

# LEGAL FRAMEWORK FOR THE INVOLVEMENT OF DISABLED PEOPLE

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## ADVICE NOTE

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### INTRODUCTION

1. This Note aims to give an overview of:
  - The legal duties on Local Authorities (**LAs**) and Clinical Commissioning Groups (**CCGs**) to involve disabled people and their representative organisations in decision making in relation to:
    - The design and delivery of services for disabled people, including commissioning;
    - Developing policies which directly affect disabled people;
  - The legal duties on LAs and CCGs to ensure the processes they use for such involvement and engagement are accessible to all disabled people;
  - How a failure to involve disabled people in decisions in breach of the above might be challenged.
2. The intention is that the information in this document is accessible to lawyers and non-lawyers alike.

### SUMMARY

3. There are various statutory duties on LAs and CCGs to involve the public in their decision-making at an early stage. This is underpinned by the Public Sector Equality Duty which flows through all decision-making and requires proper consideration of, and engagement with, disabled people affected by policies and decisions. There are also other duties to involve the public which arise under the bodies' own policies and practices, and also can arise as a matter of fairness to those concerned by the decision-making.
4. LAs and CCGs are required to ensure that public involvement processes are tailored to the needs of disabled people so they can properly participate in decisions which affect them.

5. If these duties are not adhered to, these breaches can be enforced in the High Court via judicial review, and via other methods such as the Ombudsman.

## **DUTIES OF INVOLVEMENT ON LAS AND CCGS**

### **i) The Public Sector Equality Duty**

6. The overarching duty on public bodies such as LAs and CCGs<sup>1</sup> is the Public Sector Equality Duty (“**PSED**”) under section 149 of the Equality Act 2010 (“**Equality Act**”).
7. It requires public bodies, in the exercise of their functions, to have “due regard” to the need to (s 149(1):
  - a. Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
  - 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 people who share a relevant protected characteristic and those who do not share it.
8. “Advancing equality” means 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 (s 149(3)(a));
  - (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 (s 149(3)(b));
  - (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. (s 149(3)(c))

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<sup>1</sup> Both included as public authorities to whom the PSED applies: see Schedule 9 to the Equality Act 2010.

9. In terms of what “steps” might be needed for disabled people (i.e. section 149(3)(b) above), section 149(4) states that:

*“The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons’ disabilities.”*

10. The PSED places a core duty on public bodies to consider the need to achieve these three aims in all decisions they take and policies they develop. The duty is not just a negative one i.e. to have due regard to “*eliminate*” discrimination but also a positive one i.e. to consider how to “*advance equality of opportunity*” as explained above.

11. An example of how this could be used by local authorities is as follows:

*“The duty could lead a local authority to target training and mentoring schemes at disabled people to enable them to stand as local councillors, with the aim of advancing equality of opportunity for different groups of people who have the same disability, and in particular encouraging their participation in public life.”<sup>2</sup>*

12. The PSED is not an “outcome” duty i.e. a duty to achieve specific results but it is intended to ensure that impacts on those with protected characteristics and the potential to advance their equality of opportunity are considered at a formative stage of decision-making. This is usually done by preparing an Equality Impact Assessment (although this is not a statutory requirement, but a way of demonstrating compliance with the duty). Without an EIA, it will be more difficult for the authority to show it has had “due regard”.

13. The Court of Appeal has recently said<sup>3</sup>:

*“59. A heavy burden is imposed by this section on public authorities in discharging their public sector equality duty and in ensuring that there is evidence available, if necessary, to demonstrate that they have done so. The intention seems to be that considerations of equality of opportunity, where they arise,*

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<sup>2</sup> See Explanatory Notes to the Equality Act, paragraph 484 [here](#)

<sup>3</sup> *Bracking v SSWP* [2013] EWCA Civ 1345 *per* McCombe LJ.

