Foreword

By David Lammy, Parliamentary Under Secretary of State for Health

It is our commitment to make sure the NHS delivers patient-centred care. To achieve our aim we will involve and consult patients and the public in how health services are planned and developed. Patients' views, positive and negative, about their experiences of the National Health Service should be welcomed, taken seriously, and used to bring about change.

It is clear to me times have changed. Patients and the public rightly expect to be involved and consulted in all aspects of their lives – they are more likely to ask questions and are less in awe of experts. There are more people wanting to 'have a say' in decision-making and public authorities are more open to scrutiny and challenge.

Building a partnership between health providers, patients and the public is at the centre of modernising the National Health Service. Patient and public involvement is not an end in itself but a way of achieving three fundamental objectives:

- strengthened accountability to local communities;
- a health service that genuinely responds to patients and carers; and
- a sense of ownership and trust.

Patients and the public have views to offer about the way services are operated and how they could be changed. The National Health Service must listen to this and learn from their experiences.

Patients' experience of the National Health Service can only be improved if they are given opportunities to tell us what they would like from their National Health Service and for them to be involved, with staff, to achieve it.

Acknowledgements

We have produced this guidance with the close involvement of the Section 11 Reference Group. We would like to thank all members of the group and their organisations for their support, advice and hard work.

We also want to thank all the organisations and individuals who have commented on the draft policy and practice guidance, in particular all those who organised and went to the market-testing events. We also want to thank the large number of NHS organisations that provided examples of their patient and public involvement work. (Appendix 1)

Contents

About this policy and practice guidance

We have produced this policy and practice guidance in two parts.

Part 1 – The policy

This section outlines the statutory duties created by Section 11 of the Health and Social Care Act 2001. It says what NHS organisations must do to meet their responsibilities and the expected outcomes from putting the duty into practice. It is relevant to all staff who are responsible for **developing** patient and public involvement and it will help to improve the way this is carried out.

Throughout the document we have printed signposts to relevant sections of the

practice guidance

Part 2 – The **practice guidance**

This section is for all staff who are responsible for **involving** patients and public. It gives you:

- best practice baseline measures to use as a self-assessment tool;
- a wide range of helpful information, suggestions and approaches; and
- help to understand what is meant by ongoing patient and public involvement.

This section will also be relevant to overview and scrutiny committees (OSCs) and patients' forums (when set up) as they develop their roles of scrutiny and monitoring.

Executive summary

1 Section 11 of the Health and Social Care Act 2001 places a duty on strategic health authorities, primary care trusts and NHS trusts, to make arrangements to involve and consult patients and the public in:

a planning services they are responsible for;

b developing and considering proposals for changes in the way those services are provided; and

c decisions to be made that affect how those services operate.

2 This policy and practice guidance is for:

- NHS boards and chief executives;
- all staff responsible for leading patient and public involvement in their organisations;
- overview and scrutiny committees; and
- patients' forums (when set up).

3 The new duty will lead to ways of working in the NHS that will strengthen accountability to local communities, speed up change and create patient responsive services. It will encourage trusts to build on work they have already begun and support others to effectively involve patients and the public.

4 Carrying out the duty will help NHS organisations to meet the targets outlined in the 'Priorities and Planning Framework for 2003–2006'.

5 The policy and practice guidance sets out:

- what the duty means for NHS organisations;
- a new planning process;
- best practice baseline measures for PCTs and trusts to use as a self- assessment tool; and
- other statutory consultation requirements.

6 The overall aim of Section 11 is to make sure patients and the public are involved and consulted from the very beginning of any process to develop health services or change how they operate. This will lead to patient-centred care and improvements in the patients' experience.

The policy

Introduction

Most people will need to use health services at some time in their lives. When that happens they need to be confident that the service is focused entirely on their needs. In other words it is not, for example, focusing on the needs of the institution, its staff or the latest technology. This will require staff, clinicians and managers to create a culture of involvement, listening and feedback.

A wealth of excellent patient and public involvement work is already going on in the NHS. We want all organisations to feel confident about the effects Section 11 of the **Health and Social Care Act** will have. (Please see appendix 2.) The new duty to involve and consult patients and the public will make sure that patient and public involvement is a high priority for all organisations. They should build on the good practice that has been developed, strengthening this and making sure there are consistently high standards.

