the services are delivered to users of those services, or (b) the range of health services available to those users" **(DH 2006).**

3. GUIDANCE ON s242 NHS ACT (2006) – DEPARTMENT OF HEALTH AND NHSE

Definition: "A person is a 'user' of any health services if the person is someone to whom those services are being or may be provided."

A. Excellent advice on public involvement is contained in the DH statutory guidance on public involvement in the NHS - **Real Involvement: Working with People to Improve Health Services (DH 2008)**

B. Service providers and CCGs have a statutory duty to take account of **Transforming Participation in Health and Care** (**NHSE 2013**) as the most recent guidance but it does not replace Real Involvement.

4. WHAT LEVEL OF INVOLVEMENT AND ENGAGEMENT IS REQUIRED?

A. The Duty placed on all NHS organisations is to secure service user involvement (whether by being consulted, provided with information or in other ways).

B. The level of involvement depends on the nature and impact of the change being proposed.

5. CASE LAW ON THE DUTY TO INVOLVE, ENGAGE & CONSULT

Cases that define what is required when consulting the public:

R (on application of Gunning) v Brent London Borough Council: [1985] **84 LGR 168**

- Consultation must be at a time when proposals are still at a formative stage
- Sufficient reasons must be put forward by the proposer to allow for intelligent consideration and response
- Adequate time must be given for consideration and response
- The product of consultation must be conscientiously taken into account in finalising any statutory proposals

R (on the application of Save our Surgery Ltd) v Joint Committee of Primary Care Trusts: [2013] – **EWHC 439 (Admin). Case No: CO/10505/2012**

Relating to specialist centres for paediatric cardiac surgery

R (on the application of Copson) v Dorset Healthcare University NHS Foundation Trust: [2013] – **EWHC 732 (Admin).**

Relating to Mental Health Urgent Care Services reconfiguration

R (on the application of Lewisham LBC and Save Lewisham Hospital Campaign Limited) v Secretary of State for Health (and others): [2013] – EWHC 2329 (Admin) - Case No: CO/2744/2012

Relating to the Trust Special Administrator appointed to South London Hospital.

R (on the application of Coughlan) v North and East Devon Health Authority: [1999] - EWCA 1871(Civ)

The need for nursing care for a chronically sick person might be primarily a health or a social services need, and either a health authority or a social service authority might be responsible for the care provision.

6. PROPOSALS for SIGNIFICANT CHANGES TO NHS SERVICES – DUTY TO CONSULT

A. **Consultation Principles and Guidance – (Cabinet Office 2012)**

B. **Common law duty to consult:**

R (on the application of LH) v Shropshire Council [2014] EWCA Civ 404

"In the absence of any express or implied statutory duty to consult, the obligation to consult stems from the expectation that a public body making decisions affecting the public will act fairly. If therefore the public body withdraws a benefit previously afforded to the public, it will usually be under an obligation to consult with the beneficiaries of that service before withdrawing it"… "It is not sufficient to consult about the closure of (as yet) unidentified day care centres without then consulting on specific closures".

C. **What does consultation require of all NHS bodies?**

- It is not sufficient to consult simply about principles for service reconfiguration - there must be consultation on options.
- Transparency.
- Having an open mind.
- **Willingness to genuinely take views of patient and the public into account**

7. THE SECRETARY OF STATE'S 4 TESTS FOR SERVICE RECONFIGURATION

A. The 4 tests for reconfiguration proposals were originally set out in David Nicholson's letter to the NHS (DH 2010 and was included in the 2010/11 Operating Framework. It is now set out in NHSE statutory guidance.

B. The Four Tests require demonstration of:

- **Support from GP Commissioners**
- **Strengthened public and patient engagement**
- **Clarity on the clinical evidence base**
- **Consistency with current and prospective patient choice**

8. HEALTHWATCH - PROVIDERS AND COMMISSIONERS MUST ENGAGE

Local Healthwatch was established in 2013. They are bodies with statutory powers to 'enter and view' all health and social care services, monitor the standard of care, involve and listen to the public voice and make recommendations for service development to enhance the quality and safety of health and social care.

Their statutory duties are as follows:

A. Promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of local care services.

B. Enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved.

C. Obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known to providers and Commissioners.

D. Carrying out Enter and View inspections of health and social care services.

E. Making reports and recommendations about how local care services could or ought to be improved. These should be directed to Commissioners and providers of care services, and those responsible for managing or scrutinising local care services and shared with Healthwatch England.

F. Providing advice and information about access to local care services so choices can be made about local care services.

G. Formulating views on the standard of provision and whether and how the local care services could and ought to be improved; and sharing these views with Healthwatch England.

H. Making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to Healthwatch England to publish reports about particular issues.