*should be central to the formulation of policy by all public authorities, side by side with all other pressing circumstances of whatever magnitude.*

*60. It is for this reason that advance consideration has to be given to these issues and they have to be an integral part of the mechanisms of government... There is a need for a “conscious approach” and the duty must be exercised “in substance, with rigour and with an open mind”. In the absence of evidence of a “structured attempt to focus upon the details of equality issues” ... a decision maker is likely to be in difficulties if his or her subsequent decision is challenged.”*

14. Although the PSED does not contain an explicit consultation or involvement duty, it requires public authorities to have an adequate evidence base for their decision-making, and engagement can clearly assist (and may be required) in developing that evidence base. Engaging with stakeholders and employees will therefore help public authorities to base their policies on evidence, rather than on assumptions.<sup>4</sup>

15. This will not be a legal requirement in every case. But the Courts have recently held that in certain circumstances the PSED does require some level of engagement and/or consultation. The Court of Appeal has said that if the relevant material is not available, there will be a duty to acquire it and this will frequently mean that consultation with appropriate groups is required. At the very least “*the public authority concerned will, in our view, have to have due regard to the need to take steps to gather relevant information in order that it can properly take steps to take into account disabled persons' disabilities in the context of the particular function under consideration.*”<sup>5</sup>

ii) **Duty on CCGs to reduce health inequalities**

16. CCGs are bound by the PSED, but there is also a specific duty on CCGs under section 14Q of the National Health Service Act 2006 (**NHS Act**) to “have regard to the need to:

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<sup>4</sup> See Equality and Human Rights Commission Guidance on Engagement and the PSED [here](#)

<sup>5</sup> See *Bracking* at [25] *per* McCombe LJ. This was in the context of the abolition of the Independent Living Fund. See also the Supreme Court’s decision in *Hotak v Southwark LBC* [2015] UKSC 30.

*“(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.”*

17. This is similar to the PSED in its effect<sup>6</sup>, although the focus is on *health inequalities* which may already exist between different groups of patients in terms of access and outcomes, and how these can be reduced.<sup>7</sup> This takes effect in relation to all CCGs functions including commissioning at all levels.

18. There is guidance on this particular duty for CCGs [here](#). The guidance explains how this duty fits in with wider duties in terms of commissioning for CCGs, which are all worth bearing in mind when considering how the needs of disabled people should be integrated into decision-making:

*“5.2.1 CCGs have duties to:*

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);*
- Exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved (s.14Z1);*
- Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities (s. 14Z11);*
- Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities (s. 14Z15).”*

### iii) **Specific public involvement duties on CCGs and local authorities**

19. What follows is a collection of some of the specific statutory duties of public involvement of relevance here.

#### **A: CCGs**

20. CCGs have a specific duty of “Public involvement and consultation” under section 14Z2 of the NHS Act.

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<sup>6</sup> See *Rose v Thanet CCG* [2014] EWHC 1182 (Admin) at p 123ff.

<sup>7</sup> See *The Queen (on the application of) the Pharmaceutical Services Negotiating Committee and Susan Sharpe v Secretary of State for Health v National Pharmacy Association* [2017] EWHC 1147 (Admin)

21. This requires CCGs to “make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) –

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.’ (emphasis added)

22. There is a corresponding duty on NHS England (s 13Q)<sup>8</sup> and a similar (but not identical) duty of public involvement on NHS trusts and NHS foundation trusts (s 242).

23. It is important to note that the CCG’s duty of public involvement:

- a. applies to planning of services, as well as any potential changes; and
- b. requires that “individuals to whom the services are being provided” are involved<sup>9</sup>; this is not an involvement duty which can therefore be discharged through general representative health bodies – it must be the patients or service users themselves who are involved in decision-making<sup>10</sup>.

24. The method of involvement is not prescribed and will depend on the circumstances. But CCGs are required under s 14Z2 to have published “arrangements” setting out how they will discharge their public involvement duties

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<sup>8</sup> NB where the CCG has been delegated its powers of commissioning e.g. primary care from NHS England, it will be likely that the CCG is exercising the powers and duties of NHS England – see also s 13F (promoting autonomy) s 13G (reducing inequalities – corresponding to s 14Q above), s 13H (duty to promote involvement of each patient), s 13I (patient choice) and the other duties under Chapter A1 of Part 2 of the NHS Act 2006.

