Arrangements for Public and Patient Involvement

Introduction

1. This paper seeks to provide assurance regarding NHS Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire ICBs' (the ICBs) arrangements for public and patient involvement. The paper sets out the legal framework and covers arrangements for effective engagement in the development of commissioning plans and policies and the co-production and evaluation of services, with a particular focus on underserved communities.
2. The paper also describes how the ICBs currently demonstrate that:
    a) Systems and processes are legally compliant, with clear processes to assess legal duties for change and transformation programmes, and that the ICBs meet their legal duties for engagement with Health Overview and Scrutiny Committees.
    b) The ICBs have expertise and methodologies to ensure meaningful engagement, and that the ICBs pay attention to the moral duty to engage, recognising the health and service benefits that arise from engagement, alongside our legal duties.
    c) There is governance in place to deliver and assure against these duties.
3. While there is similarity in current approaches across the ICBs, these processes will be further aligned and embedded in the coming months. A clear plan is in place to align and further mature arrangements as ICB staffing stabilises following the management of change process. This will include alignment of existing assessment processes and frameworks, taking best practice from each ICB.

Statutory duties and legal compliance framework

4. NHS organisations have a legal duty to 'make arrangements' to secure that individuals to whom services are being or may be provided and their carers/representatives are involved when commissioning services for NHS patients. The main duties on NHS bodies to make arrangements to involve the public are all set out in the National Health Service Act 2006, as amended by the Health and Care Act 2022. The full details of the Act can be found in Appendix 1. It is against these duties that the ICBs make assessments.
5. To fulfil the public involvement duty, the arrangements must provide for the public to be involved in:
    a) The planning of services.

b) The development and consideration of proposals for changes which, if implemented, would have an impact on the manner or range of services.

c) Decisions which, when implemented, would have such an impact.

6. More information about the specific legal duties in relation to working in partnership with people is provided in Working in partnership with people and communities: Statutory guidance. Each NHS organisation is accountable and liable for compliance with their public involvement obligations. Appendix 1 also contains information regarding:

   a) Key requirements of NHS England, ICBs, NHS Trusts and NHS Foundation Trusts.

   b) Discussion regarding the legal duty of 'involving' people in decision-making.

   c) Specific wording of the legislative requirements to consult the local authority where substantial development or variation changes are proposed to NHS services.

7. Notably, there is no legal definition of 'substantial development or variation' and for any particular proposed service change, commissioners and providers should seek to reach agreement with the relevant local authority on whether the duty is triggered. Where there is a duty for the commissioner to consult the local authority under the s.244 Regulations, it will almost invariably be the case that public consultation is also required.[1]

8. The Health and Care Act 2022 included new provisions regarding the powers of the Secretary of State for Health and Social Care in regard to reconfiguration. They increase the role of the Secretary of State in NHS reconfiguration proposals. They also dilute the unique role of local authorities to refer concerns about reconfigurations to the Secretary of State. Any individual or organisation can now ask for the Secretary of State to intervene using their 'call-in' powers.

9. There are also new duties for the ICB to notify the Secretary of State of relevant reconfiguration proposals and also to cooperate with the Secretary of State and the Independent Reconfiguration Panel. Commissioners are required to notify the Secretary of State of a proposal if it is a Substantial Development as set out in 23(1)(a) of the 2013 Regulations described above. This is as set out in legislation. There are also provisions in the Act for the Secretary of State to propose their own reconfigurations (the so-called 'catalysing' powers). These powers have not yet come into force. See Appendix 1 for details from the Act.

[1] Even when a proposal is 'provider-led' or driven, the responsibility for consultation sits with the commissioner.

Temporary service changes

10. There is provision in legislation and guidance that enables temporary changes to be made to services, without triggering the legal duties prescribed in the Act. These changes may be the result of urgent estates or staffing issues, which occur rapidly and unavoidably reduce the quality of care, with temporary steps required to secure the provision of services and ensure patient safety. Other types of temporary arrangements, such as service pilots for foreseen temporary service changes, continue to be subject to legal duties and should be underpinned by engagement.

11. ICBs are required to report any temporary service change to NHS England through the commissioning and contracting routes, and any proposed permanent change to services following urgent and unforeseen temporary change is required to be undertaken with full public and patient involvement, using the approaches described in this paper. It is not lawful to make a temporary service change and convert the change to a permanent position without seeking to involve the public and patients.

Moral duty

12. In addition to these legal duties, the ICBs also recognise that working in partnership with people and communities creates a better chance of developing services that meet people's needs, improve their experience of services, and ultimately improve their health outcomes. Gathering feedback from our diverse population in local communities about their experiences of care, their views and suggestions for improvement and their wider needs in order to ensure equality of access, and quality of life is a key component of an effective and high performing Integrated Care System. These insights, and the diverse thinking of people and communities will be essential in tackling health inequalities and the other challenges faced by our health and care system. The full benefits are:

Improved health outcomes	Ensuring services meet people's needs, provide a positive experience of care, and improve their outcomes. People have the knowledge, skills, experiences, and connections services need to understand, if they are to provide services that support and meet a person's physical and mental health.