I. Providing Healthwatch England with the intelligence and insight it needs to enable it to raise issues nationally and directly with Government.

s221(2) Local Government and Public Involvement in Health Act 2007 (DH 2007)

9. WHAT MAKES A WELL RUN CONSULTATION?

A. Ensure decisions regarding service changes are well informed, well made and are based on the needs of those who use services.

B. Reduce the risk of or need for a legal challenge by service users who feel their services are being run down.

C. Work collaboratively - aim to prevent divisions between patients/service users/community and NHS bodies that are proposing significant service changes.

D. Communicate well about proposed service changes, thereby reducing the potential harm of negative publicity for the NHS.

E. Ensure well-advertised and interactive public meetings, invite all service users and their families/carers who might be affected by the proposals.

F. Publicise the proposed service changes through poster campaigns in the community, NHS buildings, GP surgeries, ambulances and extensive use of the media including local radio, Twitter, Whatsapp and Facebook.

G. Active involvement of Healthwatch, Patients' Forums and other key voluntary sector organisations.

H. Make sure all feedback is valued equally and that there is evidence that feedback has been considered and influenced decision making.

"There is no set form for a consultation. It is for the NHS body undertaking the consultation to decide which form it will adopt. What matters is that clear information is given to the public; that they are able to respond; and that their responses are taken into account when making the final decision" -

REAL INVOLVEMENT (DH 2008)

10. ENSURING EFFECTIVE PUBLIC INVOLVEMENT - NHS ENGLANDS's ADVICE – THE MANDATE

A. Take a strategic sense check: explore the case for change and level of Consensus for change; ensure the full range of options are considered and the associated risks identified.

B. Assurance check: Commissioners should obtain formal assurance from their Board and other key players for their proposals before initiating wider public consultation.

C. There must be no decision to proceed with a particular option until the proposals have been fully consulted on.

D. Evidence must be provided regarding compliance with the Four Tests.

E. In exceptional circumstances, NHSE may consider the use of a formal process to support Commissioners or use intervention powers where the quality and/or safety of patient care is at potential risk.
HM Government (2014)

11. COMMISSIONERS' STATUTORY PUBLIC INVOLVEMENT DUTIES (Health & Social Act 2012, Section 26)

CLINICAL COMMISSIONING GROUPS – CCGs have a statutory duty to involve, engage with and consult patients and the public before making decisions on changes to health services:

14Z2, section 26 of the Health and Social Care Act 2012 states:

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a CCG in the exercise of its functions ("commissioning arrangements").
(2) The CCG **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 CCG.

(b) In the development and consideration of proposals by the CCG 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

Subsection 3 requires all CCGs to include in their constitution –

(a) Description of their public engagement arrangements and

(b) A statement of the principles that they will follow when implementing them.

DH (2012)

12. CCGs' OTHER STATUTORY DUTIES

Health and Social Care Act 2012, Section 26)

- Promote the **NHS Constitution** – 14P.
- Secure continuous improvements in **safety and quality** of NHS services – 14R.
- **Reduce inequalities** in access to services and outcomes of care – 14T.
- **Promote involvement of patients** in their diagnosis, prevention of illness, care and treatment – 14U.
- **Promote patient choice** in the provision of services – 14V.
- Promote integration with health and social care services to improve the quality of NHS services, reduce inequalities in access to and outcomes of service – 14Z1.

See Appendix One for more details of CCG statutory duties contained in Section 26 of the Act. DH (2012)

13. SPECIALIST AND PRIMARY CARE COMMISSIONING

BUT:

In the case where services are commissioned directly by NHS England, the duty to involve the public in planning the commissioning arrangement, and in any changes to commissioning arrangement, where such changes would affect the delivery of services, is laid out in paragraph 13Q "Public involvement and consultation by the Board" of the 2012 Health and Social Care Act (section 23). **DH (2012)**

<u>These services include:</u>

A. **Primary care,** including GP, dental, ophthalmic and pharmaceutical.

B. **Specialised services**, usually commissioned on a national basis for rare conditions, provided in few hospitals and/or accessed by small numbers of patients. These include secure mental health services.

C. Other specified services include:
   - Secondary care dental services;
   - Mental health aftercare in certain circumstances;
   - Health and justice healthcare services (Prison and Immigration Removal Centres);
   - Services for members of the armed forces and their families;
   - Some public health services commissioned on behalf of the Secretary of State for Health.

<u>See also</u>: Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning – NHS England. NHSE (2015-1)

14. NHS MUST CONSULT WITH LOCAL AUTHORITIES ON MAJOR SERVICE CHANGES

A. **The Local Authority (Public Health, Health and Wellbeing Boards and Scrutiny Regulations) 2013** arose out of Section 244 of the NHS Act 2006.

