Patient and public participation in commissioning health and care: statutory guidance

Draft for comment

9 February 2017
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Patient and public participation in commissioning health and care: statutory guidance

Foreword – Short statements from a PPV partner and from STP leader - Why do we need this guidance?

1 Introduction

1.1 Who is this guidance for and what is its status?

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, section 14z2 for CCGs and section 13Q respectively.

This statutory guidance is for clinical commissioning groups (CCGs) and NHS England. CCGs and NHS England must be able to demonstrate that they have had ‘due regard’ to it.

The guidance may also be of relevance/interest to:

- Patients and the public
- Providers of health and care services
- Commissioning Support Units
- Local Authorities including Overview and Scrutiny Committees
- Health and Wellbeing Boards
- Local Healthwatch
- The voluntary and community sector.

1.2 What is commissioning and what is public involvement in commissioning?

Commissioning is the process of planning, buying and monitoring services. The process of commissioning is illustrated in Figure 1.

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1 Having ‘due regard’ means that CCGs must consider the guidance. Where the guidance is not followed, there should be a justification and the reasons should be clearly documented.
Public involvement in commissioning is about offering people ways to voice their needs and wishes, and to contribute to plans, proposals and decisions about services. Our use of the term ‘patients and the public’ includes service users, carers, and people of all ages, including children and young people.

Involvement of groups and communities is sometimes described as engagement, participation, and patient or public voice. Consultation is another term which is used, but this is actually a specific type of involvement activity, amongst many others. Our use of the term involvement covers the whole spectrum of different types of involvement activity, as illustrated in Figure 2.
The ladder is a widely recognised model for understanding different forms and degrees of patient and public involvement. Activity at every level is valuable, with participation becoming more meaningful towards the top. The collaboration level includes ‘co-production.’

1.3 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 and must therefore be subject to a degree of public scrutiny and control. 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.’

Commissioners can better understand population health needs, and respond to what matters most to people when they listen to those who need, use and care about NHS 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.

Patients and the public can often identify innovative, effective and efficient ways of designing, delivering and joining up services. In addition, by prioritising the needs of
those who experience the poorest health outcomes, commissioners will have more power to improve access to services, reduce health inequalities in our communities and make better use of resources.

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, all our activity should start from the stance of those who experience the greatest inequality or as part of wider public participation in health and care. We should take an asset based approach to working with and empowering communities.

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

1.4 The principles of participation

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

<table>
<thead>
<tr>
<th>Working with each other</th>
<th>Working well together</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Our relationships will be conducted with equality and respect.</td>
<td>1. We will understand what’s worked in the past, and consider how to apply it to the present and the future.</td>
</tr>
<tr>
<td>2. We will listen and truly hear what is being said, proactively seeking participation from communities who experience the greatest health inequalities and poorest health outcomes.</td>
<td>2. We will have a shared goal and take responsibility for our work.</td>
</tr>
<tr>
<td>3. We will use all the strengths and talents that people bring to the table.</td>
<td>3. We will take time to plan well.</td>
</tr>
<tr>
<td>4. We will respect and encourage different beliefs and opinions.</td>
<td>4. We will start involving people as early as possible.</td>
</tr>
<tr>
<td>5. We will recognise, record and reward people’s contributions.</td>
<td>5. We will give feedback on the results of involvement.</td>
</tr>
<tr>
<td>6. We will use plain language and will openly share information.</td>
<td>6. We will provide support, training and the right kind of leadership so that we can work, learn and improve together.</td>
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</tbody>
</table>
In addition, the People and Communities Board, in conjunction with the new models of care ‘vanguards’ sites, have 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.

The ‘six principles’ set out the basis of good person centred, community focused health and care, and require that:

1. Care and support is person-centred: personalised, coordinated, and empowering
2. Services are created in partnership with citizens and communities
3. Focus is on equality and narrowing inequalities
4. Carers are identified, supported and involved
5. Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
6. Volunteering and social action are recognised as key enablers

1.5 Scope of this guidance and links to other resources

This guidance is intended to help commissioners to involve patients and the public in their work in a meaningful, fair and proportionate way, to gain the benefits of participation outlined in section 1.3. It includes, but is not restricted to, how commissioners can meet their legal duties to involve the public. The guidance links to an extensive suite of web-based resources, including bite-size guides and best practice case studies.

Web based resources to support this guidance can be found on the NHS England Involvement Hub.
2 What must commissioners do in practice?