The NHS Plan, published in July 2000, aimed to make sure that patients and the public have a real say in how NHS services are planned and developed. Now, the **Health and Social Care Act 2001** places a *duty* on strategic health authorities, primary care trusts and NHS trusts, to make arrangements to involve and consult patients and the public.

NHS organisations are already required by law to consult on substantial variations and developments to services separately from the requirements of Section 11. (see page 10 for Community Health Council regulations and Overview and Scrutiny Committee regulations)

Section 11 places a wider duty to involve and consult patients and the public:

- not just when a major change is proposed, but in the ongoing planning of services;
- not just when considering a proposal but in developing that proposal; and
- in decisions that may affect the operation of services.

'Involving and consulting' has a particular meaning in the context of Section 11. It means discussing with patients and the public their ideas, your plans, their experiences, why services need to change, what they want from services, how to make the best use of resources and so on. It is more about changing attitudes within the NHS and the way the NHS works than laying down rules for procedures.

What is important is that involvement and consultation is adequate both in terms of time and content and appropriate to the scale of the issue being considered. Part of the involvement process may be to discuss with stakeholders the most appropriate arrangements for any further involvement. For example it may become clear that:

- more effort needs to be made to involve the harder-to-reach groups that may be affected by the proposed change or more information needs to be given; or
- a formal consultation process lasting for a set period of time is not necessary.

Practice guidance 9, 10

As a general rule, proposals to change services should be informed by the views and experiences of the people who use or may use them.

Patient and public involvement is central to developing any organisation. NHS organisations must recognise and value the benefit of listening and responding to patients and recognise that the patient's experience is the catalyst for doing things differently to improve the way services are delivered.

Real patient and public involvement is not about ticking boxes, it is about NHS organisations developing constructive relationships, building strong partnerships and communicating effectively. For patients' experience of health services to really improve, NHS staff will need to have ongoing and meaningful dialogue with them, their carers and the public about improving and developing services. Through this approach NHS organisations will:

- learn more about the patients' experience of the NHS;
- make sure services are designed and adapted to respond better to patients' needs;
- tap into the enthusiasm and energy of their patients, the public and local communities to make long-term improvements;
- develop and encourage closer relationships between staff and patients;
- improve the quality of the care they are providing;
- identify ways of meeting patients' needs more appropriately;
- be able to use information provided by patients and the public to help them make improvements; and
- make sure changes make sense to those that are affected by them.

The new duty is the continuation of a process that will strengthen accountability to patients and the public and make sure there is transparency and openness in decision-making procedures. We must develop and adapt health services around the needs of patients and the public which will build trust and confidence between local communities and the NHS.

Who is responsible for making sure involvement and consultation takes place

Section 11 places a duty on:

- strategic health authorities;
- primary care trusts; and
- NHS trusts

to make arrangements to involve and consult patients and the public on the following:

- planning to provide services for which they are responsible;
- developing and considering proposals for changes to the way those services are provided;
- making decisions which affect how those services operate.

The 'responsible' organisation is the organisation which either provides the service or arranges for another organisation, person or people to provide the service for it.

Where a strategic health service is not 'responsible' for health services in this way, it may direct (tell) any PCT in its area, or any NHS trust with a hospital or other facility in its area, which is 'responsible' (provides or arranges for services to be privided) as to what the PCT or trust should do to meet the involvement and consultation requirements of section 11.

What the new duty means for NHS organisations

The Priorities and Planning Framework for 2003–2006 (see note[1] below) sets out what NHS organisations need to do over the next three years. It identifies priorities and targets that organisations need to build into their local delivery plans. You should involve the public, staff, service users and partners in developing these plans.

The Local Delivery Plan is part of the Priorities and Planning Framework. It will identify the expected progress or 'milestones' for each priority area over the three-year period. It covers a whole strategic health authority area but is based on primary care trust (PCT) level plans. Each NHS board must show, in its plans, how it will continue to involve and communicate with all its main stakeholders – its patients, public, staff and partners.

Delivering improvements depends on the determination and involvement of front-line staff and involving patients and the public in shaping services.

Within the NHS planning will be from the bottom up.

- 'PCTs (and relevant care trusts), as lead planners, will be responsible for creating local plans which describe health and service improvements in their area. These will be developed using local clinicians' knowledge as well as patients and the public. They will address the needs of the community as a whole and incorporate the national priorities.' (organisational responsibility 5.4 The Priorities and Planning Framework for 2003–06)

Appendix B of the Priorities and Planning Framework lists the priority areas and delivery targets. One of these priority areas is improving the patient experience. The objective for this priority is that:

'The NHS will be transformed through better engagement with patients, the public and staff. By regularly seeking out and acting on local feedback, the NHS will create patient responsive services that people perceive are improving.'