Value for money	Services that are designed with people and therefore effectively meet their needs are a better use of NHS resources. They improve health outcomes and reduce the need for further, additional care or treatment because a service did not meet their needs first time.
Better decision making	Business cases and decision making are improved when insight from local people is used alongside financial and clinical information. Challenge from outside voices can promote innovative thinking that can lead to new solutions that would not have been considered had the decision only been made internally.
Improved quality	Services can be designed and delivered more appropriately, because they are personalised to meet the needs and preferences of local people.
Accountability and transparency	Engaging more meaningfully with local communities helps to build public confidence, trust and support as well as being able to demonstrate public support for proposals.
Participating for health	Being involved can reduce isolation, increase confidence, and improve motivation towards wellbeing. Individuals' involvement in delivering services that are relevant to them and their community can lead to social action, formal volunteering roles and employment in health and care sectors.
Addressing health inequalities	Jointly identifying solutions to barriers to access, developed in partnership with people using community-centred approaches, can help address health inequalities.

(Source: Why work with people and communities? NHS England (2022)

13. There are additional legal frameworks and case law that guides the application of ICB governance and assessment in service changes. The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the ground of 'protected characteristics', these are:

    a) Age

b) Disability

c) Gender reassignment

d) Marriage and civil partnership

e) Pregnancy and maternity

f) Race

g) Religion or belief

h) Sex and sexual orientation.

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

a) Eliminate discrimination that is unlawful under the Equality Act 2010.

b) Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.

c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

15. This is known as the 'public sector equality duty' (section 149 of the Equality Act 2010). The equality law requirements are met through comprehensive Equality Impact Assessments, which are undertaken throughout the life-cycle of a project, and the output of which is used to inform engagement approaches to ensure those population groups who are likely to be impacted by service change, who suffer from health inequality, are embedded and targeted within our engagement activity.

Reducing health inequalities

16. NHS England and ICBs are also under a separate statutory duty to have regard to the need to reduce health inequalities between patients in access to health services and the outcomes achieved (sections 13G and 14T of the NHS Act, as amended by the Health and Social Care Act 2012, respectively). In developing engagement programmes, targeting is informed by existing insight and statistical data, working in partnership with business information teams from the NHS and Public Health and in collaboration with Voluntary, Community, Faith, and Social Enterprise (VCFSE) partners. Activity seeks to collate and review existing data, research, and evidence, ensuring that existing knowledge and insights are maximised and gaps in our knowledge can be identified, including but not limited to:

a) Census data.

b) Patient experience data (primary and secondary care providers and local authority service providers).

c) Previous engagement feedback (insight database).

d) Joint Strategic Needs Assessments.

e) Health and Wellbeing Board Strategies.

f) Population Health data.

g) Academic papers.

h) Non-academic research papers and briefings.

The Gunning principles

17. These principles, known as Gunning or Sedley, were confirmed by the Court of Appeal in 2001 (Coughlan case) and are now applicable to all public consultations that take place in the UK. The principles are:

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

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

    c) Adequate time must be given for consideration and response.

    d) The product of consultation must be conscientiously taken into account.

Assessing legal duties

18. It is important to have a consistent process for assessing legal duties, and for this to be embedded in routine business. Appendix 2 contains the assessment framework to assist with determining if the legal duties apply.

19. The ICBs currently operate assessments as individual organisations. In summary, the assessment arrangements are:

ICB	Process
NHS Derby and Derbyshire ICB (DDICB)	A simple form is completed by project leads, outlining the proposed activity, noting the possibility or change to range or choice of services, in collaboration with the allocated Public and Patient Involvement (PPI) lead. Forms are assessed by PPI lead, sense checked with PPI colleagues, signed off by the Director of Communications and Engagement and a decision communicated to the project lead. The assessment form is embedded in Programme Management Office processes as a gateway to decision-making. There is strong compliance with the process. The

ICB	Process
	register of assessments is shared bi-monthly with Health Overview and Scrutiny Committees for transparency and to inform agenda setting.
NHS Lincolnshire ICB (LICB)	Engagement representatives attend key programme boards and steering groups to advise on involvement requirements and approaches. Where applicable these are added to programme risk registers for monitoring. Promotion of the Duty to Involve occurs through Team Briefings and at Senior Leaders' meetings so strategic managers are aware of their responsibilities and can promote involvement culture across the organisation. Promotion of involvement and engagement functions on the intranet with contact details to call /email team to discuss if involvement support is required as well as scoping and designing activities. System Equality and Quality Impact Assessment processes established to promote and identify involvement requirements in change programmes – engagement representative in steering group to review. Health Inequalities Engagement Manager is aligned to all Health Inequalities projects, providing advice, guidance and undertakes engagement with health inequality groups and underserved communities. Ongoing and forthcoming involvement needs and planned activity (incl. provider and primary care) outlined at weekly System Communications and Engagement Strategic Group, ensuring awareness, support, and shared reporting updates. This also informs planning at the monthly Healthy Overview and Scrutiny Committee Agenda Setting meetings.
NHS Nottingham and Nottinghamshire ICB (NNICB)	Where proposals for service change are considered, an initial report will be received at the ICB's Commissioning Review Group which has a member of the ICB's Communications and Engagement team as a full member set out in the Terms of Reference. This enables an initial assessment of whether the duty to involve or consult is triggered. This assessment is included in the paper which will then be approved by the appropriate decision-maker (Joint Commissioning Executive Group).

20. Assessments are completed for ICB business decisions only. Business decisions made by NHS provider organisations follow local processes in compliance with legal duties; however, the ICBs will advise NHS providers on process where required. The ICB should be sighted on decisions that originate in a specific NHS Trust or NHS Foundation Trust, which may lead to a significant/ substantial change to services, as consultation with the Health Overview and Scrutiny Committee (HOSC) is likely in this scenario, as well as the duty for commissioners to notify the Secretary of State (SoS) of substantial reconfigurations, this HOSC relationship and SoS notification process is facilitated by the ICB. Moreover, any significant or substantial service change may lead to the requirement for consultation, which should be overseen by the ICB.