2.1 Constitution/policy

The CCG constitution must describe:

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

A good practice example from Bristol CCG: https://www.bristolccg.nhs.uk/media/medialibrary/2016/08/Bristol_CCG_Constitution_2016.pdf

CCG governing bodies must include at least:

- One lay person who has qualifications, expertise or experience such as to enable the person to express informed views about financial management and audit matters and chairs the audit committee.
- One lay person who has knowledge about the CCG's local area such as to enable the person to express informed views about the discharge of the CCG's functions.

In light of CCGs' increasing role in primary care commissioning and managing conflicts of interest, NHS England recommends at least three lay members.

NHS England has a patient and public participation policy (LINK TO NEW POLICY TO BE ADDED) which sets out its 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.

2.2 Commissioning/business plans

CCG commissioning plans/the NHS England business plan must explain how the public involvement duty is proposed to be discharged.

2.3 Annual reports

Annual reports produced by CCGs and NHS England must show how the public involvement duty has been discharged. NHS England has produced an annual reporting guide for CCGs and NHS England staff. It sets out the organisations’ responsibilities to report on how they meet their legal duties to involve patients and the public in their work. 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.
2.4 Promote and publicise arrangements for public involvement

Key arrangements for public involvement should be promoted and publicised in a variety of ways. Given that not everyone has access to the internet or the confidence to use it (particularly in older age groups), there should not be over-reliance on web-based information, but each CCG should publish at least the following information on its website:

- Involvement opportunities, including formal roles, consultations and public meetings
- How to make complaints and comments about NHS-commissioned services
- Summary of key local health needs and how these are being addressed
- Links to Local Healthwatch and other local organisations representing the views of patients and the public

For NHS England, the relevant information is set out on the NHS England website.

For further information on different communication channels, see section XX.

2.5 Assess, plan and take action to involve the public in commissioning

Commissioners must assess the 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. See sections 4 and 5 for guidance on how to do this.

2.6 Evaluate the effectiveness of any public involvement exercise and feed back to those involved – closing the loop

This is an important action which is unfortunately often overlooked, and can therefore have a detrimental impact on future relationships and public participation. Section 6 provides further information.

2.7 Evaluation and assurance

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 within their Annual Reports. In addition, in-year evaluation and assurance of activity and impact is necessary for continuous improvement. See section 7 for further information.

2.8 Focus on promoting equality and reducing health inequalities

Commissioners should be able to demonstrate, using the Equality Delivery System (EDS2) tool, how they have tried to ensure that:

- Participation activity reaches communities and groups with distinct health needs, those who experience difficulties accessing health services, who have health problems that are caused or affected by their socio-economic circumstances, or who otherwise experience poor health outcomes.
- 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.

See Section XX for further information.

### 2.9 Provide information, training and support to staff, and to patients and the public, to enable effective involvement

Commissioning staff in CCGs and NHS England 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 chairing of meetings involving patient and public voice partners or representatives to ensure that their voice is heard. In addition, all staff should be encouraged and supported to use within their work, as appropriate to their role, their personal experiences and their own views as users of NHS services and members of communities. As a minimum, information should be provided to all staff (including through induction processes) to raise awareness of the benefits of involving the public in the NHS.

Induction information and training and further development and support should be provided as appropriate to patients and the public who are involved on a voluntary basis in the work of CCGs and NHS England.

The NHS England Involvement Hub provides information, including details of training and development opportunities for staff, and for patients and the public. In addition, there are resources available on the organisation’s intranet.

### 2.10 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 general practice. This includes service condition 12 which outlines contractual requirements in relation to communicating with and involving service users, the public and staff (https://www.england.nhs.uk/nhs-standard-contract/17-18/).
3 Assessing the requirement for public involvement

Commissioners 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 which they commission. In some cases, the impact of commissioning activity on services and patients will be so significant and likely that the requirement to involve the public will be obvious. However, in other cases, there will be a need to assess more carefully whether the duty applies and, if so, what kind of public involvement is appropriate.

The following list indicates some of the circumstances in which the legal duty to involve the public is likely to apply and there is a need to assess this and determine the appropriate response. As it is not possible to anticipate every such situation, the list is not exhaustive.