<sup>9</sup> See *Keep Wythenshaw Special* [2016] EWHC 17 (Admin) at [69]

<sup>10</sup> Compare s 242 which refers to representatives being sufficient.

which should give details of this. Very often, these “arrangements” do not give very much if any detail (and tend to be in the standard form provided by NHS England which in turn does not appear to comply with the duty or the guidance below). This is a prime area for DDPOs to seek to influence.

25. There are two other key duties of involvement on CCGs:

- a. section 14U of the NHS Act 2006 specifically states that CCGs must promote involvement of each individual, their carer and (should there be any) their representatives in decisions relating to the prevention or diagnosis of illness, or their care or treatment; and
- b. section 14V states that CCGs must, in the exercise of their functions, act with a view to enabling individuals to make choices with respect to aspects of health services provided to them.<sup>11</sup>

26. There is NHS/DoH statutory guidance on both sets of duties which CCGs are required to have regard to in exercising the above duties:

- a. *“Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England”*<sup>12</sup>
- b. *“Involving people in their own health and care”*<sup>13</sup>

27. These statutory duties demonstrate that patient and public involvement must be at the centre of CCG decision making. The reasons for this are explained by NHS England as follows:

*“The links between individual and collective involvement in health are clear; people who have advanced knowledge, skills and confidence to manage their own health are more likely to get involved at a group/community level in having a say about health and health services. Equally, those who have been involved in the commissioning process (planning, buying and monitoring) health services are more likely to be informed about health and health services; they will therefore be better placed to manage their own health and be involved about decisions relating to their care and treatment.*

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<sup>11</sup> See also the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996

<sup>12</sup> which is available at <https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>

<sup>13</sup> which is available at <https://www.england.nhs.uk/publication/involving-people-in-their-own-health-and-care-statutory-guidance-for-clinical-commissioning-groups-and-nhs-england/>

*Voluntary community and social enterprise (VCSE) partners are vital in connecting CCGs and NHS England to people and communities. They can support people to be involved in their own health and care and at a community level, particularly those who experience the poorest health outcomes.”*

#### Duty on CCG to consult local authority in health matters

28. Section 244 of the 2006 Act creates a health review and scrutiny function for local authorities – generally county councils. They must set up a health overview and scrutiny committee.
29. There is a duty on a CCG to consult this local authority body when the CCG is considering “*any proposal for a substantial development of the health service in the area of a local authority*”, or for a “*substantial variation*” in the provision of such service.<sup>14</sup> This in turn then may involve the local authority undertaking (further) public consultation.
30. This gives the local authority the power to give feedback on the proposal and also to refer it to the Secretary of State for Health to resolve any dispute if “*the authority considers that the proposal would not be in the interests of the health service in its area*”. The DoH guidance (2014) on this duty explains how the duty to consult the local authority coincides with the duty to involve the public, with the emphasis on doing so at an early stage of planning:

#### *4.1 The context of consultation*

*4.1.1 The duty on relevant NHS bodies and health service providers to consult health scrutiny bodies on substantial reconfiguration proposals should be seen in the context of NHS duties to involve and consult the public.*

*Focusing solely on consultation with health scrutiny bodies will not be sufficient to meet the NHS’s public involvement and consultation duties as these are separate. The NHS should therefore ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed.”*

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<sup>14</sup> See s 244(2)(c) NHS Act 2006 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, regulation 23 onwards.

## Healthwatch bodies: Local Government and Public Involvement in Health Act 2007

31. Local authorities are required to establish Healthwatch bodies under this Act who are then required to be consulted on various health-related issues: see s 221ff of the 2007 Act.

### **B: Local authority public involvement duties**

32. There are a wide range of duties on local authorities to consult, depending on the function they are exercising.

### Best value duty – funding decisions:

33. Local authorities are under a duty “to make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness” (s 3(1) of the Local Government Act 1999) i.e. the “best value duty”;

34. In deciding how to fulfil this duty, there is a duty to consult:

- i. Council tax payers in the area;
- ii. Non-domestic rate payers in the area;
- iii. Representatives of persons who use or are likely to use services provided by the authority, and
- iv. representatives of persons appearing to the authority to have an interest in any area within which the authority carries out functions.