21. An assessment of the above processes provides the following assurances per ICB currently:

	DDICB	LICB	NNICB
Arrangements meet the requirements for compliance with legal duties.	✓	✓	✓
Appropriate controls and sign off arrangements are in place.	✓	✓	✓
Opportunity for alignment of the current individual processes into a 'cluster' process is attainable.	✓	✓	✓

Framework for engagement and co-production

22. Each ICB has its own strategy for working with people and communities. These were a pre-requisite of the establishment of ICBs in 2022 and have been built upon since then. A cluster-wide strategy refresh will be undertaken in 2026/27, following the conclusion of the management of change process. Prior to that, the overall ethos for our work with people and communities can be described as:

    a) To embed our work with people and communities at the heart of planning, priority setting and decision-making to drive neighbourhood initiatives, system transformation work, commissioning of services and quality improvement programmes ensuring the voices of patients, service users, communities and staff are sought out, listened to, and utilised resulting in better health and care outcomes for our population.

    b) To promote relationship building and authentic conversation, including its importance in increasing trust and improving involvement. To raise awareness of the need to consider how this is done in a planned, and

systematic way, on a continuous basis, with the required investment of time and resource.

c) To ensure our own practice reflects the relationship we wish to foster with the public, seeks to understand the experiences of people and communities, and support the sharing of power, to create authentic connections, which bring people and communities into the discussion, including through the use of co-production techniques, rather than talking to them about the decision.

Engagement in commissioning and service change

23. The existing strategies for Working with People and Communities have reference to the NHS England assurance requirements for major service change. The best practice guidance published by NHS England was informed through conversations with our ICB teams and is embedded in local processes.

24. NHS England requirements on gateways and pre-consultation business cases are built into guidance and are triggered where service changes may be deemed substantial through discussion with Health Overview and Scrutiny Committees. In particular, ICBs are expected to provide assurance, and likely to go through the Major Service Change process, when changes related to NHS bedded care.

Engagement with Health Overview and Scrutiny Committees

25. Health Overview and Scrutiny Committees (HOSCs) have a range of statutory powers in relation to health services. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013[2], local authorities in England have the power to:

a) Review and scrutinise matters relating to the planning, provision, and operation of the health service in the area. This may well include scrutinising the finances of local health services.

b) Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.

c) Require employees, including non-executive directors of certain NHS bodies, to attend before them to answer questions.

d) Make reports and recommendations to certain NHS bodies and expect a response within 28 days.

[2] The Health and Care Act 2022 introduced a power for the Secretary of State to call in and take decisions on or connected to reconfiguration proposals at any stage in the proposal's process. This does not change local authorities' scrutiny responsibilities for service change.

e) Have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals.

f) Where practicable, set up joint health overview and scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.

g) Have a mechanism in place to deal with referrals made by local Healthwatch organisations.

h) Report disputed reconfiguration proposals to the Secretary of State until the new reconfiguration provisions take effect, if they consider that:

   i) The consultation has been inadequate in relation to the content, or the amount of time allowed.

   ii) The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.

   iii) A proposal would not be in the interests of the health service in its area.

26. District and borough councils are also required to hold scrutiny committees, focussed primarily on scrutiny of council business. Health legislation does not mandate ICB or NHS engagement with districts and boroughs, although on occasion committees request this. It is recommended that this approach remains, and requests to attend borough or district council committees are managed on their individual merits, with appropriate referral to HOSCs as required. The Local Government Reform programme will likely have further impact on this position in due course.

27. The ICBs have undertaken a stocktake of existing approaches to HOSC engagement. There is significant similarity, and a single process will be established following the conclusion of the wave two management of change process. In particular, this will see the accountability for all HOSC relationships sitting under a single ICB Director. Processes will also be aligned across the ICBs, subject to specific local practices and agreements with HOSC Chairs.

Supporting PPI infrastructure

28. Engagement activity is developed to be bespoke to each project, subject to the type of change, the population affected and especially where a change may impact on health inequalities, informed by Equality Impact Assessments. ICBs do have a range of established mechanisms to support general engagement and involvement, and to support our bespoke engagement plans. These include:

a) Patient Participation Groups, which involve patients about the range and quality of services provided by their GP practice and how commissioners plan services.

b) Annual public meetings.

c) Community engagement events.

d) Conversations via our social media channels.

e) Citizen's Panel and Reader's Panels.

f) An online engagement platform, to document the processes and information used in service change and other engagement activity. Opportunities provided to get involved in several ways.

g) A cohort of Public and Patient Partners, who have lived experience and work with ICB and other NHS officers in project teams and other settings to provide advice and guidance from the patient perspective.

h) Communities of Practice across the NHS and Local Authorities to share approaches and initiatives to allow for maximising of public sector assets.

i) Engagement bulletins and opportunities to get involved shared with stakeholders and groups.

j) Engagement steering groups with wide range of partners, operating in various formats across the ICBs.

Engagement, co-production and underserved communities

29. Engagement teams will also work in partnership with people who have relevant lived experience (expert patients, service users, unpaid carers, and people in paid lived experience roles) and with learnt experience (staff), will enable us to directly connect with multiple and diverse voices including with those from underserved communities. Building equal and reciprocal partnerships from the very start of, and throughout, all our work will be crucial.

30. Co-production ensures that people with lived experience are empowered and involved in developing, shaping, and making decisions about support and services as an equal partner to professionals. It is about valuing the insight and contribution of people that use services, and working with people, not doing to people, or doing for people. Co-production supports a balanced relationship where both people with lived experience and professionals are experts in their own right, relocating power, with staff becoming facilitators, rather than fixers.