3.1 Examples of possible triggers

Changes to commissioning arrangements
- The strategic planning of services, for example:
  - Plans to reconfigure or transform services to improve health.
  - Plans in response to the latest Joint Strategic Needs Assessment or Health and Wellbeing Strategy.
- Developing and considering proposals to change commissioning arrangements, for example: new service specifications, piloting new services or making changes to existing services or service reconfiguration.

- Commencing a major procurement process.

Overview and Scrutiny referral
- Any instance in which a referral has been made to the local Overview and Scrutiny Committee.

Equality
- Any instance in which an Equality Impact Assessment is proposed or carried out.

Triggers may be identified at a number of stages throughout a single commissioning process. On each occasion this should prompt a consideration of whether a public involvement exercise is required. However, a new public involvement exercise is not required at every step, so long as existing plans are sufficient to secure the necessary public involvement.

For example
- Beginning to develop and consider options for a new service would trigger the public involvement duty, as would developing the final specification, starting a procurement exercise and awarding a contract to the successful bidder. However, plans for involving the public throughout this process can be formulated at the outset. Those plans could be for CCGs to consult the public on a shortlist of options following development by CCGs with stakeholders and representatives. Provided that there is no significant change to proposals following consultation, CCGs can consider the outcome of the initial consultation when developing the final specification, carrying out the procurement and awarding the contract without developing additional involvement plans for those activities. For service change and reconfiguration it will
be decided during the assurance process whether public consultation is required. Public involvement should continue throughout the process regardless and the outcome of consultation activities should be referenced in proposals taken forward to decision making.

An assessment process is summarised below and in a flowchart at Appendix B. The assessment should be documented. The Public Involvement Assessment Form (Appendix C) is used for this purpose in NHS England and may also be adapted and used by CCGs.

**Step 1 - 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 duty does not apply, but you should consider the further guidance on what other matters may need to be considered at the end of this section.

**Step 2 - what type of activity is it?**

The scope of the duty is limited to certain types of commissioning activity. These are:

1. **Planning** – commissioners are required to always have arrangements in place to involve the public in the planning of its commissioning arrangements, regardless of what the impact upon services such plans would have if they were implemented. If the activity relates to planning, go directly to step 4.

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 which 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 below they often overlap and sometimes a plan, proposal or decision can fall into more than one category.
### Examples of commissioning activities

<table>
<thead>
<tr>
<th>Planning</th>
<th>Proposals for change</th>
<th>Operational decisions</th>
</tr>
</thead>
</table>
| • The development of a CCG wide 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. | • Development of options for the reconfiguration of Accident and Emergency services in a particular area and the subsequent consideration of any developed options or model.  
• Making changes to the services a provider is required to provide or the locations from which such services are to be provided.  
• The closure of a fracture clinic for operational reasons. | |

### Step 3 – in respect of proposals for change or operational decisions, would there be an impact on the manner or range of services?

If yes, go to step 4.

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 (see section 5). This is particularly important where there is likely to be significant public interest or when a promise to consult has been made or a precedent to do so has been set.

An impact on services can arise in two ways:
1. An impact on the manner in which the services are delivered to individuals at their point of delivery (e.g. the transfer of a service to another location); and/or
2. The range of health services available to individuals (e.g. the closure of a service).

The impact on services should be considered from the patient’s perspective 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.

### Examples of impacts on services

<table>
<thead>
<tr>
<th>Impact on services</th>
<th>No impact on services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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 how far individuals will have to travel to access another GP</td>
<td>• 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 public involvement is unlikely</td>
</tr>
</tbody>
</table>
practice as well as any specific care that may have been provided at the practice. In such circumstances it is likely that the public need to be involved in some way.

- 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 there may be no legal requirement to involve the public.

**Step 4** – 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 required, put in place additional arrangements before proceeding (see guidance in section 5).
4 Planning and taking action on public involvement

4.1 Review existing insight and previous involvement activities as a first step

As part of the need to act efficiently and proportionately, commissioners should consider whether there are existing sources of feedback and insight on the views and experiences of different groups of people, such as:

- Complaints
- Surveys
- Social media
- Healthwatch
- Care Quality Commission (CQC) reviews
- Academic research
- Intelligence from NHS bodies, the voluntary sector or local authorities.
- Staff feedback
- Previous public involvement exercises

Full details on source of insight and its use in commissioning are available on the NHS England website.

Commissioners should also consider if there has been a previous public involvement exercise that is relevant to the plans, proposals or decisions in question. As part of reviewing previous public involvement exercises, commissioners should consider:

- Is the new proposal the same as the one previously considered?
- Did the earlier exercise involve the public in considering the basic features of the proposal now being considered, or was it something significantly different?
- 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 fully address the diversity of patients and communities?
- Is there new information which the public need 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?