B. **Local Authority Regulations (Regulation 23) under NHS Act 2006:** Consultation by "responsible persons" means an NHS body: NHS Trusts, Foundation Trusts, CCG or NHS England**.**

C. THE DUTY TO CONSULT A LOCAL AUTHORITY

23.—(1) Where a responsible person has under consideration any proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service, the responsible person must …

(a) Consult the local authority;
(b) When consulting, provide the local authority with—
(i) the proposed date by which the responsible person intends to make a decision as to whether to proceed with the proposal; and
(ii) the date by which the responsible person requires the local authority to provide any comments;

The local authority's response to the health body's proposals may be through their Health Overview and Scrutiny Committee but, they are no longer required to have a Health OSC.

D. CCG OR NHS ENGLAND MAY ACT ON BEHALF OF PROVIDERS

The CCG or NHS England will in many cases act on behalf of the provider if the service change is one for which the Commissioners are responsible for arranging the provision. In cases where the proposals for service change cover an area of more than one health body, they may operate jointly in relation to their consultation with the local authority.

E. REQUIREMENT TO RESOLVE ISSUE LOCALLY IF POSSIBLE

If a local authority makes a recommendation to a health body which they do not accept, they must negotiate to find a resolution to the disagreement – this negotiation may include both the Commissioner/s and Provider. The local authority can require members or employees of the health body to attend a meeting of the local authority to answer their questions.

F. REFERRAL TO THE SECRETARY OF STATE FOR HEALTH

23. – (9)-(13) If agreement is not reached between the local authority and health body within a reasonable time, a referral may be made by the LA to the Secretary of State for Health. Referral to the SoS may be because the consultation has not been adequate or the responses from the health body/ies is inadequate or where the 'local authority considers that the proposal would be detrimental to the health services in its area'. The report must be evidence based and explain why the referral is being made, including

evidence of the "effect or potential effect of the proposal on health services in the area of the local authority.

For further information see: Local Authority Health Scrutiny Guidance to support Local Authorities and their partners to deliver effective health scrutiny.
DH (2014)

G. INDEPENDENT RECONFIGURATION PANEL - IRP

The SoS may refer the matter of dispute to the IRP for advice. The local authority or any other connected body may also seek advice from the IRP.
IRP 2018

15. PUBLIC SECTOR EQUALITY DUTY (PSED) & PUBLIC INVOLVEMENT

When a public body is proposing changes that will affect people with protected characteristics, it must have regard to the PSED (s149 (1) of the Equality Act 2010).

Their needs must be met before or at the time any policy is being considered. Courts refer to it as being an "essential preliminary" and not a "rearguard action". NHS providers and Commissioners, and local authorities, must ensure that they:

A. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by the Equalities Act.

B. Advance equality of opportunity between persons who share protected characteristics and those who do not share these characteristics, e.g. race, age, disability, or sexual orientation.

C. Remove or minimise any disadvantage suffered by persons with protected characteristics.

D. Take steps to meet the needs of those with protected characteristics.

E. Undertake **equality impact analyses** in order to demonstrate compliance with the PSED, and evidence that people with protected characteristics have influenced the work of the NHS body or local authority.

Guidance for NHS Commissioners on equality and health inequalities legal duties. NHS England (2015-2)

Protected Characteristics:

Age; Disability; Gender Reassignment; Pregnancy and Maternity; Race; Religion or Belief; Sex; Sexual Orientation.

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17. APPENDIX ONE – SPECIFIC DUTIES FROM HEALTH AND SOCIAL CARE ACT

Health and Social Care Act 2012 Section 26 **DH (2012)**

14P. Duty to promote NHS Constitution

(1) Each Clinical Commissioning Group must, in the exercise of its functions—

(a) Act with a view to securing that health services are provided in a way which promotes the NHS Constitution, and (b) promote awareness of the NHS Constitution among patients, staff and members of the public.

14R Duty as to improvement in quality of services

Each CCG must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness. The outcomes include those which show—

(a) The effectiveness of the services.

(b) The safety of the services, and

(c) The quality of the experience undergone by patients.

14T Duties as to reducing inequalities

Each CCG must, in the exercise of its functions, have regard to the need to—

(a) Reduce inequalities between patients with respect to their ability to access health services, and

(b) Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

14U Duty to promote involvement of each patient

(1) Each CCG must, in the exercise of its functions, promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to—

(a) The prevention or diagnosis of illness in the patients, or

(b) Their care or treatment.

14V Duty as to patient choice

Each CCG must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

14Z1 Duty as to promoting integration

(1) Each clinical commissioning group must exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would—

(a) Improve the quality of those services (including the outcomes that are achieved from their provision).

(b) Reduce inequalities between persons with respect to their ability to access those services, or

(c) Reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

14Z2 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 CCG in the exercise of its functions ("commissioning arrangements").