31. Strategic coproduction is where a group of committed and knowledgeable people with relevant lived experience feel confident to contribute effectively and consistently. The collective voice of a strategic co-production group is significantly different from individual people inputting their own perspectives at

meetings. This approach to co-production is applied across the ICBs through different teams and will be consolidated through the wave three management of change process.

32. Our work is often developed and deployed in liaison with the VCFSE sector. It is fully acknowledged that VCFSE colleagues have the best connections with underserved local communities who are experiencing the greatest health inequality, as well as local leaders to facilitate the NHS in building trusted relationships at community level. This has seen significant success and deeper engagement with communities, particularly since the Covid-19 pandemic. The three ICBs have different models for VCFSE engagement, through alliances and strategic partnerships, and maintaining this will be crucial in the ICB cluster arrangements to ensure relationships are maintained and benefit the engagement in improving health and reducing health inequalities.

33. While co-production frameworks exist and will be aligned, each piece of work requires specific structure to ensure it meets the needs of local communities. Communities may be defined as a geographic community, a demographic community, a community of 'condition' or a community of 'practice'; for example, those with similar professional or cultural interests. Using evidence from Equality and Quality Impact Assessments, demographic and census data, known insights, intelligence from existing community leaders and specific situational or SWOT analysis, and other bespoke sources of intelligence will be used to inform the necessary approach. Historic issues and barriers may also be factored into the approach to co-production and community engagement.

34. Each approach will necessarily be different and seek to build connections, relationships, and trust, to ensure that co-production conversations are representative and seek to share power with citizens to avoid focussing solely on an ICB agenda. Specific engagement mechanisms are then meaningfully co-created, informed by community views and achieve the best possible outcomes for both the community and the commissioner. Of significant importance is the need to evidence acting on feedback received and ensuring the completion of feedback loops to demonstrate this. It is also proven that communities see benefit in continued conversation and co-production opportunities, and for commissioners to avoid an 'issues focus' that can be perceived as a one-off conversation which serves only the ICB's specific and isolated purpose. There are a range of examples from across the cluster where this type of work has seen ongoing and mutual benefits.

Insights

35. All three ICBs have developed a form on insight hub or library to capture the breadth of insight, intelligence and engagement feedback that already exists across the health and care sectors, and others. Intelligence includes findings

drawn from all system partners including statutory sector, Voluntary, Community and Social Enterprise, Healthwatch, citizens' panel and networks at Place and neighbourhood level. These systems also draw in data and insights created and published from outside our system, e.g., census data, ONS reports, and wider public sector focussed reports, surveys, and research. Data is captured and recorded in a database enabling a systematic record of what we know about certain communities or geographies, and this is utilised in planning engagement to understand what ICBs have already heard from citizens and communities and aids the targeting of engagement activity to close insight gaps.

36. It is worth noting that existing insight has fed into the production of the ICBs' Five-Year Population Health Strategy. This output can be seen in Appendix 3 as a case study.

Governance and internal assurance arrangements

37. The ICBs' Boards have overall responsibility for oversight of arrangements to deliver against legal duties relating to public and patient involvement and are responsible for ensuring adequate resources are available to ensure its implementation.

38. The governance of the ICBs has delegated assurance on public and patient involvement and co-production to the Joint Strategic Commissioning Committee. The Executive Director of Strategy and Citizen Experience leads on the broader strategic agenda, while the Executive Director of Quality (Nursing) leads on co-production. These two senior owners are committed to working closely together to ensure that the two facets of the overall strategy are aligned and complementary whilst also respecting their separate roles and contexts.

39. NHS England manages the major service change programme, which seeks to assure significant service change activity. Part of this process includes access to clinical senates, where sense checks are enabled on emerging clinical policy. The ICBs are able to connect with these mechanisms and have a track record of positive dialogue and compliance.

40. ICBs are also required to provide an update on their public and patient involvement arrangements and activity in annual reports and accounts, and this information is used by NHS England in undertaking annual assessments of ICBs. Detailed PPI Annual Reports are produced to demonstrate involvement activities, their outcomes and impacts, evidencing that statutory duties are being met.

41. It is proposed that a routine report on activity is provided to the Joint Strategic Commissioning Committee for assurance, the timetable for which is to be agreed.

Monitoring, audit and recommendations

42. NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB have recently been reviewed by internal auditors as part of the ongoing audit programme. These included comprehensive reviews of governance, strategy, policy, and approach, with the following levels of assurance provided:

ICB	Audit Opinion
DDICB	**A moderate opinion** has been provided, as although the ICB has a number of frameworks and guidance documents to underpin ways of working and the process to follow to engage with patients and the public, at the time of the audit there was not a transparent assurance process that patient and public involvement activities were being undertaken in line with policies and processes and that the public were an integral part of designing, commissioning, transforming and monitoring services. Since the ICB clustered with NHS Nottingham and Nottinghamshire ICB and NHS Lincolnshire ICB a new Joint Strategic Commissioning Committee has been established but arrangements are still to be embedded.
LICB	**RAG rated 'Green'.** Confidence that the ICB People and Communities Strategy sets out how the ICB will deliver its duties and principles to understand and empower the communities it serves. This is underpinned by the NHS England principles of engagement. The ICB has established governance and reporting structures with appropriate oversight by relevant committees. The draft ICB Target Operating Model (TOM) demonstrates engagement is embedded throughout the commissioning model, public involvement and engagement is a key function within the ICB and a dedicated ICB communication and engagement team provides support across the organisation. The Quality and Equality Impact Assessment system processes ensure that

ICB	Audit Opinion
	system partners have an approach which includes engagement as a key consideration. Review of the Equality and Health Inequality Impact Assessment Tool and the Quality Impact Assessment guidance confirmed that public engagement and / or consultation with affected groups / the wider public and the legal duty to involve people and communities are undertaken as part of the process. Information and documentation on engagement is provided, and the PPI Annual Report highlight the range of involvement activities undertaken by the ICB and their outcomes including success and impact. Reasonable assurance accepted with three recommendations identified which form part of the post Management of Change schedule of activity.