4.3 Who needs to be involved?

Commissioners should involve current patients, service users and those who may use services in future. It may be helpful to involve carers, members of self-help and support groups, Healthwatch, patient groups or charities, as part of an ‘asset-based’ approach. ABCD stands for Asset-Based Community Development and it refers to a type of community development based on the work of Professors Jody Kretzmann and John McKnight. It demonstrates that local assets (people, physical assets, etc.) and individual strengths are key to ensure sustainable community development, and that people have a life of their own choosing.
Case law has established that in some circumstances, public involvement can take place via representatives. For example, a policy or review group with appropriate expertise and representatives of those affected may be sufficient. Where involvement takes place via representatives, they should offer a fair representation of the views of the people they represent.

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.

**Example to be added**

Planning involvement proactively (including identifying resources and support, and working with partners, including people with lived experience) helps commissioners to reach those who experience the greatest health needs, those who face barriers to access and participation, and those groups protected under the Equality Act 2010. An equality and health inequality analysis can help to identify those groups. **NHS England has produced guidance for NHS commissioners on equality and health inequality legal duties.**

Activities should be planned and adapted to ensure fair and equitable access to public participation opportunities regardless of a person’s cultural, linguistic, religious background, communication and accessibility needs. A holistic approach should be taken which recognises people’s lived experience and the range of barriers they experience, rather than tick box approaches to addressing barriers. Engagement approaches should be based on principles of mutual respect and listening, understanding and acting on different experiences and perspectives.

Commissioners should connect with existing patient, service user and voluntary, community and social enterprise (VCSE) organisations to reach in to and develop relationships with diverse communities, and especially with ‘seldom heard’ groups.

Auditing and monitoring participation of equalities protected groups, for example in events and formal governance roles, supports commissioners to manage and improve performance in involving a more reflective range of people.

Commissioners 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, other members of the public, commissioners will not be able to respond to the Duty in a meaningful way. Commissioners should use **The Equality Delivery System** for the NHS (EDS2), a tool to help deliver better outcomes for patients and communities and better working environments, which are personalised, fair and diverse.

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2 list of groups protected under the Equalities Act
4.2 Decide how to involve the public

Where public involvement is required, commissioners will need to make a judgement on what is a ‘fair and proportionate’ approach to the circumstances.

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 principles relate to what constitutes a fair 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.

The *Gunning* principles require decision makers to:

1. **Consultation must take place when the proposal is still at a formative stage** – consultation cannot take place on a decision that has already been made. Decision makers can consult on a ‘preferred option’ (of which those being consulted should be informed) and even a ‘decision in principle’ as long as they are genuinely open to influence.

2. **Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response** – those being consulted 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.

3. **Adequate time must be given for consideration and response** – there is no automatically required time frame within which the consultation must take place unless statutory time requirements are prescribed. A rationale must be set out for any departure from that expected timeframe.

4. **The product of consultation must be conscientiously taken into account** – decision makers must properly consider the material produced by the consultation.

Additionally, the Cabinet Office published revised [Consultation Principles](#) in February 2016.

Proportionate

Commissioners need to consider their duty to involve the public alongside their duty to act effectively, efficiently and economically. Commissioners 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.
Commissioners 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.

Examples to be added.

Ways to involve

1. Examples of ways to involve patients and the public
   - Letters or emails to affected individuals
   - Newsletters
   - Information on notice boards
   - Suggestion boxes
   - Leaflet drops
   - Dedicated events to enable discussion
   - Online surveys or feedback pages
   - Seeking views at local events or venues e.g. festivals, markets, schools, leisure centres, libraries etc.
   - Working with local voluntary and community sector organisations, Local Healthwatch and the Patient Participation Group (PPG) at GP practices
   - Providing opportunities for the public to meet commissioners.
   - Formal consultation
   - Social media e.g. Twitter, Facebook
   - Public and patient advisory or reference groups
   - Patient and public representatives involved in governance

4.2.1 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. Commissioners 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 voluntary sector is through councils for voluntary services (CVS), which are sometimes called local development and support agencies. These organisations can help commissioners reach large numbers of VCSE organisations in their area. The CVS often supports a network of organisations working
in health and social care, which can be useful for commissioners and policy-makers to work with and is a good starting point in developing a suitable local approach to engagement.