One of the targets for achieving this is to:

- 'Strengthen accountability to local communities through improved engagement with them, as evidenced by annual Patient Forum reports to the Commission for Patient and Public Involvement in Health, and annual publication of the patient prospectus covering local health services.'

Fulfilling the requirements of Section 11 should help NHS organisations to meet this target. To demonstrate their commitment to the new duty the expectation is that primary care trusts (PCTs) and NHS trusts will do the following.

1 **Improvement, Expansion and Reform:** The next 3 years, The Priorities and Planning Framework for 2003–06.

1 Carry out a **baseline assessment** of current work and your arrangements to involve and consult patients and the public. The baseline assessment will inform how your Local Delivery Plan develops (see 8.2 Priorities and Planning Framework 03–06).

Practice guidance 1

2 Develop **a strategy** for involving patients and the public.

Practice guidance 2

3 Make sure there is a **planning process** for patient and public involvement that brings together the feedback from the Patient Advice and Liaison Service (PALS), patients' forums (when set up), overview and scrutiny committees, complaints and the annual patients' survey. The process should run alongside your existing planning and updating mechanisms, in particular for your Local Delivery Plan.

Practice guidance 3

We recommend that you:

- have arrangements in place locally to make sure that your Local Delivery Plan takes account of the baseline assessment;
- involve the patients' forum (when set up) and local OSC on priorities for involving and consulting patients and the public;

Practice guidance 3

- use the best practice baseline measures (Introduction to the practice guidance, pages xi-xv) as a self-assessment tool to help develop suitable processes for involving and consulting patients and the public; and
- include evidence in your **Annual Report** of how involving patients and the public has had an effect on developing services.

Strategic health authorities should make sure that there is reference to the local arrangements for involving and consulting patients and the public in the Local Delivery Plan and that this section is developed, refined and improved in years 2 and 3.

You should be aware that:

- the best practice baseline measures will be used by OSCs, patients' forums (when set up) and the Independent Reconfiguration Panel (IRP) in their roles, to assess the quality of the processes for involving patients and the public;
- CHI routinely assesses patient and public involvement as part of its clinical governance review process and will take account of your self-assessment as part of this; and
- you may have to produce evidence to support your processes.

Finally, strategic health authorities, trusts and PCTs should be aware that meeting these measures will impact on the trusts' and PCTs' ability to deliver improvements to health services and their patients' experience of care. Trusts' star ratings may in future years be calculated with reference to their ability to deliver these improvements.

Strengthening accountability

The NHS working through the voluntary sector

Community and voluntary groups play an important role in improving the health of local people. We recognise that the voluntary and community sector has an important role to play in helping the NHS achieve its aims. As independent, not-for-profit organisations, they play a crucial role and act as pathfinders for involving users in designing and improving services, often acting as advocates for those who otherwise would have no voice. They help to reduce the effects of poverty, improve the quality of life and involve socially-excluded groups, for example refugees and asylum seekers.

The Compact, launched in November 1998, provides a framework that sets out the principles that should form the background of the relationship between the voluntary and community sector and government.

The Compact:

- aims to create a new approach to working in partnership;
- builds effective relationships; and
- has undertakings on both sides and codes of good practice.

The aim is for **local compacts** to be negotiated at a local level between the voluntary and community sector, local authorities and other local public organisations, including the NHS.

It is important that NHS organisations are aware of and have signed up to their local compact. Through this they will identify a jointly agreed way of involving and consulting the voluntary and community sector.

Part of putting the compact into practice is to move beyond a broad framework and concentrate on getting it applied correctly nationally, regionally and locally. To help this, the Compact and local compacts are supported by five individual codes of good practice:

- community groups (including faith groups);
- black and minority ethnic voluntary and community groups;
- consultation and policy appraisal;
- volunteering;
- funding.

Practice guidance 4

Link www.homeoffice.gov.uk/acu/acu.htm

A new planning process

Pressure to change services may come from any number of starting points – both negative and positive. Some examples might be:

- outdated buildings and facilities;
- new standards (such as National Service Frameworks);
- evidence of what works;
- workforce pressures;
- advances in technology and technique;
- new thinking about how services are designed; and
- the needs of local people.