43. The audits have resulted in the recommendations and actions included in Appendix 4, and these are being factored into the cluster-wide development of our approach to PPI activity and governance. This paper is the first step to addressing the actions relating to assurance arrangements; a further review will take place of the consolidation of existing sub-group and supporting arrangements. A new People and Communities/Citizen Experience Strategy will be presented to Committee at the right time, in line with the deadlines agreed with auditors.

Workforce capability and training

44. There is national training available to public and patient involvement and co-production teams. This is a mixture of formal qualification, NHS England training, and training delivered by the re-established Consultation Institute, which provides accreditation for engagement practitioners.

45. ICB Commissioning Managers and others are supported through training to understand the ICB legal duties in relation to public and patient involvement. This is in addition to the routine support available to commissioning teams from the ICBs' engagement teams.

46. There is a dependency on the conclusion of the management of change process and recruitment to identify remaining capacity for continued delivery of

legal duties, and to allocate named roles into activities. This applies equally to commissioning teams, and ICB organisational development approaches will ensure patient and public involvement requirements form part of staff training and committee development to embed consistency of approach and ensure continued assurance. Interim arrangements are in place to ensure focussed leadership on service change approaches, including routine collaboration across Directors of Communications and Engagement to ensure a unified approach.

Appendix 1 – Legal Duties of ICBs in Public and Patient Involvement

Legal requirements to engage the public and patients

The relevant sections of the National Health Services Act 2006, as amended by the Health and Care Act 2022 are:

- section 13Q for NHS England
- section 14Z45 for Integrated Care Boards (ICBs)
- section 242(1B) for NHS trusts and NHS foundation trusts

Key requirements of NHS England, ICBs, NHS Trusts and NHS Foundation Trusts include that they:

- Assess the need for public involvement and plan and conduct involvement activity
- Clearly document at all stages how involvement activity has informed decision-making and the rationale for decisions
- Have systems to assure themselves that they are meeting their legal duty to involve – these systems need to be reported on in annual reports.

Discussion regarding the legal duty of 'involving' people in decision-making

The legal duties require arrangements to secure that people are 'involved':

- This can be achieved by consulting people, providing people with information, or in other ways. This gives organisations a considerable degree of discretion as to how people are involved, subject to the below requirements.
- Neither the legal duties, nor this statutory guidance, seek to prescribe exactly how to involve people in any given case. What is necessary will always depend upon the circumstances.
- Public bodies are required to act rationally, and this applies to the arrangements they make to involve people. Public bodies can demonstrate that they are acting rationally by keeping good records of decisions taken about when and how to involve the public.
- Involvement must be in the preliminary stages of the project and when proposals are still at a formative stage and undertaken proportionately to the scale and significance of the change.
- Statutory duties, such as the involvement duties set out above, are not the only circumstances in which a duty to consult may arise. Under common law, a duty to consult *may* also arise where there has been a promise to consult, where there

has been an established practice of consultation, or, in exceptional cases, it would be conspicuously unfair not to consult. There will also be circumstances in which working with people and communities would be beneficial even if doing so is not legal requirement. Therefore, whether or not the involvement duties apply is not the only consideration when deciding whether and how to work with people and communities.

Legal Requirements to Engagement with Local Authorities

When engaging with local authorities, the partial wording of the Regulation ("the 2013 Regulations") made under s.244 NHS Act 2006) is as follows;

23 Consultation by responsible persons

(1) Subject to paragraphs (2) and (12) and regulation 24, where a responsible person ("R") has under consideration any proposal for a substantial development of the health service in the area of a local authority ("the authority"), or for a substantial variation in the provision of such service, R must—

(a) consult the authority;

(b) when consulting, provide the authority with—

(i) the proposed date by which R intends to make a decision as to whether to proceed with the proposal; and

(ii) the date by which R requires the authority to provide any comments under paragraph (4);

(c) inform the authority of any change to the dates provided under paragraph (b); and

(d) publish those dates, including any change to those dates.

(2) Paragraph (1) does not apply to any proposals on which R is satisfied that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff.

