The Health and Social Care Act 2012
Your guide to the Act and what it means for you

NHS Confederation 2012
www.mills-reeve.com
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In this NHS Confederation special, we take stock following the enactment of the Health and Social Care Act 2012 as we await further commencement orders and secondary legislation.

We are very grateful to Nigel Edwards for providing a foreword to this conference special as well as for chairing of our very successful Mental Health Conference held at the King’s Fund earlier this year.

Our specialist teams have analysed the key provisions of the Act and assessed their impact on health and social care providers, commissioners and regulators. We have prepared a range of publications looking at how the changes brought about by the Act will impact on your business; how to take advantage of the reforms and how to mitigate any new or increased risks.

The end point of the current reforms is clearer. However, the real impact of the reforms depends not on their design, but on implementation, making this an important time for the health sector.

Sir David Nicholson said that meeting the delivery challenge of the White Paper “requires a relentless focus on implementation”. The task of implementation lies now in the hands of others, beyond government, who may re-interpret the vision and have their own priorities. Whether these reforms deliver on the government’s vision and have the desired impact of improving outcomes, will depend on the actions of the new national and local entities.

However, this structural change and legislative changes are overshadowed by the current huge financial challenge. What keeps chief executive officers and senior NHS managers awake at night is how they are going to make four per cent efficiency changes each year until 2015 and still ensure that local services stay safe and viable. They know they need to make changes as to how hospitals and primary care work in the future and that mergers and difficult decisions will be required.

Also, while working through the changes required by the Act, the NHS is also braced awaiting Robert Francis QC’s report of the public inquiry into the shortcomings of Stafford hospital and its regulators. As NHS managers focus on implementing this radical reorganisation, they need to be ready to adapt the new NHS system even further once the requirements from the Francis report are published.

We would be very interested to hear your views, and any information you may have on the various articles covered in our publication. Please feel free to contact the individual authors or simply use my contact details above to get in touch.
Now the Health and Social Care Act – the largest single piece of legislation on the NHS ever – is finally on the statute book attention has shifted to what it will mean in practice. There are a number of uncertainties, risks and opportunities.

The first uncertainty is whether new methods of central control will be developed. Although a number of the traditional levers of power have been removed there are signs that new ones are emerging. Academic health science networks, clinical networks and the development of commissioning guidance that CCGs will be expected to follow, create some new dynamics that put the emphasis on more standardised approaches and have the potential to create new levers. The NHS Commissioning Board’s (NHSCB) control over primary care and specialist commissioning and potentially the approach of clinical networks could also prove influential mechanisms if the NHSCB chooses to use them.

A second uncertainty is how Monitor will operate as a competition regulator that is also required to promote integration. This makes both its price setting and market management roles much more complex than before the Future Forum.

CCGs are proving to be very diverse and many at present appear to be consumed with authorisation. They are going to have to get to grips with some very difficult issues that they have inherited and find some new ways of working that makes the best use of a fairly limited management resource. They will have to address the need for change in the shape of the provider system, including the challenging task of getting to grips with primary care performance when they don’t hold the contract will be important.

Meanwhile, another new actor, the Trust Development Authority, will have the unenviable task of getting over 100 organisations to FT status, taken over or broken up. Many of these have not met the FT criteria for reasons that are not just because of a lack of grip. Deep unresolved issues remain and it is far from clear whether the unsustainable provider regime will solve them – expect to see this tested fairly soon.

In Mental Health, at a recent seminar run by Mills & Reeve at the King’s Fund, we heard about the ambition to implement the national strategy and to invest in recovery, personalisation and improved outcomes. But the impact of the reforms has been to hold back progress. There are many uncertainties here including the financial position, the continued absence of a tariff and the squeeze that is affecting local government and the voluntary sector. There is great vision but mental health commissioning has often been the poor relation – can the CCGs raise the game here and do so quickly? It’s not clear.

Finally, there is a major concern about social care. Many councils are starting to warn that within a few years their entire budget will be consumed by social care. This almost certainly means that increased pressure will come on NHS budgets both locally and nationally. Expect to see the flat real settlement for the NHS becoming negative as money for health is increasingly channelled to stave off a crisis in care for the vulnerable elderly.

I wonder if in common with all the reforms of the last 12 years, what will mark out the successful from the “also ran” will be the ability to carve out their own vision and make it happen, not wait to be told what to do? This time though they will also need to have some very radical approaches to changing the design of their services.
Spelling out the challenges

Jill Mason, head of mental health and patient-related law
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I am not quite sure where the time has gone but here we all are at the NHS Confederation Conference again. We would love to talk to you now or post Confed about all the interesting, current, topical issues affecting the health sector of which there are many! Do get in touch.

C Consultation: when do you have a duty to consult and how will you approach making changes to health services? CCGs - how are you getting on drafting your constitutions? Take a look at our commissioning portal: www.commissioningportal.co.uk

O Overwhelmed: this may be how you are feeling at the moment! We can steer you through the tsunami of legislation and guidance expected over the coming months.

N Nicholson challenge or NHS Commissioning Board – both ever present and playing a large part in everything you do. NHS Constitution – don’t forget to have regard to that. No decision about me without me - relevant to consultation and so much else. NICE has an expanded title and functions – let us help you to apply their guidance and hopefully avoid any judicial reviews!

F Francis: we await the report on Mid Staffordshire Hospitals NHS Foundation Trust (now due out in October) with baited breath. Foundation Trusts – we can help you with constitutional issues, governor training, mergers and acquisitions and private charges.

