

Legal duties for clinical commissioning groups and NHS England

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, especially with regard to how NHS commissioners will function. These amendments include two complementary duties for clinical commissioning groups with respect to patient and public participation. This document sets out the relevant statutory duties and provides a summary of related legislation that commissioners will find useful when developing their response. All references are to the NHS Act 2006 (as amended) ('the Act') unless otherwise stated.

Individual participation duties

Clinical commissioning groups (CCGs) and NHS England must promote the involvement of patients and carers in decisions which relate to their care or treatment. This requires collaboration between patients, carers and professionals, recognising the expertise and contribution made by all. The duty requires CCGs to ensure that they commission services which promote involvement of patients across the full spectrum of prevention or diagnosis, care planning, treatment and care management.

This includes

- personalised care planning, including 'patient choice' and the option of a personal health budget when a person is eligible.
- shared decision making, regarding individual episodes of care and longer term care.
- self-care and self-management support to better manage health and prevent illness.
- information with targeted support to enable patients to be more in control of their health.

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The relevant clauses in the Act as they relate to CCGs are as follows:

S.14U of the Act - Duty to promote involvement of each patient

- 1) Each clinical commissioning group must, in the exercise of its functions, promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to –
 - a) The prevention or diagnosis of illness in the patients, or
 - b) Their care or treatment.
- 2) The Board must publish guidance for clinical commissioning groups on the discharge of their duties under this section.
- 3) A clinical commissioning group must have regard to any guidance published by the Board under subsection (2).

The reasons for any deviation from this need to be clearly set out when such action is taken.

S.13H of the Act - Duty to promote involvement of each patient

The relevant clause in the Act as it relates to NHS England (the 'Board') is as follows:

The [CCG] Board must, in the exercise of its functions promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to –

- a) the prevention or diagnosis of illness in the patients, or
- b) their care or treatment.

S.13I of the Act - Duty as to patient choice

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

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Public Participation duties

The second duty places a requirement on CCGs and NHS England to ensure public involvement and consultation in commissioning processes and decisions. A description of these arrangements must be included in a CCG's Constitution. It includes involvement of the public, patients and carers in:

- planning of commissioning arrangements, which might include consideration of allocation of resources, needs assessment and service specification.
- proposed changes to services which may impact on patients.

The relevant clauses in the Act as they relate to CCGs are as follows:

S.14Z2 Public involvement and consultation by clinical commissioning groups

- 1) This section applies 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 or 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.

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- 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 principles which it follow in implementing those arrangements.

4) The 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).

The key clause in the Act as it relates to NHS England (the “Board”) is as follows:

S.13Q of the Act - Public involvement and consultation by the Board

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 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.

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Reporting Requirements

14Z15 of the Act sets out the requirements that, in each financial year (other than its first financial year) each CCG must prepare an annual report on how it has discharged its functions in the previous financial year. In particular, it must 'explain how the clinical commissioning group has discharged its duties' under 14Z22 as quoted above. Each CCG must consult with its relevant Health and wellbeing board in preparing this report. NHS England may give directions to CCGs as to the form and content of the report, and each report must be published and a meeting held to present the report to members of the public. **(s.14Z15(6) of the Act).**

NHS England will develop guidance for CCGs about the production of this element of their annual report in time for reporting on 2015/16 activity.

NHS England must also produce an annual report as soon as is practical after the end of each financial year. This will include the extent to which it met objectives and requirements specified in the Mandate and an account of how effectively it discharged its duties under section 13Q, the Board's duty for public involvement. The annual report will be laid before Parliament and sent to the Secretary of the State. The Secretary of State will respond to this with an assessment of the Board's performance for the period covered by the Board's report.

Related legislation

The Health and Social Care Act 2012 ('the Act') amends the Local Government and Public Involvement in Health Act 2007 ('the 2007 Act') to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). The Department of Health has produced Statutory Guidance that explains the statutory duties and powers relating to the JSNA and JHWS. In particular it explains the following in relation to involving the local Healthwatch organisation through the JSNA and JHWS process (p.12):

"Health and wellbeing boards must involve the local Healthwatch organisation and the local community, and this should be continuous throughout the JSNA and JHWS process. When involving the local community, boards should consider inclusive ways to involve people from different parts of the community including people with particular communication needs to ensure that differing health and social care needs are understood, reflected, and can be addressed by commissioners. This should recognise the need to engage with parts of the community that are socially excluded and vulnerable. Involvement should aim to allow active participation of the community throughout the process – enabling people to input their views and experiences of local services, needs and assets as part of qualitative evidence; and to have a genuine voice and influence over the planning of their services."