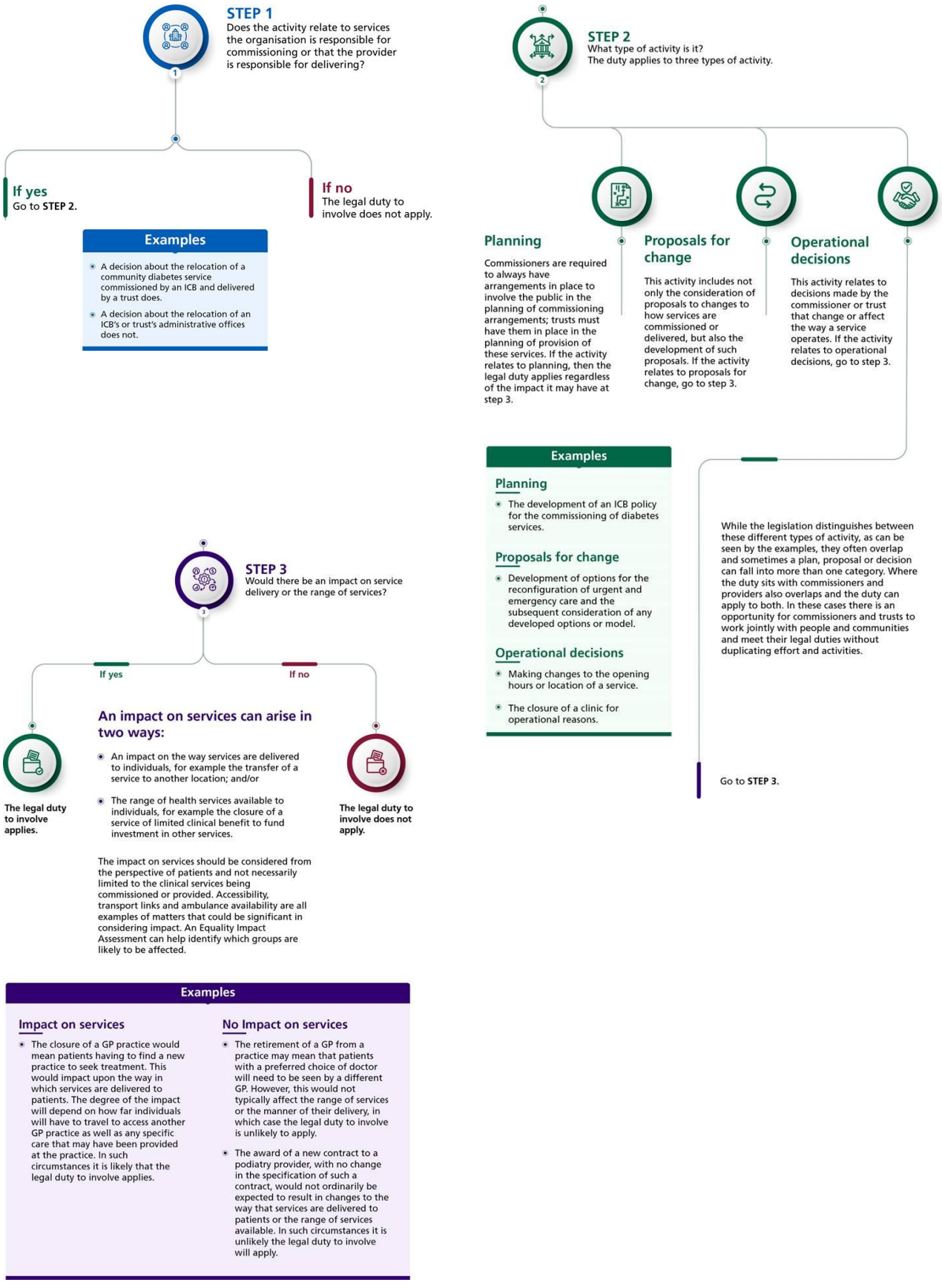
Review Powers of the Secretary of State

Power to require consideration of proposals for reconfiguration.

5 (1) The Secretary of State may direct an NHS commissioning body to consider a reconfiguration of NHS services.

(2) The Secretary of State must publish any direction under this paragraph, together with an explanation of the reasons for giving it.

Appendix 2 – Assessment Framework



Appendix 3 – Public and Patient Involvement in action

DLN ICBs Five-Year Population Health Strategy

In preparing the foundation for the first Cluster strategy development, colleagues leading the strategy development worked closely with communications and involvement to ensure the communities the strategy served were represented; demographically as well as their voice in terms of wants and needs to support their health and wellbeing.

To achieve this within the parameters of the brief (schedule, geography etc) we compiled a wealth of intelligence which had been recently and relevantly gathered through such exercises as the Ten-Year Health Plan public involvement, and local work programmes. The summary content, considered by the DLN ICBs Cluster Board and subsequently the strategy development process, is below.

The ICBs' Five-Year Population Health Strategy also states it will behave as a 'living document' i.e. engagement and testing will be ongoing; the underpinning data, analysis and insights will continue to be refined; through the Commissioning Plan it will integrate with commissioning teams; there will be a continual focus on execution; and feedback loops will be established to understand what is working and what is not.

Therefore, following approval of the DLN ICBs Cluster Population Health Strategy, a programme of public and patient involvement will be established to:

- Test and inform the evolution of our strategic approaches and priorities.
- Ensure public voice is influential in the development of implementation plans and decision making.

What people have told us matters

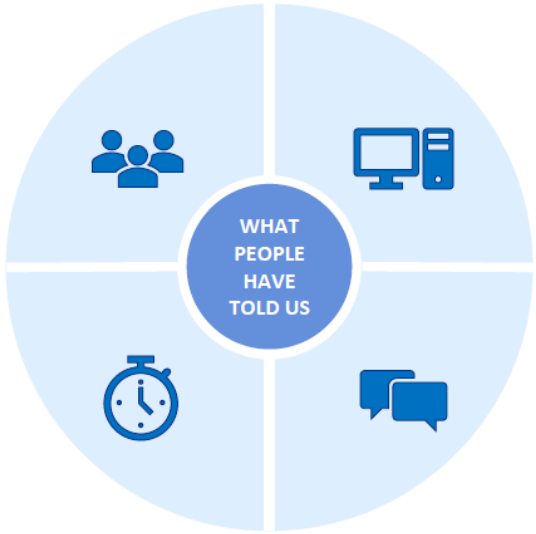
Our communities have told us clearly what matters most to them. Across Derby & Derbyshire, Lincolnshire and Nottingham & Nottinghamshire people consistently emphasised the need for timely access, clear communication, care closer to home and greater control over their health and care.