Commissioners can also access a database of local support and development organisations, available from NAVCA, the national voice of local support and development organisations.

NHS England commissioners can also access support through the Voluntary Community and Social Enterprise (VCSE) Health and Wellbeing Alliance, run by NHS England, Department of Health and Public Health England.

Possible case studies – St George’s Crypt, Young Epilepsy, Friends and Families Together, Changing our Lives

4.2.2 Working with Healthwatch

Healthwatch was created to understand the needs, experiences and concerns of patients and the public and to speak out on their behalf. It has statutory powers to provide NHS England and CCGs with information and advice on the views of people who uses health and social care services, including how they feel about the quality and availability of services.

Local Healthwatch organisations operate across England and work with commissioners and providers in their area, including through Health and Wellbeing Boards.

Healthwatch is well placed to carry out engagement activity because of its links with patients and the public and local networks, including the VCSE sector and local authority health overview and scrutiny committees. These links enable Healthwatch to reach ‘seldom heard’ groups and those who have problems accessing services. It is a good source of existing patient and public insight into how services are being used at a local level. The Patient Experience Library contains many examples of Healthwatch reports produced across England.

Case study – Healthwatch Norfolk – veterans project

4.4 When should public involvement take place?

Commissioners should decide on the best timing for public involvement, bearing in mind the need for fairness, as set out in the Gunning principles in section 4.2. The public does not necessarily need to be involved at the earliest possible opportunity. If involvement takes place too early there may be insufficient information for the public to consider. It will sometimes be appropriate to first develop a proposal, shortlist of options, a preferred option or even a decision in principle. However, involvement should never be left to the last minute.

Involvement should not typically be a stand-alone exercise (e.g. a formal consultation open for 12 weeks). 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
document a communications and engagement plan (ADD TEMPLATE LINK) to set out objectives and methods, and to provide regular communications to stakeholders throughout the commissioning activity.

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

- In developing options
- In refining options
- In formal consultation on a limited range of options
- In being informed about the outcome of the consultation and the decision taken

**Example:**

A CCG is considering reducing the number of GP practices in a local area. A comprehensive review into primary care services in the area was undertaken a year ago and made a number of recommendations. The public were widely involved in this process. However, the population of the local area has changed significantly since this time and there are a number of significant 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 support them to better understand the needs and views of the current population. They also plan public involvement to support the implementation of the recommendations.

Commissioners 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 protected characteristic) have not been adequately considered as part of the proposal;
- Where there is an unexpectedly small response from a group that NHS England anticipated would be significantly affected by the proposal;
- Where a lot of feedback queries the same point, suggesting that it is has not been clearly conveyed or that consultees lacked sufficient information; or
- If the response to a consultation or attendance at public events has been very poor.

If such issues arise, commissioners 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 voluntary and community sector groups for advice on how to reach certain groups.

**4.4.1 What if a decision needs to be taken urgently?**

In an urgent situation, it may be necessary to balance the duty to involve the public with 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 commissioners 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 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.
5 Feeding back to those involved – closing the loop

The outcome of any consultation or engagement exercise should be fed back to participants. Feedback should include an explanation of how views have been considered and impacted on decisions, as well as the rationale for decisions taken. This important stage is often overlooked but is central to good participation and will encourage further participation.
6 Assurance

CCGs

NHS England aims to promote and support effective public participation across the NHS. 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.

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 their local communities. It supports strong partnerships with voluntary and community 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 commencing 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.

NHS England

NHS England’s patient and public participation policy sets out its internal assurance arrangements. (INSERT LINK TO NEW POLICY)

Reconfiguration: Planning, assuring and delivering service change for patients

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

There are four tests against which proposals are assessed, 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.

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.

- Commissioners 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 their duty to involve the public under section 14Z2 and 13Q. However, the duties frequently overlap, particularly where significant changes to the configuration of local health services are under consideration.

  For further information, see Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (INSERT LINK).
7 Co-commissioning and 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 individual commissioners 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 Plans (STPs), are place-based and built around the needs of local populations.

7.1 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, 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 commissioning can be found on the NHS England website.

7.2 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.