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NHS Act 2006 (as amended)

s.1C Duty as to reducing inequalities (Secretary of State)

In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.

s.13G Duty as to reducing inequalities (NHS England)

The Board must, in the exercise of its functions, have regard to the need to –

- (a) reduce inequalities between patients with respect to their ability to access health services, and
- (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

s. 14T Duties as to reducing inequalities (Clinical Commissioning Group)

Each clinical commissioning group must, in the exercise of its functions, have regard to the need to:

- (a) reduce inequalities between patients with respect to their ability to access health services, and
- (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

Duty to Involve

Chapter 2, Section 242 (applicable to NHS Trusts and NHS Foundation Trusts)

(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in –

- (a) the planning of the provision of those services,
- (b) the development and consideration of proposals for changes in the way those services are provided, and

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- (c) decisions to be made by that body affecting the operation of those services.
- (1C) Subsection (1B)(b) applies to a proposal only if implementation of the proposal would have an impact on –
 - (a) the manner in which the services are delivered to users of those services, or
 - (b) the range of health services available to those users.
- (1D) Subsection (1B)(c) applies to a decision only if implementation of the decision (if made) would have an impact on –
 - (a) the manner in which the services are delivered to users of those services, or
 - (b) the range of health services available to those users.
- (1E) The reference in each of subsections (1C)(a) and (1D)(a) to the delivery of services is to their delivery at the point when they are received by users.
- (1F) For the purposes of subsections (1B) to (1E), a person is a “user” of any health services if the person is someone to whom those services are being or may be provided.
- (1G) A relevant English body must have regard to any guidance given by the Secretary of State as to the discharge of the body’s duty under subsection (1B).
- (1H) The guidance mentioned in subsection (1G) includes (in particular) –
 - (a) guidance given by the Secretary of State as to when, or how often, involvement under arrangements under subsection (1B) is to be carried out;
 - (b) guidance given by the Secretary of State as to the form to be taken by such involvement in any case specified by the guidance.

Equality Act 2010

The [Equality Act 2010](#) legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations. It sets out the different ways in which it’s unlawful to treat someone.

The intention of the general equality duty is to ensure that a public authority must, in the exercise of its functions, have due regard to three main aims:

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- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

- (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

Three useful guidance documents have been produced to support public bodies to meet this duty:

[The Essential Guide to the Public Sector Equality Duty;](#)

[Meeting the Equality Duty in Policy and Decision Making;](#)

[Engagement and the Equality Duty: a guide for public authorities.](#)

Equality Act 2010, Part 11, Chapter 1, Section 149

Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to –

- (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
- (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

Mental Capacity Act (2005)

The Mental Capacity Act gained Royal Assent in April 2005 and was fully implemented in October 2007. It provides a clear legal framework for people who lack capacity, and their family and carers, to be involved as far as possible in decisions about their care. It sets out [key principles, procedures and safeguards](#). [A code of practice](#) was published in April 2007.

The Act sets out [five principles](#):

1. A person must be assumed to have capacity unless it is established that he lacks capacity.

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2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

These principles of the Mental Capacity Act apply whether the decisions are life changing or every day matters. The [underlying philosophy](#) is to ensure that individuals are empowered to make decisions where possible and where this is not possible, that any decision made or action taken is made in their best interests.

The Mental Capacity Act Code of Practice also describes the role of the Independent Mental Advocate Service (IMCA) which was set up under the Act. This service provides support for those particularly vulnerable individuals who lack capacity and have no family or friends so that their views are represented to those working out their best interests.

Anyone who cares for or works with an adult who lacks capacity has a legal duty to act within the bounds of the Mental Capacity Act and its five principles to ensure those individuals are empowered and protected. This is not optional.

The Human Rights Act

The Human Rights Act 1998 (also known as the Act or the HRA) came into force in the United Kingdom in October 2000. All public bodies (such as courts, police, local governments, hospitals, publicly funded schools, and others) and other bodies carrying out public functions have to comply with the Convention rights. The Act sets out the fundamental rights and freedoms that individuals in the UK have access to.

A series of guides produced by the Equality and Human Rights Commission can be found [here](#).

Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

S244 of the NHS Act 2006 (as amended) outlines the duty for NHS bodies to consult the relevant Local Authority Health Scrutiny Committee around the planning and delivery of service change in certain circumstances. Further detail is provided by the [Local Authority \(Public Health, Health and Wellbeing Boards and Health Scrutiny\) Regulations 2013](#).

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The United Nations Convention on the Rights of the Child

The [United Nations Convention on the Rights of the Child](#) (commonly abbreviated as the CRC, CROC, or UNCRC) is a human rights treaty setting out the civil, political, economic, social, health and cultural rights of children. The Convention defines a child as any human being under the age of eighteen, unless the age of majority is reached earlier under a state's own domestic legislation.

Article 12 of the convention states that 'parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'.