35. In deciding how, who and in what form to consult, the LA must take into account the Secretary of State’s guidance. That guidance can be found [here](#). It says in particular, at para 3:

*“Authorities should include local voluntary and community organisations and small businesses in such consultation. This should apply at all stages of the commissioning cycle, including when considering the decommissioning of services. In the interests of economy and efficiency, it is not necessary for*

*authorities to undertake lifestyle or diversity questionnaires of suppliers or residents.”*

#### Care Act section 1: well-being duty

36. This section imposes a set of duties on local authorities when exercising functions in relation to individuals under the Care Act 2014 e.g. the provision of care and support, the first being a duty to promote the individual in question's well-being; “well-being” is very broadly defined under s 1. The statutory guidance on the Care Act is available [here](#).

37. In deciding how to do so, the LA must take into account the following factors:

- (a) the importance of beginning with the assumption that the individual is best-placed to judge the individual's well-being;
- (b) the individual's views, wishes, feelings and beliefs;
- (c) the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist;
- (d) the need to ensure that decisions about the individual are made having regard to all the individual's circumstances (and are not based only on the individual's age or appearance or any condition of the individual's or aspect of the individual's behaviour which might lead others to make unjustified assumptions about the individual's well-being);
- (e) the importance of the individual participating as fully as possible in decisions relating to the exercise of the function concerned and being provided with the information and support necessary to enable the individual to participate;
- (f) the importance of achieving a balance between the individual's well-being and that of any friends or relatives who are involved in caring for the individual;
- (g) the need to protect people from abuse and neglect;
- (h) the need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary for achieving the purpose for which the function is being exercised.

38. A number of these factors will plainly require direct involvement with the person for who the LA is considering providing services or otherwise taking steps to improve their well-being: in particular (b) (wishes and feelings) and (d) (regard to all individual's circumstances) & (e) (importance of participation). There are also specific duties to do so elsewhere in the Act (e.g. s 25(3): duty on the LA to involve both the adult and any carer that the adult has in the preparation of a care and support plan).

39. Regard should be had to the Care Act guidance on well-being (see Chapter 1).

Care Act: sections 5 (promoting diversity and quality in services) and 6 (co-operation)

40. Section 5 places LAs under a “market shaping” duty to “*promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market—*

*(a) has a variety of providers to choose from who (taken together) provide a variety of services;*

*(b) has a variety of high quality services to choose from;*

*(c) has sufficient information to make an informed decision about how to meet the needs in question” (S 5(1)).*

41. The detail of this duty is outside the scope of this Note but s 5(2) provides importantly, for the purposes of involvement:

*“(2) In performing that duty, a local authority must have regard to the following matters in particular—*

*(a) the need to ensure that the authority has, and makes available, information about the providers of services for meeting care and support needs and the types of services they provide;*

*(b) the need to ensure that it is aware of current and likely future demand for such services and to consider how providers might meet that demand;*

*(c) the importance of enabling adults with needs for care and support, and carers with needs for support, who wish to do so to participate in work, education or training;*

*(d) the importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not);*

*(e) the importance of fostering continuous improvement in the quality of such services and the efficiency and effectiveness with which such services are provided and of encouraging innovation in their provision;*

*(f) the importance of fostering a workforce whose members are able to ensure the delivery of high quality services (because, for example, they have relevant skills and appropriate working conditions).*

42. As to the market shaping duty under s 5, it is clear that involvement with stakeholders such as DPDOs is envisaged. Chapter 4 of the Care Act guidance ([here](#)) makes various references to the importance of involvement. It explains that:

*4.6 **Market shaping** means the local authority collaborating closely with other relevant partners, including people with care and support needs, carers and families, to encourage and facilitate the whole market in its area for care, support and related services....*

*4.7 The core activities of market shaping are to engage with stakeholders to develop understanding of supply and demand and articulate likely trends that reflect people’s evolving needs and aspirations, and based on evidence, to signal to the market the types of services needed now and in the future to meet them, encourage innovation, investment and continuous improvement.*