E Equality Duty: this applies when you are exercising any of your functions. Estates are in the spotlight given the arrival of Prop Co – let our Real Estate experts guide you through how this will work.

D Duties: everyone has them from the Secretary of State downwards. With duties come responsibilities and is an area ripe for judicial review. Dental services contracts and list management - always a thorny area along with that relating to pharmacists. How will national and local management play out?

E Efficiency savings: we are working with our clients to deliver our services to you in a cost effective and innovative way – ask us about our Tailored Inquest Service or Health Procurement Portal.

R Regulators: CQC has a new Chief Executive and Monitor is expanding its role. How will they be operating and how will you respond?

A Any Qualified Provider: who are the new kids on the block? Authorisation – will your CCG or CSS get through the hoops? Arms Length Bodies – many are being abolished so where will their functions transfer to?

T Trusts: soon to be more. If you are not already a Foundation Trust can we assist you with your preparations? Large scale transfers of employees are prevalent - does TUPE apply to you?

I Integration is the word of the moment: how are you going to achieve service improvement? Implementation – how will all the reforms impact on a day to day basis? Inquests – with the focus on quality and Coroner’s becoming ever more exacting you will find that more time is needed to prepare properly for these. Information Governance – the Information Commissioner is increasing the levels of fines so this area is gaining a higher profile by the minute. Be particularly aware of your responsibilities through this transition period.

O Outsourcing: is this something you are thinking of. One of our commercial health specialists can talk you through the complexities. Overview and Scrutiny- how will your Local Authority be exercising its powers? The requirement to consult them now applies to a wider audience.

N NHS: remember it’s great and the envy of many countries
**Who we are**

We work with over 100 NHS bodies including acute trusts, mental health trusts, ambulance trusts, primary care trusts and clinical commissioners, and strategic health authorities. We would love to talk to you about how we can add value for your team.

If you would like to talk to us about how Mills & Reeve can help you achieve your ambitions, please contact one of our specialist partners below, or read a little more about us at [www.mills-reeve.com/health](http://www.mills-reeve.com/health).

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Commissioning

General duties of clinical commissioning groups (CCGs):

What's changed?
Primary care trusts have always had, under the National Health Service Act 2006 and earlier legislation, a number of general duties to exercise their functions in a particular way. These general duties can be distinguished from their specific duties eg, to arrange for the provision of primary care services, to involve and consult the public and in relation to internal financial matters.

Under new provisions to be introduced into the 2006 Act CCGs' general duties include a number of notable additions to those that currently apply to primary care trusts. The following are of particular note and will in our view have a significant impact on the way that CCGs do business as compared to their statutory predecessors.

NHS Constitution
Firstly, CCGs will have a general duty to promote the NHS Constitution in the exercise of their functions and to act both so as to ensure that health services are provided in a way which promotes the NHS Constitution, and so as to promote awareness of the Constitution among patients staff and the public. The Health Act 2009 placed a far less prescriptive statutory duty on all NHS bodies, including primary care trusts, to have regard to the NHS Constitution but the prescriptive provisions of the new duties are entirely new. The explanatory notes to the Act interpret the duty to promote NHS constitutional awareness as meaning that CCGs must ensure that people are made aware of their NHS constitutional rights, including by contributing to the advancement of the Constitution's principles, rights, responsibilities and values through their own actions and through facilitating the actions of stakeholders, partners and providers.

Quality
Secondly, CCGs will have a general duty to exercise their functions so as to improve the quality of services, specifically primary medical services (even though they will not be the commissioners of those services, but the providers), and in doing so must act with a view to continually improving outcomes. Outcomes are defined as including effectiveness and safety of the services provided and the quality of patient experience. In complying with this duty CCGs must at the same time have regard to guidance published by the NHS Commissioning Board (the Board), and must specifically assist and support the Board in discharging its duty to secure continuous improvement in the quality of primary medical services. This broad duty contrasts with the current limited duty on primary care trusts to improve the quality of “health care” provided to patients with regard to published standards only, with no mention of outcomes or patient experience.

No decision about me without me
Thirdly, CCGs have a duty to promote individual patient involvement in the form of shared decision-making with patients (and their carers and representatives) about their own care, in line with the commitment outlined in the White Paper, Equity and Excellence: Liberating the NHS to the policy of “no decision about me without me”. The Board has a duty to publish guidance on how CCGs are to discharge this duty and CCGs must have regard to that guidance. Therefore, in contrast to the NHS Act 2006 there is a specific duty in the Act to involve patients in decisions about the provision of services generally (which will also apply to CCGs), this duty relates to decisions about an individual’s healthcare and requires patient participation in treatment decisions and the provision of support to patients to enable them to make informed choices about their own healthcare.

Public involvement and consultation
There is a requirement for CCGs and the Board to make arrangements to secure public involvement and consultation in:
the planning of commissioning arrangements;

- the development and consideration of proposals for service change where they would have an impact on the range of services provided and/or the manner in which they are provided; and

- decisions affecting the operating of commissioning decisions

Essentially this reflects the duty that applied to PCTs under s242 NHS Act 2006. In addition, each CCG must set out in its constitution a description of the arrangements made by it to fulfil this duty and a statement of the principles it will follow in implementing those arrangements.

The Board may publish guidance on how to discharge duties under this section and CCGs must have regard to that.

The explanatory notes suggest at paragraph 331 that the Board could give guidance on:

- effective ways of engaging and seeking views from members of the public including how to engage people who do not regularly use healthcare services or are from disadvantaged communities; and

- helping CCGs decide in what circumstances the duty to involve might most appropriately be met by providing information and in what circumstances a CCG should actively seek people’s views through consultation.