(2). The CCG 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

(d) 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.

18. APPENDIX TWO

Ten rules for an effective, lawful consultation process

1. Consult when your proposals are at a formative stage

It is unlawful to make a decision on a change to services, and then consult on that decision. If an NHS body is strongly of the view that only one of a number of alternatives is realistic, then it must say so and explain why. The public must be given the opportunity to disagree.

2. Language

The consultation document must not give the appearance to the public that a decision has already been taken and the consultation a sham.

3. NHS bodies must set out exactly what they are proposing; what the options are; and why these changes are needed

The public body must give out information that contains sufficient reasons for particular proposals, to allow those consulted to give the proposals intelligent consideration and an intelligent response. If the public do not know what they are being consulted about or why a change needs to be made, they cannot properly take part in the consultation process.

4. NHS bodies must be up front about the reasons for their proposed change

If the driver for change is financial the NHS body must say so and set out the financial position that It is faced with. Hiding behind other reasons to change a service may result in the NHS body's consultation being struck down as unlawful.

5. How long should the consultation last for?

The public must have adequate time to respond. The *Cabinet Office Principles* state "timeframes should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response".

6. Responses must be taken into account before a final decision is made.

NHS bodies are not bound by the views of the public, but courts expect that the public's views will be fully considered by the decision makers and will take those views

into account when reaching their decision. NHS bodies must ensure a paper-trail demonstrating that this was done. If a public body takes a decision that goes against the general views of the public, it needs to have good reasons for it and to make sure those reasons are recorded.

7. There is no set form for a consultation

How to conduct the consultation is a decision for the NHS body. The courts have approved consultations that involve responses on paper or electronically, public meetings and citizens' juries. What matters is whether the consultation is fairly conducted and complies with the Public Sector Equality Duty.

8. NHS bodies may consult on a single option

If an NHS body identifies only one serious option to put to the public, it is lawful to consult on implementing that single option. However, the public body may need to justify why only one option was realistic. NHS bodies must allow members of the public to suggest alternative options and, if they do so, those options must be given genuine consideration.

9. NHS bodies can reach a final decision that was not an option put forward in the consultation

There must be good reasons for such a change of approach – usually it will be based on information discovered as part of the consultation. Secondly, if the final decision departs very substantially from the initial options, it may be necessary to undertake a second consultation. NHS bodies do not have to give consultees the opportunity to see and to comment on the responses of other consultees. However, if a response has opened up a new issue that the NHS body is taking into account, it should consider giving other consultees the opportunity to comment on that issue.

10. Making promises to the public

If the NHS body makes clear that unequivocal promises have been made to individual service users or groups as part of the consultation process, the NHS body will have created a "legitimate expectation" that those promises will be kept.

If the NHS body wants to go back on them, it will need to redo the consultation exercise. Failure to do this may result in the whole process being struck down by the courts.

Mills and Reeve (2015)

19. MISSION STATEMENT OF THE PATIENTS' FORUM

The Charity aims to influence the development of emergency and urgent health care and improvements to patient transport services, by speaking up for patients and by promoting and encouraging excellence. We will:

(1) Optimise working arrangements with the London Ambulance Service and other providers and commissioners of urgent and emergency care.

(2) Work with other service user networks that champion the needs of patients.

(3) Further develop campaigns for better and more effective emergency and urgent care services, and more effective and consistent approaches to service provision that reduce deaths and disability.

(4) Work towards better systems for all patients and carers to communicate their clinical conditions effectively to LAS clinical staff and receive effective and timely responses.

(5) Promote the development of compulsory patient focussed quality standards for Patient Transport Services.

(6) Work with partners to develop better solutions for the care, transport and disposition of people with severe mental health problems and their carers, that respect their wishes and meet their needs. The Forum promotes sensitivity to their vulnerability, safety, culture and the gravity of their situation.

(7) Campaign to convince the Commissioners for the LAS and the LAS Board to develop better assessment, clinical effectiveness and care for people who suffer from cognitive impairment and dementia.

(8) Work with the LAS to develop effective systems and protocols, to ensure that the wishes of patients with Advance Directives and Care Plans are respected, and that their care is provided completely in accordance with their prior decisions and wishes.

(9) Work with the LAS equality, diversity and inclusion leads to promote effective training of all LAS front-line staff in the provision of care for London's diverse communities, in relation to all protected categories identified by the Equality Act 2010.

(10) Work with the LAS Equality and Inclusion Committee to develop a workforce that reflects the diversity of communities across London, and provides care based on culturally and ethnically based needs, when this is appropriate – for example, in relation to sickle cell disorders and mental health care.

Patients' Forum for the London Ambulance Service (2019)