1. Control & Personalised Care

- ✓ Greater involvement in decisions about their care & treatment
- ✓ Clear, jargon-free information on conditions & self-care
- ✓ Prevention, early help & support to stay well
- ✓ Carers to be included & recognised

2. Timely Access & Joined-Up Local Services

- ✓ Waiting times for GP appointments, diagnostics & elective care
- ✓ Care closer to home, including neighbourhood hubs
- ✓ Integrated care to avoid duplication & repeating their story
- ✓ Improved access for rural & coastal areas



3. Digital Tools (that enable but don't exclude)

- ✓ Support digital tools (NHS App, virtual consultations, online forms) when optional, simple and safe
- ✓ Concerns about digital exclusion – especially older people, those with low digital literacy and rural communities
- ✓ Want choice between digital and face-to-face options

4. Clear, Inclusive, Consistent Communication

- ✓ Transparent communication about waiting times, referrals & discharge
- ✓ Information in multiple formats
- ✓ Plain language and culturally competent communication
- ✓ Ongoing engagement, visible action on feedback & simpler ways to share feedback

The lived experience, expectations and priorities of citizens across the DLN ICB Cluster have directly shaped the development of this 5-Year Population Health Strategy. These insights are reflected through this Population Health Strategy.

Source: NHS Derby and Derbyshire Commissioning Intentions Insight 2025; NHS Lincolnshire ICB Commissioning Intentions Insights September 2025; Nottingham and Nottinghamshire NHS wants and needs v2 December 2025

Voice of our citizens and communities

Engagement with our citizens and communities has told us people want more control over their care, timely access to local services and clear, joined-up communication. They value digital tools – but only if inclusive, simple and optional. Feedback highlights the need for equity, cultural sensitivity and continuity. These insights have shaped our priorities and ensure our strategy reflects what matters most to people.

Patient Empowerment	Access To Services	Communication with Services
Shared Decision-Making & Personalised Care • Citizens want **more control and decision-making in their care**, including being fully informed about what to expect and the support available, and expect to see others taking responsibility for their own health • Carers should be **actively involved in decision-making** • People value **community-based specialist clinics** (e.g. diabetes, respiratory) to **avoid unnecessary hospital visits**	**Timely & Flexible Access** • Ongoing frustration with **long waits for GP appointments, elective procedures, and diagnostics**, often pushing patients to A&E • Citizens want **same-day or next-day access for urgent needs**, better triage systems, and extended hours • Calls for **streamlined referral processes** and co-located services to reduce delays and improve safety	**Clear & Accessible Information** • Citizens want **timely and transparent communication** that meets their need, waiting times, and discharge plans • **Information should be available in multiple formats** (Easy Read, BSL, translated) and repeated as needed for accessibility • People continually stress the importance of **plain language and culturally appropriate communication** to build trust
Self-Management & Proactive Care • Citizens stressed the need for **clear, jargon-free information** about conditions, treatments, and self-care options • Strong support for **prevention and proactive care**, including health checks, lifestyle support, and early intervention for long-term condition • People want **education and awareness campaigns** to improve NHS literacy and reduce misinformation	**Localised & Integrated Care** • People want **care closer to home**, including community hubs offering multiple services under one roof, and **more use of lower acuity appointments** • Strong support for **joined-up care pathways** between hospitals, GPs, and social care to reduce duplication and improve continuity • Positive experiences with providers outside of the NHS are broad, with lots of citizens advocating **better use of the VSFSE** sector	**Joined-Up Care & Interoperability** • Citizens are frustrated as having to **repeat 'their story' multiple times** repeating medical history and poor information sharing between providers • Citizens want **consistent digital systems across practices** to avoid confusion and improve care coordination • Better **integration between health and social care** is seen as critical to reducing delays and improving patient experience
Digital Inclusion & Choice • Citizens support **digital tools** (NHS App, AskMyGP, virtual consultations) but want user-friendly systems and consistency • **Concerns about digital exclusion** for older adults, rural communities, those with low digital literacy; and **misdiagnosis** • People want **choice between digital and face-to-face appointments**, ensuring inclusivity for all preferences	**Equity & Transport Solutions** • **Rural and coastal communities face transport barriers**, requesting improved public transport links or mobile health units • Citizens call for **interpreters and culturally sensitive care** to overcome language and cultural barriers • Digital inclusion initiatives are needed to ensure **online services do not widen inequalities**, especially for older and disabled people	**Continuous Engagement & Feedback Loops** • Citizens want **ongoing engagement opportunities**, not one-off consultations, and visible action on feedback • Calls for **simplified feedback routes** (QR codes, SMS) and public reporting of changes made based on feedback • People value **co-production of services** with local communities and seldom-heard groups to ensure inclusivity

Source: NHS Derby and Derbyshire Commissioning Intentions Insight 2025; NHS Lincolnshire ICB Commissioning Intentions Insights September 2025; Nottingham and Nottinghamshire NHS wants and needs v2 December 2025