43. In particular, the Guidance discusses “Co-production” at 4.51 as follows:

*4.51 Local authorities should pursue the principle that market shaping and commissioning should be shared endeavours, with commissioners working alongside people with care and support needs, carers, family members, care providers, representatives of care workers, relevant voluntary, user and other support organisations and the public to find shared and agreed solutions. This should be in line with the Building Capacity and Partnership in Care Agreement. The TLAP<sup>15</sup> guidance on co-production may be helpful, in particular the web-based tool People not process – Co-production in Commissioning concept of “market shaping.”*

44. Paragraph 4.55 explains that “A co-produced approach will stress the value of meaningful engagement with people at all stages, through design, delivery and

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<sup>15</sup> Think Personal Act Local; their guidance on co-production is available on their website.

*evaluation, rather than simply as 'feedback'. Local authorities should publish and make available their local strategies for market shaping and commissioning, giving an indication of timescales, milestones and frequency of activities, to support local accountability and engagement with the provider market and the public."*

45. Also relevant is that LAs are also under important duties of co-operation with other bodies under the Care Act in relation to its functions concerning care and support. LAs must cooperate with:

- a. its "relevant partners" (which are other local authorities, NHS bodies and others: see s 6(7)); and
- b. importantly, "*such other persons as it considers appropriate who exercise functions, or are engaged in activities, in the authority's area relating to adults with needs for care and support or relating to carers*": s 6(2).

46. Examples of those "other persons" whom the LAs may wish to cooperate with include service providers meeting adults' needs for care and support, carers' needs for support or services, facilities or resources of the kind referred to in section 2(1) (i.e. services for preventing and delaying care needs arising): s 6(4)(a). This part of the Act will be able to be relied on by DPDOs to encourage co-operation with service providers for disabled people and their carers in appropriate cases.

47. The examples also include:

- a. a person who provides primary medical services, primary dental services, primary ophthalmic services, pharmaceutical services or local pharmaceutical services under the National Health Service Act 2006; and
- b. a person in whom a hospital in England is vested which is not a health service hospital as defined by that Act;
- c. a private registered provider of social housing (s 6(4)(b)-(d)).

48. The LAs are required to co-operate to achieve the following aims:

- (a) promoting the well-being of adults with needs for care and support and of carers in the authority's area,

- (b) improving the quality of care and support for adults and support for carers provided in the authority's area (including the outcomes that are achieved from such provision),
- (c) smoothing the transition to the system provided for by this Part for persons in relation to whom functions under sections 58 to 65 are exercisable,
- (d) protecting adults with needs for care and support who are experiencing, or are at risk of, abuse or neglect, and
- (e) identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect and applying those lessons to future cases.

49. The Care Act guidance addresses the duty of co-operation and integration in detail in Chapter 15 [here](#).

#### Children and Families Act 2014

50. There is a duty on LAs to “support and involve” children and young people under section 19 when exercising its functions in relation to them under the Act.

51. A LA must have regard to the following matters in particular (which reflects the Care Act)—

- (a) the views, wishes and feelings of the child and his or her parent, or the young person;
- (b) the importance of the child and his or her parent, or the young person, participating as fully as possible in decisions relating to the exercise of the function concerned;
- (c) the importance of the child and his or her parent, or the young person, being provided with the information and support necessary to enable participation in those decisions;
- (d) the need to support the child and his or her parent, or the young person, in order to facilitate the development of the child or young person and to help him or her achieve the best possible educational and other outcomes.

52. This plainly requires the involvement of the child or young person involved and any relevant parent or carer in the relevant decision making.<sup>16</sup>

53. In relation to specific matters under the Act there are also specific consultation duties. For example, in relation to a local offer for children and young people with special education needs or a disability (under section 30), the local authority is required to consult the children and young people with special educational needs and a disability, and their parents of children with special educational needs (along with a whole list of other educational and other bodies): see (SI 2014/1530).<sup>17</sup>

#### Other duties of consultation

54. There are various other duties on local authorities to consult and involve the public and/or particular groups of the public: e.g. Neighbourhood planning under the Localism Act 2011, and consultation with tenants under the Housing Act 1996. It is beyond the scope of this Note to go through all of these.