Choice

CCGs have a general duty to act with a view to enabling patient choice and it is this duty that may have the most significant impact on CCG behaviour as compared to that of primary care trusts. The explanatory notes to the Act interpret this duty to mean, for example, that CCGs must commission services so as to allow patients a choice of treatments or a choice of providers. This could mean that, to comply with this duty, CCGs may need to aim to commission a range of treatments from more than one provider in order to provide patient choice. Therefore, when tendering for services it may not be appropriate for CCGs to limit themselves to selecting one preferred provider from whom to commission one treatment, but may instead be looking, wherever possible, to commission alternative treatments from two or more preferred providers. This is likely to result in more service providers and greater fragmentation of services.

Integration

Finally, CCGs will have a completely new duty to promote the integration of health services with health-related or social care services, where this would benefit patients by improving quality or reducing inequality of either access or outcome. However, it should be noted that integration of services is not the aim itself, but it is to be used as a tool to encourage service improvement.

Who does this affect and how?

The need to have regard to all the general duties will affect CCG members and their governing bodies. They will need to bear these duties in mind in everything they say and everything they do and will, most importantly, have to be able to evidence that they have considered their statutory duties in every commissioning decision which they make. The risks of not doing so, or not being able to evidence that you have done so, even if you have, will be to expose the CCG to challenge in the courts.
What do I need to do differently?
We are seeing a significant increase in legal challenges to commissioning decisions. When taking decisions that will involve cutting or even just reorganising services, CCGs will need to work on the basis that every part of the decision-making process will be scrutinised, from Board meetings approving budgets to individual commissioning decisions. Not only is it essential for CCGs to consider their consultation and public sector equality duties; they need to ensure that they have evidence that the duties set out above were considered and taken into account whenever relevant.

Consider this example: a CCG cuts a service, following a consultation exercise, but that exercise makes no reference to the duties to enable patient choice or to promote the integration of health services. The cut follows a Board meeting where a challenging budget was approved and the minutes of that meeting make no reference to these duties either. This absence of evidence that the duties were considered by the decision-makers, or that they informed the consultation exercise, may well be used by patients or providers to challenge the decision by a judicial review. The focus of a judicial review is not on the merit of the decision, it is on whether the public body which took the decision has followed the proper process. This includes whether it has taken into account those things that it is lawfully required to take into account.

So, CCGs need to be aware of these duties; they need to take them into account when making commissioning decisions; and they need to clearly record the fact that they have done so. There will be those who think that the list of requirements and processes that are involved in commissioning has become unnecessarily bureaucratic and burdensome, which will prevent CCGs from acting quickly to implement service redesign. The counter argument, is that these new duties and other obligations, such as the duty to consult, reinforce that CCGs are taking decisions about the public; for the public; using the public's money. Time will tell whether the quality of decision-making is improved or if we risk seeing an ever greater number of court challenges to commissioners, diverting them from the tasks they have been set up to carry out.

For further information or advice please contact Philip Grey on 01223 222463 or Julie Jordan on 01223 222478.

National Health Service Commissioning Board
The Board will be subject to a duty, concurrently with the Secretary of State (SoS), to promote a comprehensive health service in England (as set out in section 1 of the NHS Act 2006). It will commission some of the services itself including primary care and specialised services and will have a key role in relation to CCGs.

The main features of the Board are as follows:

- It will be accountable to the SoS for meeting the requirements outlined in a document called the mandate. Ministers will set the Board’s objectives, requirements and financial allocation through the mandate. The mandate itself will be subjected to consultation, publication and consideration in Parliament. Proposals for the first mandate are currently being developed with the aim of consulting on them this summer.

- The Board will become a full statutory body in October 2012 and most CCGs are expected to be authorised by April 2013. The Board will take over full responsibility for the £80billion NHS commissioning budget from April 2013.

- Before the start of each financial year, the Board must publish a business plan setting out how it proposes to exercise its functions in that year and each of the next two financial years. After each financial year, the Board must publish a report on how it exercised its functions during the preceding year. The Board will have a duty to break even each financial year and directions will be issued containing further details on use of funding.
The Act places various shared duties on the Board and CCGs including: promoting the NHS Constitution; ensuring effectiveness and efficiency; securing continuous improvements in the quality of services commissioned; reducing inequalities; enabling choice; promoting patient involvement; securing integration; promoting education and training, innovation and research. For a more detailed review of these duties see the section above on commissioning.

The Board also has specific duties including: promoting autonomy; ensuring regard is given to the impact on services in certain areas (ie; to have regard to the possible consequences of its commissioning decisions on the provision of health services to those living in areas of Scotland or Wales close to the English border); avoidance of variation in provision of health services (the Board must not, as part of its functions, set out to vary the proportion of services delivered by providers due to their status, ie, public or private sector).

The Board is required to obtain advice from people with “a broad range of professional expertise”. In undertaking this, input can be sought from clinical senates and clinical networks (although these bodies are not mentioned in the Act). The Act also calls for close working with Health and Wellbeing Boards (H&WBB).

The Board will oversee CCGs and they will be financially accountable to it. The Board will also provide guidance and advice to CCGs.

Authorisation of a CCG by the Board will only happen if certain criteria are met (eg, that the CCG has the means to undertake commissioning responsibilities; an accountable officer; a governing body with lay and wider clinical membership; a constitution which outlines processes for decision making, accountability and dealing with any conflicts of interest). The final draft authorisation guide for CCGs published following approval by the Board on 13 April 2012 can be accessed online.