7.3 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:

1. ‘Seat at the table’ for commissioning decisions
2. Joint decision making
3. Delegated commissioning arrangements
4. Fully devolved commissioning (i.e. transfer of functions)

More information about devolution can be found on the NHS England website.
7.4 Guiding principles

Commissioners should take into account the following principles when making arrangements for public involvement:

- **Joint arrangements for public involvement are almost always desirable**
  - 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 are consistent with commissioners’ duties to act effectively, efficiently and economically and to co-operate 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:

- It is usually desirable for the day-to-day responsibility for public involvement to rest with the organisation which has responsibility for commissioning. Separating commissioning from public involvement may risk the two not being properly joined together.

- 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. Commissioners should not be in any doubt as to who has day-to-day responsibility for public involvement that are necessary to meet their duty.

- With the sole exception of the fully devolved commissioning model (#4), under current legislation, the commissioning organisation (CCGs 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.
**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.

<table>
<thead>
<tr>
<th>Form of primary care co-commissioning</th>
<th>Equivalent overarching model on devolution spectrum</th>
<th>NHS England involvement duty engaged (section 13Q)</th>
<th>CCG involvement duty engaged (section 14Z2)</th>
<th>Arrangements for commissioning and public involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Greater involvement in primary care decision making</td>
<td>1. ‘Seat at the table’ for commissioning decisions</td>
<td>✓</td>
<td>✗</td>
<td>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 is engaged. The CCG’s involvement duty is not engaged.</td>
</tr>
<tr>
<td>2. Joint commissioning arrangements</td>
<td>2. Joint decision making</td>
<td>✓</td>
<td>✓</td>
<td>NHS England and CCG 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 CCG’s involvement duties are engaged.</td>
</tr>
<tr>
<td>3. Delegated commissioning arrangements</td>
<td>3. Delegated commissioning arrangements</td>
<td>✓</td>
<td>✓</td>
<td>NHS England arranges the a 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 are engaged. However, NHS England relies up the CCG to make the necessary arrangements to involve the public.</td>
</tr>
</tbody>
</table>

Note: the above is based upon the template delegation agreement and terms of reference published on the NHS England website. Local arrangements may vary.
Appendix A - The legal duty to involve the public - What the law says

Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012 (hereafter referred to as ‘the Act’) - 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 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 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 in the exercise of its functions (“commissioning arrangements”).

(2) The Board 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,

(b) in the development and consideration of proposals by the Board 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 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 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).

Related legislation

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These are the ‘protected characteristics’.

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 respectively).
Appendix B: Public Involvement Assessment Process

Does the activity relate to NHS England’s commissioning responsibilities?

Yes

What type of activity is

Planning

Proposals for change

Operational decision

No

If implemented, would there be an impact upon services?
This could be:
The manner in which the services are delivered to individuals at their point of delivery; and/or
The range of health services available to individuals.

Yes

Arrangements for involving the public are required under section 14Z2.

Document assessment using Public Involvement Assessment and Planning Form.

Review existing arrangements for involving the public in this activity (if any) and, where required, put in place additional arrangements before proceeding.

No

Arrangements for involving the public are not required under section 14Z2.

Document assessment using Public Involvement Assessment and Planning Form.

Consider whether any previous promises or established practice give rise to a separate duty to consult.
Consider whether public involvement may nonetheless be beneficial.
**Appendix C: Public Involvement Assessment and Planning Form**

**Introduction**
NHS England has a duty under Section 13Q of the NHS Act 2006 (as amended) to ‘make arrangements’ to involve the public in commissioning.
- Additionally, NHS England has a legal duty to promote equality under the Equality Act (2010) and seek to reduce health inequalities under the Health and Social Care Act (2012).
- This form is a tool to help commissioners 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 public are involved where appropriate. Additionally, that where the statutory duty does apply, a fair and proportionate level of patient and public participation will be planned.
- Completed forms may be used as evidence in the event of a legal challenge. Please retain a copy within your local system and return an electronic copy to XX.

If you are unsure as to the answer to any of these questions, please contact:
Central Patent and Public Participation Team - england.engagement@nhs.net

<table>
<thead>
<tr>
<th>Step 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location: e.g. town, CCG, area</td>
</tr>
<tr>
<td>Title and Brief Description of Proposed Activity:</td>
</tr>
<tr>
<td>Key Objectives of the Proposed Activity:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the plans, proposals or decisions are implemented, do you think there will be:</td>
</tr>
<tr>
<td>(a) An impact on how services are delivered?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Please explain your answer and provide further details:</td>
</tr>
</tbody>
</table>
Choose an item.