#### **iv) Other potential sources of the duty to consult and/or involve**

55. Even if there is no statutory duty to consult, a duty to consult particular service users can arise at public law either:

- a. under the PSED duty or under the health inequalities duty (as above) if the information is required for a lawful assessment of that duty;
- b. or at common law as a matter of fairness. This can arise either because there has been a promise to do so or practice of consultation in the past by the authority in similar situations (often called “legitimate expectations”), or there might be a commitment in a particular policy to do so, or in certain cases because it would be completely unfair not to consult people in a certain situation before removing a previous benefit.<sup>18</sup>

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<sup>16</sup> An argument regarding a failure to involve under the 2014 Act was raised in *R (on the application D and litigation friend SA) v Brent Council* [2015] EWHC 3224 (Admin) but was rejected on the facts (there had been and was ongoing involvement.)

<sup>17</sup> See for a recent case on these duties *R (L & P) v Warwickshire CC* [2015] ELR Mostyn J

<sup>18</sup> See for a summary of the principles *R (L & P) v Warwickshire CC* [2015] ELR Mostyn J and *Moseley v Haringey LBC* [2014] UKSC 56.

- c. in certain cases, under the Human Rights Act 1998, especially Article 8 ECHR which protects a person's right to respect for their private and family life and home<sup>19</sup>. Where decisions engage Article 8 ECHR, there may well be a procedural obligation to involve the person concerned in decisions made about them, and to ensure that clear criteria are available in respect of those decisions. Two examples of this are i) where a decision is being taken which will affect the person's home (such as in the case of *Coughlan*<sup>20</sup> where a LA's decision to close a care home was said to require prior consultation with the Claimant in that case because of the impact on her of losing what had been promised to be her "home for life") and ii) decisions by a health body which affect physical or psychological integrity or dignity (such as in the case of *Tracey*<sup>21</sup> in which the Court held that there was a duty on the hospital to consult the patient and her family before issuing a Do Not Resuscitate notice and to ensure the criteria for doing so were clearly available to her). Whether such an issue arises and/or adds anything to the other statutory duties in place will depend on the circumstances of the individual case.

### **LAS & CCGS' DUTIES TO ENSURE ACCESSIBLE ENGAGEMENT PROCESSES**

56. The core obligation on LAs and CCGs to make their public involvement processes accessible to disabled people is the "duty to make reasonable adjustments" for disabled people under the Equality Act and to avoid disability discrimination.
57. If a practice of a LA or CCG (i.e. a consultation process) puts a disabled person at a "substantial disadvantage" when compared with persons who are not disabled, the LA or CCG is required to take such steps as it is reasonable to take to avoid the disadvantage<sup>22</sup>. So, this could extend to providing a braille or audio

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<sup>19</sup> Procedural obligations also apply in relation to other human rights e.g. Article 2 (right to life) and Article 3 (right to freedom from inhuman and degrading treatment). However, it seems likely that Article 8 is most applicable here.

<sup>20</sup> *Regina v North and East Devon Health Authority ex parte Coughlan* [2001] Q.B. 213

<sup>21</sup> *Regina (Tracey) v Cambridge University Hospitals NHS Foundation Trust* [2014] EWCA Civ 822; [2015] Q.B. 543

<sup>22</sup> Sections 20 and 29 of the Equality Act 2010, and also section 15 in relation to disability discrimination.

version of a consultation document, or ensuring that public meetings held are fully accessible to wheelchair users and/or others with physical or mental barriers, and /or that there is appropriate consultation with disabled groups with particular needs or barriers to traditional forms of consultation (e.g. learning disabled users).