Where the Board is commissioning services it will be subject to competition provisions, including the duties to comply with good procurement practice and promote competition.

While much information is available on the Board, there is a range of detail that is still missing and requires secondary legislation, further regulations, guidance and operational development. We have highlighted some of the areas where uncertainty remains. These include:

- **SoS’s mandate**: how it will look, what the specific requirements will be and how the Board’s performance will be measured against it, and the scope of the “choice mandate”.
- **Organisational structure**: the final structure and responsibilities of the Board’s directorates, and precise details of the 50 local offices, including London.
- **Legislative duties**: how the Board will reconcile the numerous potentially conflicting duties it has. For example, promoting integration and education and training, at the same time as promoting patient choice (and thereby competition).
- **Pricing**: whether the Board will make any significant changes to the national tariff and other pricing mechanisms (Commissioning for Quality and Innovation payment framework, best practice tariff).

In addition to setting the Board’s mandate, the SoS has powers of intervention if the Board is failing to discharge its functions. This has led some to question how free the Board will be from central control. In a recent interview with the Health Service Journal commissioning Board chair, Professor Malcolm Grant is
quoted as saying that the DH’s “grip” and top down approach to the management of the service would have to loosen and allow leaders to follow a philosophy of “assumed liberty” for CCGs, as opposed to “earned autonomy”.

For further information or advice please contact Tania Richards on 01223 222476 or Gill Thomas on 01223 222237.

Integrated service provision and partnering arrangements

The Act imposes a duty on both the Board and CCGs to commission in such a manner so as to promote integration. This is integration across health providers and integration between health and social care services. Service provision must be integrated where this will improve the quality of services, reduce inequalities in relation to accessing services or reduce inequalities in respect of the outcomes of such services.

There is however, little in the Act regarding how integration is to be achieved. The duty undoubtedly puts an obligation on commissioners to consider integrated service provision as an integral part of commissioning decisions. It will be difficult to demonstrate how this duty is fulfilled if services are commissioned in isolation from one another, without strategic consideration of the impact service delivery under one contract or in one specialism may have on other aspects of service provision.

The Act also emphasises the importance of joint working between CCGs and across health and social care. One or more CCGs may delegate the exercise of its functions to another CCG or CCGs may exercise their functions jointly. CCGs will also have the flexibility primary care trusts currently enjoy with local authorities to establish pooled funds to discharge these commissioning arrangements. Similarly, the Board must encourage CCGs to enter into partnership arrangements with local authorities under section 75 of the NHS Act 2006 where this will secure integrated service provision (although further legislation is required to enable this to happen).

Similar obligations are imposed on local authorities. The Act amends the Local Government and Public Involvement in Health Act 2007 and requires local authorities in conjunction with their partner CCG to prepare a strategy for meeting the needs of their local population. This strategy must consider the extent to which local needs can be more effectively met by partnering arrangements between CCGs and local authorities.

Finally, similar obligations are placed on H&WBBs. They must work in an integrated manner and provide advice, assistance and other support to encourage partnership working between CCGs and local authorities under section 75 of the NHS Act 2006.

The Act delivers on what was proposed in the White Paper by making partnerships between health and local authorities a preferred approach to commissioning rather than one of many options. This is then underpinned by making integration a duty on commissioners, something that has not been in the statute book to date. The balancing act for commissioners will be promoting patient choice and competition on the one hand with integrated commissioning on the other.

For further information or advice please contact Gill Thomas on 01223 222237 or Jayne Herlihy 0121 456 8280.

Providers

Provider services: independent/voluntary sector/Any Qualified Provider (AQP) policy

The changes highlighted elsewhere in this update have a mixed (but, overall positive) impact upon independent sector providers. There should be more opportunities, but there will also be an increase in regulation. Some of the key developments for the independent sector are highlighted below.
Any qualified provider (AQP)
Although not specifically mentioned in the Act, much of the opportunity for non-NHS providers will be driven by the AQP commissioning model. This is being developed as the way in which choice can be offered to patients, as well as a way of driving up standards as local providers compete for a patient’s affection.

By September 2012, many patients will be able to choose from at least three locally selected providers of community and mental health services. Local commissioners have already decided on the first wave of services based upon local need. The most popular choices were adult hearing services, podiatry and diagnostic services.

From 2013/14, CCGs and the Board will add further services.

Further secondary legislation protecting and promoting patient choice is anticipated.

Licensing regime
Monitor, which is currently the regulator of foundation trusts (FTs), will in future be the economic regulator for all healthcare providers. Monitor’s main duty is to exercise its functions to protect and promote the interests of patients by promoting healthcare services that are economic, efficient and effective, and maintain or improve quality.

These duties must be exercised with a view to preventing anti-competitive behaviour “which is against the interests of people who use health care services”. The language is notable for the absence of a duty to promote competition.

In order to do this, Monitor will license all providers of NHS services, including those in the independent sector, imposing such conditions as are necessary in order to deliver its obligations. Current NHS FTs will be deemed to have made an application while other providers will need to make formal applications in accordance with published criteria. The Act allows for exemptions to be created and for standard conditions and special conditions to be made.

Exactly when the regime will begin to apply to independent sector providers is not yet clear, but could be as early as April 2013.

The whole licensing regime is in addition to Care Quality Commission (CQC) registration although Monitor and CQC are expected to work towards a joint-licensing regime.