Any of these could trigger a wider debate.

Whatever the starting point, patients and the public perform a central role as partners with the NHS, working with them to find the right solution for local services in the future. The principles behind this should be:

- designing services with local populations, not for them;
- solutions developed for health communities rather than individual hospitals or organisations; and
- using service improvement techniques, including changing working patterns and redesigning services.

The route map (figure 1 page 9) outlines how the new planning process on the provision of health services will work. The NHS needs to understand and be connected with local people by asking what they want and need. Information about current services and the problems they face needs to be shared openly so people can get involved in a meaningful discussion. We should encourage modernisation – including redesigning services, new technology and techniques and changing workforce patterns – to make sure that options for the future are long-term and meet the needs and wishes of local people.

The main emphasis from the new duty is that open discussion with patients, the public, and with staff, needs to begin right at the beginning – before minds have been made up about how services could or should change. And this discussion needs to continue right through the process. All stakeholders need to feel that they have had the opportunity to influence the debate at important stages, and that they have been kept properly informed throughout.

At the start, it is about all the stakeholders understanding each other's positions and priorities, and setting a joint agenda for discussion. This is followed by all stakeholders working together to develop a vision for the whole local health system. This will help to open up other solutions to what may at first appear to be an issue in one local hospital.

In the next steps you can use approaches for redesigning services to move away from traditional thinking to offer new options that will help to secure long-term, locally accessible services in line with the jointly-agreed vision. By continuing discussion and debate with patients, the public and staff, it will allow everyone's thinking to evolve and develop as the practicalities and necessary trade-offs become clear.

A more formal consultation process in line with Cabinet Office guidelines, could take place on the most likely options or it may be more appropriate for this to be earlier in the process to test out thinking. Following the consultation period, the NHS organisation responsible for the process will have to make a decision on the best way forward. Even with the best possible consultation process, this will not always be an easy decision.