Appendix 4 – Audit Action Plan

NHS Derby and Derbyshire ICB

1. Patient and public engagement groups/forums (governance issue)	
Finding: At the time of the audit the DDICB Strategic Commissioning and Integration Committee had not taken on the full patient and public engagement duties of the former Public Partnership Committee, but rather statutory duties only. Therefore, it was not transparent where public involvement/engagement reporting was taking place within the ICB, for example, monitoring delivery of the Engagement Strategy, assurance that the forms and stages within the Engagement Model are being completed/adhered to, and seeking assurance on the public involvement/engagement processes/activities and of work to reach underserved groups. As a Board committee the newly established Joint Strategic Commissioning Committee does not have any sub-committees reporting into it and is an assurance committee only. It is noted that the former DDICB Public Partnership Committee had established sub-groups, with membership across all population groups and sectors, and through which the operational work on patient and public engagement was shaped and delivered - outcomes were reported directly to the Public Partnership Committee as further assurance that the public were an integral part of designing, commissioning, transforming and monitoring services.	
Risk: If operational groups and forums are not established then assurance may not be received on the operational work in relation to delivery of patient and public engagement activities.	**Medium** (Impact x likelihood) 3 x 3

1. Patient and public engagement groups/forums (governance issue)	
Action: 1.1 – Patient and public engagement groups/forums, with membership across all population groups and sectors, to be established within the directorate to receive operational activity updates and provide further assurance that the public are an integral part of the governance/decision making processes.	**Responsible officer**: Clair Raybould, Executive Director for Strategy and Citizen Experience **Implementation dates**: 30 June 2026
Management response: Agreed.	
Evidence required to demonstrate implementation of actions: Terms of Reference for the directorate groups/forums showing patient and public engagement responsibilities and membership.	

2. Strategy (governance issue)	
Finding: At the time of the audit, the ICS, Joined Up Care Derbyshire (JUCD), had developed a 'People and Communities Strategic Approach to Engagement' strategy document, dated 2022/23, which had a purpose to outline JUCD's strategic approach to engagement with people and communities. The strategy did not include any monitoring and/or review arrangements of its ambitions/next steps or how this will be evidenced. It is noted that the former Public Partnership Committee received updates on key areas within the strategy, but this responsibility was not transferred directly to the ICB Strategic Commissioning and Integration Committee, which was the committee with responsibility at the time of the audit. Following clustering, a Population Health Strategy is in the process of prepared, whereby patient and public engagement will form a component.	
Risk: If patient and public involvement deliverables are not included within the Population Health Strategy or routinely reported upon, then progress against objectives may not be effectively measured and monitored, which may lead to the ICB not achieving its statutory duties.	**Medium** (Impact x likelihood) 3 x 3

2. Strategy (governance issue)	
Action: 2.1 – The Population Health Strategy to include patient and public involvement key deliverables, monitoring/review arrangements and how this will be evidenced.	**Responsible officer**: Clair Raybould, Executive Director for Strategy and Citizen Experience **Implementation dates**: 31 May 2026
Management response: Agreed.	
Evidence required to demonstrate implementation of actions: Population Health Strategy detailing patient and public involvement key deliverables and monitoring/review arrangements.	

NHS Lincolnshire ICB

Id	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	GF	The People and Communities Strategy was published in January 2024 and has no review date.	To formally agree the frequency of review for the People and Communities Strategy and this be documented on the Strategy.	2	*It was identified in 2025 that this review would need to be undertaken in accordance with new cluster structure and arrangement. A proposal to develop an DLN ICB Cluster People and Communities Strategy including underpinning policies and procedures was drafted early January 2026.* *This is to be informed by the direction of travel for the Cluster and DLN Commissioning Plan, expected February / March 2026.* *DLN Cluster teams are expected to be in place to take this work forward in May 2026 with an expectation of a revised Cluster People and Community Strategy by July 2026. This will be reviewed annually with an accompanying delivery plan.* *Consideration will be given to any amendments to the statutory duties and revised national guidance which is expected although timescales are not yet confirmed.*	*July 2026*	*Clair Raybould, Executive Director of Strategy and Citizen Experience*

Id	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	PM	Review of the terms of reference (ToR) of some groups which manage and have oversight of experience / feedback and engagement activities identified the following: • The ToR for the Operational Quality Assurance Group (OQAG) was dated June 2023 and has a review date of June 2024. The Patient Council has a review date of April 2024. Both were overdue for a review. • Two ToR were not finalised; the Quality & Equality Impact Assessment (EQIA) Review Group ToR was dated February 2025 and the Tissue Viability & Pressure Ulcer Prevention Quality Improvement Steering Group ToR dated August 2025; and • The Medicine Optimisation – Pain Medication Patient Advisory Group ToR is not dated.	The terms of reference (ToR) for the various groups be appropriately approved and kept up to date.	2	*These meetings / groups fall outside the direct remit and responsibility of the Communications and Engagement team, though they are fully supported through our partnership approaches.* *It is not currently finalised which meetings / groups will continue in the DLN Cluster – once confirmed, arrangements will be made with these groups to support updating and finalising of their TOR as per standard practise.*	*July 2026*	*Clair Raybould, Executive Director of Strategy and Citizen Experience*
3	C	In 2024/25, the People and Communities Strategy was supported by a delivery plan (Patient and Public Engagement (PPE) Plan) which set out the 10 principles in the NHSE ICS design framework and how each of these will be adopted in activities in 2024/25. However, a delivery plan was not completed for 2025/26 due to the ongoing changes to NHS structures and functions. This is considered low risk as it is noted that there was evidence of engagement and involvement by the ICB.	To develop and formally agree the Patient and Public Engagement (PPE) Plan for 2026/27.	3	*During the original schedule for updating, the process of ICB clustering clarified the appropriate need for a collective DLN approach to this delivery planning. A DLN ICB Cluster forward plan was briefed in Q3 25/26 in readiness for 26/27 and is currently in development.* *A full People and Communities delivery plan will be developed alongside the revised Cluster 26/27 strategy.*	*April 2026* *July 2026*	*Clair Raybould, Executive Director of Strategy and Citizen Experience*