Commissioning
Under the Act, regulations may be introduced to require the Board and CCGs to adhere to good procurement practice, protect and promote patient choice and refrain from anti-competitive behaviour.

These regulations may also impose requirements relating to competitive tendering and management of conflicts. They may give powers to Monitor to investigate failings (for example) and, where failings are sufficiently serious, declare that awarded contracts are ineffective and to direct that services be tendered.

These powers should ensure patient choice is not curtailed by constraints imposed by commissioners in the same way which they tried to influence choice of providers of elective care services under the AWP scheme. This should result in a more level playing field for all organisations wishing to provide NHS services.

There is an expectation that one of the consequences of the Act will be more tenders for clinical services. Under the Act, the SoS can pass regulations to ensure that commissioning adheres to good practice and impose
requirements to competitively tender. This would mean that the current policy position is likely to be embedded in law, giving a much stronger remedy for unsuccessful bidders where there has been a breach.

While this is likely to lead to increased market opportunities, it may act as an impediment to the development of innovative approaches to service delivery given the constraints of the competitive tendering process.

As mentioned elsewhere in this update, the Board and CCGs now have a duty to promote integrated health and social care services. This is the first time the duty has been imposed and it is likely to impact on the way services are commissioned; how NHS bodies work together; and how the NHS and local authorities work together to commission services.

Increase in numbers of FT’s leading to further opportunity for partnering with NHS
With certain exceptions, all NHS trusts are to become FTs as soon as clinically feasible. Although the Act does not specify a precise timetable, 2014 has been suggested in earlier DH guidance. There may be an advantage to the private sector here in that, generally speaking, consent of the SoS is not required by FTs to form a corporate joint venture with the private sector. Early signs that this is an innovative and mutually beneficial way of partnership working with the NHS may become more common.

For further information or advice please contact Julian Smith on 0121 456 8392 or Duncan Astill on 01223 222477.

FTs and aspirant FTs
What’s changed?
FTs no longer need to have primary care trust governors. The Board of Governors is to be called the Council of Governors (already the most popular name adopted by FTs). For the first time, directors and governors have statutory duties. The directors’ duties are to promote the success of the FT for the benefit of members and the public and to avoid conflicts of interest. Ironically, the wording of the former duty (“for the benefit of members… and the public”) itself creates the potential for conflict between the interests of those two groups, without any clue how to resolve it. The wording of the principal purpose stays the same, but the wording of the other purposes changes. Governors now have the statutory duty to hold the non-executive directors (NEDs) individually and collectively to account for the performance of the trust. This is logical, as the governors have no direct influence over executive directors (who are appointed by the NEDs). In order to give governors greater control over FTs, in anticipation of Monitor relaxing its grip in 2016, changes to constitutions, mergers, acquisitions and demergers will all require the approval of governors. Where a change to the constitution relates to the governors, members’ approval will also be required. “Significant transactions” will also require governors’ approval, if the trust chooses to define that term in its constitution. The rules on private charges have changed and an FT wishing to adopt a plan anticipating an increase of five per cent in its non NHS income must seek governor approval first. Existing FTs may need to change their constituencies to ensure that their membership is representative of their service users.

Who does this affect and how?
Everyone! For example, all FT Board of directors’ meetings will have to start as public meetings. This has caused much comment, but is a relatively trivial development. What is much more important is that the governors are now entitled to see all directors’ agendas (public and private) and minutes (public and private). For aspirants who do not make FT by the longstop date, franchising, dissolution or merger with an existing FT are the only options.

What do I need to do differently?
From the structure of the amendments, constitutions will need to be amended to reflect the new purposes and duties and the new rules on changes to the constitution. FTs will need to define a class of “significant transactions” or add a clause into their constitutions to the effect that the trust has decided not to do so. Constitutions should be amended to remove any provisions that conflict with the Act. FTs should also consider requiring their governors to
treat as confidential (and take to the private part of the council of governors’ meeting) any matters discussed by the directors at their private Board meetings. FTs should also be considering how to fulfil the new obligation to take steps to equip their governors with the skills and knowledge they will need to perform their enhanced role.

For further information or advice please contact Tim Winn on 0121 456 8355.

Regulators
Monitor, as economic regulator
What’s changed?
Compared to prior to the Act, this is all new.

Who does this affect and how?
Monitor becomes economic regulator for healthcare and competition regulator for health and social care.

- **General duties:** Monitor must promote the efficient use of resources and the quality of care. In doing so Monitor must seek to prevent anti-competitive practices, but must promote integration where this would make services more efficient or reduce inequalities. Monitor cannot favour NHS or private sector providers.

- **Licensing:** all providers of NHS funded care will need to have a licence from Monitor. Based on Monitor’s current proposals, all providers will be subject to the same licence conditions except (i) FTs will be additionally regulated, until 2016 at least; (ii) tougher licence conditions will apply to those providing essential services (determined by PCTs); and (iii) NHS trusts will not be subject to the same financial standing tests as other providers. The proposals for restrictions on providers of essential “commissioner requested” services are onerous. Independent sector providers are concerned these proposals favour FTs, because they do not need to pay dividends and their borrowings are unsecured.

- **Competition:** in relation to providers, Monitor has a duty to prevent anti-competitive behaviour, which in practice is the same thing as promoting competition. On mergers, Monitor’s powers are concurrent with the Office of Fair Trading (OFT), which is already investigating a proposed FT merger under pre-existing legislation. Monitor’s remit extends to enforcing rules to be set by secondary legislation (regulations) about how commissioners (the Board and CCGs) should conduct procurement, promote patient choice and not indulge in anti-competitive behaviour. In theory, competition can legitimately be for the market (sole provider) or within the market (AQP and Choice). Procurement can be about competition for the market or within the market, but Choice is all about competition within the market (otherwise there is no actual choice for patients to make). We will have to see what happens in practice and what the rules say about integration.