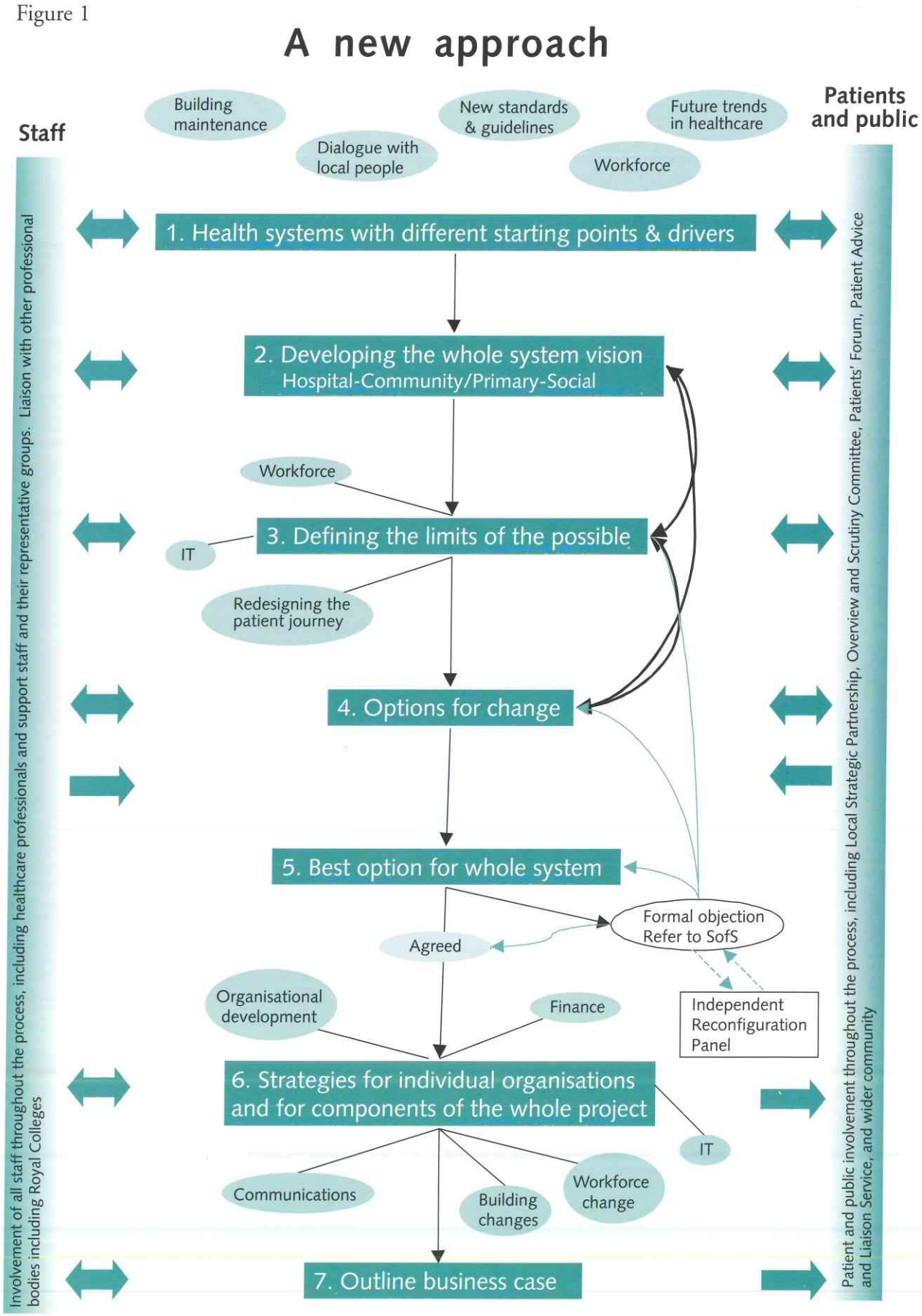
Practice guidance 6

Once the preferred option has been agreed, the process moves towards putting into practice. Significant challenges here include:

- the effects on training and workforce development of operating services differently;
- keeping patients and the public informed and up to date with progress; and
- the need to manage the move towards the new pattern of service.

Link www.doh.gov.uk/configuring hospitals

Figure 1


A new approach
Staff
Patients and public
Building maintenance
New standards & guidelines
Future trends in healthcare
Dialogue with local people
Workforce
1. Health systems with different starting points & drivers
2. Developing the whole system vision
Hospital-Community/Primary-Social
Workforce
3. Defining the limits of the possible
IT
Redesigning the patient journey
4. Options for change
5. Best option for whole system
Formal objection
Refer to SofS
Agreed
Organisational development
Finance
Independent Reconfiguration Panel
6. Strategies for individual organisations and for components of the whole project
IT
Communications
Building changes
Workforce change
7. Outline business case
Involvement of all staff throughout the process, including healthcare professionals and support staff and their representative groups. Liaison with other professional bodies including Royal Colleges
Patient and public involvement throughout the process, including Local Strategic Partnership, Overview and Scrutiny Committee, Patients' Forum, Patient Advice and Liaison Service, and wider community

Other statutory consultation requirements

Consultation on a 'substantial variation or development to health services'

Consultation on changes to health services is not a new requirement. The Community Health Council Regulations 1996 require strategic health authorities (previously health authorities) to consult on proposals for any substantial development or variation to health services.

The Overview and Scrutiny Committee Regulations under section 7 of the Health and Social Care Act now also requires NHS organisations to consult the overview and scrutiny committee or committees on any proposal for a substantial development or variation of the health service. (These regulations will eventually take the place of Community Health Council Regulations.) What constitutes a 'substantial development or variation' is not defined in the legislation. The section 11 duty to involve and consult patients and the public still applies whether or not a proposal constitutes a substantial variation or development.

You can find details of the roles and responsibilities for consultation on substantial variation or development of health services in the OSC Guidance.

Link OSC Guidance

Link OSC Regulations 2002

www.legislation.hmso.gov/si/200230.htm

Consultation on changes to NHS organisations

1 Regulations are being drafted in connection with consultation on varying the area of, abolishing, establishing, or changing the name of strategic health authorities and are expected to come into force in the spring of 2003.

Link http://www.cabinet-office.gov.uk/servicefirst/2000/consult/code/ConsultationCode.htm

2 Legislation on PCT consultation is in the Primary Care Trust (Consultation on Establishment, Dissolution and Transfer of Staff) Regulations 1999 (SI 1999/2337). The amending SIs are 2001/3787 and 2002/2469.

3 Legislation for changes to NHS trusts is in the National Health Service Trusts (Consultation on Establishment and Dissolution) Regulations 1996 (SI 1996/653). The amending SI is 2001/3786.