58. This obligation is also triggered by the various other duties:

- a. The PSED requires LAs and CCGs before deciding how to do something (e.g. run a public involvement process) to consider how they will exercise that function having regard to the need to eliminate discrimination of disabled people, and to consider taking steps to meet disabled people's needs and eliminate disadvantage in relation to those needs;
- b. The requirement to involve individual patients and service-users in decision-making includes specific obligations to ensure e.g. that their wishes and feelings are considered, and that they can participate in decision-making involved with the appropriate support needed to do so,<sup>23</sup>
- c. The statutory guidance and other policies on the involvement duties (noted above) explain the methods which should be used to ensure the involvement is accessible to all users;
- d. LAs' and CCGs' statements of community involvement / public involvement policies should explain how they will go about this (and this should include some provision for disability access); they are required to follow these policies, unless they have good reason to do so;
- e. The Government's published principles on a fair consultation [here](#) explain that a body should "*consider how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.*"
- f. As a matter of common law fairness i.e. a consultation cannot be a fair one if it is designed in such a way that a main group affected (e.g. deaf

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<sup>23</sup> e.g. Care Act, s 1, Children and Families Act 2014, s 19, and s 14U NHS Act 2006.

people who access a particular community service threatened with closure) cannot access it.<sup>24</sup>

## **CAN A FAILURE TO INVOLVE DISABLED PEOPLE BE CHALLENGED LEGALLY?**

59. Yes, is the short answer, depending on the circumstances.

60. If a decision has been made without appropriate public involvement, then this can be challenged in a number of ways.

- a. A complaint could be made to the local authority or CCG via their own internal process; often, if the decision has yet to be finalised, involvement may be able to occur properly at this stage;
- b. If the decision has been taken, it may be possible to challenge it by way of judicial review in the Administrative Court (a division of the High Court). This is subject to very tight time limits: a claim must be brought promptly and in any event within 3 months at the latest. Urgent action should be taken via a solicitor as soon as it becomes apparent that a decision is being threatened or has been made, and a pre-action letter can be written (this may persuade the LA or CCG to think again). Failing that, it may be possible to bring a claim for judicial review.

61. What would the grounds be for a claim? A legal claim can be brought by judicial review if:

- a. there is a statutory (or other) obligation to consult or involve the public which has not been followed,
- b. or if the process followed was flawed (too short, inaccessible) or did not give a proper explanation of the options or e.g. the alternatives were not explained;
- c. it may also be possible to argue that the consultation was not done at the right time i.e. the decision being put forward had already been taken;

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<sup>24</sup> A lawful consultation must i) be at a time when proposals are still at a formative stage; ii) include sufficient reasons for any proposal to permit of intelligent consideration and response. iii) include adequate time must be given for consideration and response and iv) the product of consultation must be conscientiously taken into account in finalising any statutory proposals: see *Moseley* (above). It must also be fair as a whole. If a process excludes a group then it cannot be treated as giving *them* sufficient reasons to permit of proper consideration, nor giving *them* adequate time for the response if they are unable to access it in the first place.

- d. it may also be possible to argue that the decision-maker has failed to understand or take into account what was said in the consultation in the decision-making process;
- e. it may also be possible to argue that the PSED or health inequalities duty was not properly considered, for example, because there was inadequate involvement with the relevant groups, or because the equality impact assessment does not explain the impacts that were pointed out via the consultation.

62. The potential risk with challenges to consultation processes is that it can in some cases be too late to change the decision by that stage. The Court on a judicial review claim is usually limited to ordering the public authority to do the consultation process again or to go back and take the decision properly. The Court does not have the power to make the decision itself. This can mean that, if the Court thinks the same decision would be taken even if the consultation was carried out, it may not take any action other than indicating that the LA or CCG got it wrong. However, there may be major points that were not considered which could well have changed the position, or it may be that the consultation would have resulted in the matter being resolved by the Secretary of State for Health (e.g. in a substantial change to healthcare provision).

63. It may also be possible or advisable to complain to the Local Government or Parliamentary & Health Service Ombudsman if there has been maladministration in the process. The Ombudsmen have the power to recommend financial awards to reflect financial losses or distress and inconvenience.

**ZOE LEVENTHAL**  
**Matrix Chambers**  
**22 November 2017**