- **Price setting:** Monitor will set the national tariff, including giving instructions for deciding how services for which no price is given should be priced. Local variations can be agreed between commissioner and provider, but only if Monitor also agrees.

- **Insolvency regime:** all providers of “commissioner requested services” will potentially be subject to a special administration regime. This is an intermediate step before any insolvency rules apply, and has to be because the proposal to make FTs subject to the *Insolvency Act* was dropped. Health Special Administration allows the administrator to dispose of the business and maintain continuity of service. This is another provision worrying independent sector providers and their funders.

What do I need to do differently?
Providers will need to apply for a licence. Commissioner Requested Services providers need to consider whether they can meet Monitor’s financial standing requirements, and independent sector providers are likely to need to refinance without security or cross guarantees.

For further information or advice please contact Tim Winn on 0121 456 8355.

CQC/HealthWatch

HealthWatch England will be a statutory committee of the CQC. The Government successfully fended off attempts to make this body truly independent. HealthWatch England will be a national consumer champion with its purpose now set out clearly in the Act. The purpose of the HealthWatch England committee is “to provide the Commission or other persons with advice, information or other assistance”. We await the regulations which will set out how its members are to be appointed, but the Act makes it clear that the majority of its members cannot be members of the CQC.

The functions to be performed are also now set out in the Act. These are functions of the CQC which they must arrange for HealthWatch England to perform in its behalf. These include:

- a duty to provide local HealthWatch organisations with advice of a general nature in relation to the making of arrangements with local authorities relating to patient and public involvement in health and social care;
- a power to make recommendations to local authorities about the making of arrangements with local HealthWatch organisations;
- a duty to advise and provide information to the SoS, the Board, Monitor and local authorities on the views of users of health and social care services and the need for such services by others; and
- advice to the CQC on the views of health and social care users or others who have need for these services.

The annual reporting requirement remains, but it is now clearer how this will operate. The CQC’s requirement to report on health and social care functions is separate from HealthWatch England’s report. The latter must be separately referred to in the CQC’s report.

The CQC is preparing for the launch of HealthWatch England in October 2012. With all the bad press that the CQC has had of late, many sceptics will say that they could do without having another major organisation under its umbrella. However, if HealthWatch England truly has its organisational finger on the pulse of the public on health and social care issues, then the information which will be fed back to the CQC, if acted on, will enable the CQC to play a pivotal role in the development of health and social care policy.

For further information or advice please contact Dawn Brathwaite on 0121 456 8224.

Local authority, public health and social care interface

Health and Wellbeing Boards

Many of the proposed changes were trailed in our February 2011 Health Legal Update Special Edition. Each upper tier local authority must establish a H&WBB. Approximately 48 H&WBBs are already operating in shadow form. The Act sets out the mandatory composition, but there is enough room for these to be tailored to each authority’s objectives. Each H&WBB should comprise:
The makeup of shadow H&WBBs varies enormously. Few have representation from the third sector or acute trust providers. Most are chaired by one of the directors listed above or an elected member, but one in the south rotates the chair between an elected member and a GP, while at least one has an independent chair with experience in the area of health and social care.

Many have asked whether these H&WBBs will have any teeth. Only time will tell. The Act makes it clear that the functions of the local authority and the partner CCG to prepare a joint needs assessment is to be discharged by the H&WBB. This assessment will then dictate the joint health and wellbeing strategy that is agreed to meet those identified local needs. This could be high level and strategic and not detailed commissioning plans. The duty on CCGs, local authority and the Board (in relation to its local commissioning responsibilities) is “to have regard” to the assessment and strategy when carrying out their functions. What does this mean in reality?

In the initial stages, many of the parties who are part of the H&WBB will come to the table with a plan. The challenge will be to achieve buy-in to a plan, which may not reflect the priorities of one of the core members of the H&WBB against limited resources. There is no mandatory requirement for representation from one of the key local stakeholders, the local acute trust provider. However, the Act sets out the duty placed on the Board “to encourage” persons who arrange for the provision of any health or social care services to work in an integrated manner. CCGs mindful of their budgetary constraints only have to pay “due regard”. This may not be a high enough threshold to secure true engagement and unless the H&WBB is seen to be carrying out an indispensable role and not just a talking shop, it may find that it is sidelined.

On the positive side however, there is a great opportunity for stakeholders to start afresh and try to achieve true partnership working on a local basis, notwithstanding the challenges.

For further information or advice please contact Dawn Brathwaite on 0121 456 8224.

Local authority scrutiny
As proposed in the Bill, local authorities are no longer required to have a Health Overview and Scrutiny Committee (HOSC). They will however, continue to have oversight and scrutiny powers which can be discharged in various ways.

Regulations previously provided for NHS bodies to consult the HOSC. As trailed in the Bill, they will be amended so that the requirement to consult will also apply to relevant health service providers. The regulations will therefore, potentially include CCGs, the Board, local authorities and, interestingly, the independent sector.
Regulations could make provision with regard to what local authorities must be consulted upon and the circumstances when reference could be made to the SoS, the Board or Monitor.

For further information or advice please contact Jill Mason on 0121 456 8367, Jill Weston on 0121 456 8450, Lucy Johnston on 01223 222366 or Laura Jolley on 01223 222448.