4 The consultation requirements set out in the Overview and Scrutiny Regulations (see paragraph 1 above; see also the Community Health Council Regulations 1996. These will no longer apply in England when CHCs are abolished) do not apply to any proposal to establish or dissolve a NHS trust.

5 For Care Trusts requirements are set out in Care Trusts (Applications and Consultation) Regulation 2001. The SI is 2001/3788.

Link http://www.hmso.gov.uk

Practice guidance 14

Appendix 1

Acknowledgements

Membership of the Section 11 Reference Group includes representatives from:

Association of Community Health Councils for England and Wales
Breakthrough Breast Cancer
Cancerlink
CHI
Dorset and Somerset Strategic Health Authority
Leadership Centre of the Modernisation Agency
Local Government Association
North West London Strategic Health Authority
The Patients' Forum
Society of CHC Staff
South East London Strategic Health Authority
Sydenham Green Group Practice
Wells Park Practice
West Herefordshire Hospitals NHS Trust
West Norfolk PCT
Whipps Cross University Hospital
Wolverhampton VSC.

We would also like to thank all the organisations and individuals who have commented on the draft policy and practice guidance, in particular all the people who organised and went to the market-testing events at:

Greater Manchester Strategic Health Authority
Haringey PCT
Leicestershire, Northants and Rutland Strategic Health Authority
Northumberland, Tyne and Wear Strategic Health Authority
North East Yorkshire and North Lincolnshire Strategic Health Authority
Norfolk, Suffolk and Cambridgeshire Strategic Health Authority
West Yorkshire Strategic Health Authority.

We also want to thank the large number of NHS organisations that provided examples of their work, including:

Bedford Health Authority
Central Liverpool PCT
The former Cheltenham and Tewkesbury PCG
Derbyshire Royal Infirmary
DHSC London, Diversity Team
East Devon PCT
East Kent Hospitals NHS Trust
East Somerset NHS Trust
Hull and East Riding Community Health NHS Trust
The former Kent Weald PCG
Leeds Health Authority
Leeds Health Action Zone
Lewisham Community Development Partnership
Nottingham City Hospital
The former Rotherham PCG
Somerset PCTs
South East Regional Office
Southend PCT, Castle Point PCT and Southend District CHC
Wakefield and Pontefract Community Health
The former Wakefield West PCG
Walsall Health Authority
The former Walsall South East PCG

Appendix 2

Plain English Campaign's Crystal Mark does not apply to this appendix.

The Health and Social Care Act 2001 (Section 11)

It is the duty of every body to which this section applies to make arrangements with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are, directly or through representatives, involved in and consulted on –

(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.

(2) This section applies to –

(a) Strategic Health Authorities,

(b) Primary Care Trusts, and

(c) NHS trusts.

(3) For the purposes of this section a body is responsible for health services –

(a) if the body provides or is to provide those services to individuals, or

(b) if another person provides, or is to provide, those services to individuals –

(i) at that body's direction,

(ii) on its behalf, or

(iii) in accordance with an agreement or arrangements made by that body with that other person,

and references in this section to the provision of services include references to the provision of services jointly with another person.

Explanatory note taken from the Act

Section 11 confers on each health authority, Primary Care Trust and NHS trust a new statutory duty to make arrangements with the aim of involving patients and the public in the planning and decision making processes of that body, in so far as they affect the operation of the health services for which the body is responsible. In relation to health authorities, this would cover both the hospital and community health services for which they are responsible and the family health services provided by practitioners in their area.

Schedule 8 in the National Health Service Reform and Health Care Professions Act 2002[2] amends Section 11 The Health and Social Care Act 2001 as follows:

- Section 2 applies to Strategic Health Authorities
- After subsection (3) there is inserted –

(4) Subsection (5) applies to health services for which a Strategic Health Authority is not responsible by virtue of subsection (3), but which are provided or to be provided to individuals in the area of the Authority, and for which –

(a) a Primary Care Trust any part of whose area falls within the Authority's area, or

(b) an NHS trust which provides services at or from a hospital or other establishment or facility which falls within the Authority's area.

is responsible by virtue of subsection (3)

(5) A Strategic Health Authority may give directions to Primary Care Trusts falling within paragraph (a) of subsection (4), and NHS trusts falling within paragraph (b) of that subsection (1) in relation to health services to which this subsection applies.

(6) It is the duty of each Primary Care Trust and each NHS trust to which such directions are given to comply with them.

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2 Health Service Reform and Health Care Professions Act 2002, Chapter 17 page 98