(b) An impact on the range of health services available?  
☐ Yes  ☐ No  
Please explain your answer and provide further details:

(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 Section 13Q duty applies. Note: the duty always applies to planning of commissioning arrangements (regardless of impact).

Does the Section 13Q duty apply to the activity?  ☐ Yes  ☐ No  
Please explain briefly why you have answered yes or no to the above:

Please note that if you have determined that Section 13Q does not apply to this particular activity you are still required to retain a copy of the form locally and return to england.ppp-north@nhs.net as a record of your decision making.

<table>
<thead>
<tr>
<th>Step 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 other commissioners, Healthwatch and voluntary and community organisations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please briefly complete each question below:</td>
</tr>
<tr>
<td>(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):</td>
</tr>
<tr>
<td>(b) How will the insight available to you help to inform your decision?</td>
</tr>
<tr>
<td>Please note that consideration of existing arrangement and patient and public insight will help inform any additional arrangements required under step 4.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4 – Are additional arrangements for patient and public involvement required for this activity and 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? (In due course, it may be appropriate to develop a full communications and engagement plan).</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) If yes, provide a brief outline of your approach and objectives for any additional patient and public participation:</td>
</tr>
<tr>
<td>b) Have you considered the following:</td>
</tr>
<tr>
<td>Seldom-heard groups  ☐ Yes  ☐ No</td>
</tr>
<tr>
<td>Nine Protected Characteristics  ☐ Yes  ☐ No</td>
</tr>
</tbody>
</table>
### Step 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.

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

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

<table>
<thead>
<tr>
<th>Name of person completing the form:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Title:</td>
</tr>
<tr>
<td>E-mail address:</td>
</tr>
<tr>
<td>Team:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

Where senior sign off arrangements apply, name of person signing off the form:

<table>
<thead>
<tr>
<th>Job Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail address:</td>
</tr>
<tr>
<td>Team:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>
Additional public participation resources available on the Involvement Hub and NHS England website to support commissioners:

NHS England’s series of bite-size participation guides:
1. Principles for participation
2. Planning for participation
3. Governance for participation
4. Budgeting for participation
5. Improving deafblind patient and carer public voice in the NHS
6. Diverse and inclusive participation
7. Grants for the voluntary sector
8. Partner participation
9. Event planning and delivery
10. Running focus groups
11. Online participation
12. Engaging with communities
13. Mediation between patients
14. Involving carers

Other existing participation documents:
NHS England - Annual reporting on the legal duty to involve patients and the public in commissioning
NHS England Planning, assuring and delivering service change for patients
Combined commissioning and engagement cycle
Ladder of participation
NHS England – patient and public participation policy and five frameworks (each area of direct commissioning)
NHS England – expenses policy for PPV partners
Coalition for Collaborative Care – coproduction model
NHS England – accessible communications policy
NHS Youth Forum’s top tips for engaging young people

In development:
Decommissioning guide
‘Having difficult conversations with patients and the public (when aspirations and resources don’t match)’
Following the Accessible Information Standard in Public Participation Activities
The Compact with the Community & Voluntary sector
Designing Accessible Events

NAPP - ‘Working with PPGs – tips for CCGs'

NHS England Patient and Public Voice Partners Policy

15 steps challenges

**Useful news articles:**


Article from Health Service Journal.docx

**NHS England’s series of bite-size insight guides:**

1. [How and when to commission new insight and feedback](#)
2. [What’s already available](#)
3. [Patient Reported Outcome Measures (PROMs)](#)

**In development:**

Guide 4 – Helping people with a learning disability to give feedback

Guide 5 – Building greater insight through qualitative research

Guide 6 (Working title) – The benefits of using insight in commissioning

**Other insight resources:**

Friends and Family Test (FFT) Guidance (Updated March 2015) for NHS-funded services

FFT Guidance for GP practices

Advice about GP FFT for commissioners

FFT Guidance for dental services

FFT FAQs

FFT Guidance for maternity services

Guidance on the submission of FFT data

FFT patient data

Staff FFT data
Choose an item.

- Guidance on implementing the Staff FFT
- Guidance on the submission of Staff FFT data
- Staff FFT FAQs
- Resources for making the FFT inclusive
- FFT communications resources
- Staff FFT communications resources
- Eight films covering insight presentations and panel discussions at the Patient Insight & Feedback Conference
- FFT video case studies, featuring five national FFT Awards winners
- FFT written case studies