Workforce issues

Workforce implications of the Act

One key impact of the Act will be the potential large scale transfer of employees currently employed by primary care trusts, strategic health authorities and arms length bodies (sender organisations) to CCGs, the Board, local authorities, Public Health England and other organisations (receiving organisations). However, a simple transfer of employment along with the protection of the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) and/or by statutory staff transfer orders will not apply to everyone.

The Act provides that CCGs are to be granted the status of employing authorities and will be required to offer the NHS Pension Scheme to their employees. CCGs will be required to appoint an accountable officer whose appointment must be approved by the Board which can also remove them from office. The Board will host Commissioning Support Services (CSS) until 2016 when it is proposed that CSSs will move to become freestanding models. We are awaiting clarity as to whether local authorities will be able to offer the NHS Pension Scheme to those NHS public health employees transferring to them. Due to a late amendment to the Act, local authorities must have regard to any guidance given by the SoS in relation to the appointment and terms and conditions of employment of Directors of Public Health, who have also been added to the list of statutory chief officers in local Government.

TUPE applies when an economic entity (an organised grouping of resources) transfers and retains its identity post transfer as a result of which employees assigned to the economic entity automatically transfer (the classic TUPE definition); or where there is a service provision change, which essentially is a transfer of activities, with employees carrying out those activities (the relevant activities) transferring to the incoming service provider. A key proviso of a service provision change TUPE transfer is prior to the transfer there must be an organised grouping of employees, which has as its principal purpose the carrying out of the relevant activities for the client which continue after the transfer. Furthermore the “activities” which transfer must be fundamentally or essentially the same after the transfer. Recent case law developments have made service provision change transfers much less likely.

TUPE operates to protect transferred employees so that their contracts of employment, rights and liabilities including continuous service (but excluding pensions) transfer from the sending organisations to the receiving organisations.

Given the historic drive for a flexible workforce often servicing more than one client (as is the case with all shared services models), the often significant changes to models of care and service delivery and the potential fragmentation of service delivery, it is envisaged that there will be many circumstances where TUPE will not apply. A functions and people map will be developed to understand which functions are transferring to which receiving organisations. Whether TUPE applies in any particular case, to any particular group of employees, will depend on the factors referred to above. Where TUPE does apply, all the relevant employees automatically transfer (although they have the absolute right to refuse to do so). The aim is to inform employees by December 2012 of their future destinations.

The SoS also has the power under Schedule 23 of the Act to make staff transfer orders. This enables a specified NHS employer or qualifying company to receive specific employees by implementing a staff transfer scheme and
confers TUPE-like protection, even in those circumstances where TUPE itself does not apply. Staff transfer orders will only be made by the DH where both sending and receiving organisations agree that they are required. Of course, receiving organisations are unlikely to want employees, or perhaps more specifically the redundancy costs of such employees, they do not have posts for. It is to be noted that where TUPE applies in circumstances where there is also a staff transfer order, the legal requirements of TUPE must also therefore be followed.

TUPE provides that any dismissal of employees because of the transfer itself or for a reason connected with the transfer are automatically unfair unless the dismissing employer can show that it had an economic, technical or organisational reason entailing changes in the workforce (ETO reason) for the dismissals. A dismissal connected with a transfer which is for an ETO reason will not be automatically unfair. There are two key points to note about ETO dismissals. First a sender organisation cannot rely on a receiving organisation’s ETO reason. So for example, if the receiving organisation does not want or need all of the transferring employees those transferring employees will be in a redundancy situation only after the transfer. The sender organisation cannot make pre-transfer redundancies based on what the receiving organisation may want post-transfer. Secondly, it is not enough for the dismissing employer to have an ETO reason for effecting dismissals. The reason must also “entail changes in the workforce” which means a change in the numbers employed or their job functions.

Therefore, sender organisations must not carry out pre-transfer dismissals where TUPE applies as it will be for receiving organisations to carry out any such dismissal following fair dismissal processes. However, there are likely to be further re-organisations not related to TUPE taking place in primary care trusts and strategic health authorities, as part of the on-going drive to decrease management and running costs prior to the abolition of primary care trusts and strategic health authorities on 31 March 2013. Such processes will need to be carefully managed to ensure that they are not challenged as being dismissals connected to TUPE.

TUPE provides also for the provision of information and consultation. Sender organisations are required to inform (and, where any measures are envisaged by the sender organizations, consult with) trade union representatives of any employees who may be affected by the TUPE transfer or measures taken in connection with it.

For further information or advice please contact Jog Hundle on 0121 456 8206, Stuart Craig on 01223 222280 or Martin Brewer on 0121 456 8357.

Real estate, PFI and LIFT

What’s changed through the Act?
Not very much is contained in the Act itself from a property perspective, the Act simply contains the mechanical provisions expanding the SoS’s powers in relation to how transfer orders can be made, as well as setting out which kind of bodies and organisations can be recipients.

However, significant changes and developments will be happening. There will be the abolition of primary care trusts and strategic health authorities; a huge amount of property needing new owners; and managers and related estates and facilities teams needing new homes.

During the Act’s lengthy passage through Parliament guidance and policy relating to the treatment of NHS primary and community care estate has been coming out of the DH. There is more to come, but a view of the future is now emerging.

Who does this affect and how?
Initial guidance set out that the aspirant community foundation trusts would have a right to acquire estate, which related to services that were being delivered by them following the commissioner / provider split effected by the
Transforming Community Services initiative. This guidance was subsequently issued in more detail when it also extended this “right to acquire” to all FTs and NHS trust providers. Providers would have the option to acquire service critical clinical infrastructure that was intended for longer term ownership. This extends to all tenures including freehold, long and short leaseholds. Where there are properties which are occupied by more than one provider then they will transfer to the major occupier.

Any transfers are to be subject to overage and option rights in favour of the SoS, which have been set out in a proforma transfer document issued with the guidance. The intention is that overage entitlements will ensure any windfall profits are shared if property becomes surplus, and the option right will allow the SoS to make the property available to another provider if circumstances so require. These provisions may impact on the appetite of trusts to acquire property in the first place.

Note, surplus and administrative estate does not transfer under this guidance nor are social enterprises or independent or voluntary sector providers entitled to this estate. This means that those providers will either source their own properties or they will take leasehold and underlease hold interests from the successors to the PCT’s estate (including relevant NHS providers).

The DH has also issued guidance about how the primary care trusts and strategic health authority administrative estate should be dealt with, indicating that wherever possible CCGs should make use of existing primary care trust and strategic health authority premises.

Just before Christmas a new company called NHS Property Services Limited (known as “PropCo”) was incorporated and a formal announcement regarding its inception was made in January of this year. We await further guidance as to exactly how this company will operate, but our understanding is there will be regional and local offices which will house residual primary care trust estates teams who will manage any primary and community care estate not transferred to NHS and FT providers. Interesting questions arise over how PropCo will work with commissioners in relation to service commissioning and managing voids.

We are awaiting policy guidance from the DH in relation to Local Improvement Finance Trusts (LIFT) Private Finance Initiatives (PFI) and Third Party Developments (3PD).

What do I need to do differently?
For those in PCTs the coming year looks busy. A timetable has been set to ensure that teams get their estates holdings in order putting together packs of information about each site including searches, replies to enquiries and getting all outstanding leases in place and ownership issues resolved. By the end of this financial year there will be transfer orders taking the ownership of sites from PCTs to either NHS provider trusts or PropCo (as the case may be). The Act includes a much longer list of possible recipients so there is much more flexibility legally as to where the property can go post PCT than is envisaged in the guidance issued so far, time will tell if this flexibility is taken advantage of.

If you are in a PCT estates team then it is likely that you will be transferring into a PropCo office near you. This is of course a totally different entity to the PCT and so while before the reforms you would have had the freedom to manage all the estate (albeit within Estate Code), from within PropCo the powers are not so certain and we have noted that views amongst our client groups are mixed. Some are envisaging that procurement of new projects (whatever existing or new model of delivery is chosen as a preferred structure) will be PropCo’s responsibility and others are looking to the regional and local outposts of the Board or CCGs (with or without CSS support as the case may be) to be the drivers for new projects.
Early indications from CCGs are they are concerned about making ends meet within the £25 per capita budget they have been allocated to cover all their management costs including professional advice. We envisage that, certainly initially, procuring new estate is not going to be a priority for them.

As mentioned above details of who will take over the contracts and leases (and in the case of LIFT shareholding) of existing PFI, LIFT and 3PD projects is awaited so in that regard it is literally “watch this space!”

For further information or advice please contact Bridget Archibald on 01223 222436.

Duties of the Secretary of State

The Act places duties on the SoS to promote a comprehensive health service in England and also to promote autonomy. The Act outlines that the SoS retains ministerial responsibility to Parliament for the provision of the health service in England, and explains that the duty to promote a comprehensive health service will take priority over the duty to promote autonomy should they conflict. This strikes us as an area ripe for judicial review!

The Act also places duties on the SoS to:

- Act to secure improvement in the quality of services; the relevant outcomes will be effectiveness, safety and quality;
- have regard to the need to reduce health inequalities;
- promote research on areas relevant to the health service and the use of evidence within the health service;
- promote equality of provision;
- ensure that there is an effective system for the planning and delivery of education and training; and
- protect public health.

The SoS also has powers of intervention in relation to failure by various bodies connected with the health service. The Act enables the SoS to set priorities for the NHS through a mandate for the Board. The SoS also has regulation making powers outlining requirements for NHS commissioners.

For further information or advice please contact Tania Richards on 01223 222476.

Abolition of arms length bodies.

Below is a list of arms length bodies which are to be abolished under the Act and a few words as to what will happen after this. As yet the relevant sections of the Act are, for the most part not in force and at the time of writing there is no definite indication of when they will be.

- Alcohol Education and Research Council (AERC): Alcohol Research UK, an independent registered charity which was set up in September 2011 has taken over the work of the AERC.

- Appointments Commission (AC): The AC is due to close in October 2012. The DH will now be responsible for:

  (i) remaining appointments to national health and social care bodies;
(ii) transition resourcing; and

(iii) outplacement support services.

- **General Social Care Council (GSCC):** Regulatory functions will transfer to the Health Professions Council (HPC) on 31 July 2012 when it is envisaged the GSCC will close. The HPC will change its name to the Health and Care Professions Council (HCPC) to underline its additional role. After the transfer of functions, all social workers in England must register with the HCPC.

- **Health Protection Agency:** Functions transfer to new public health service to be established in April 2013, Public Health England.

- **National Information Centre for Health and Social Care:** Rises from the ashes as a corporate body with powers to establish information systems for the collection, analysis and dissemination of data. It will also be responsible for producing a code of practice in relation to the treatment of confidential information in the health and social care sector. The development of a system of accreditation for information service providers and a database providing quality indicators in relation to care providers are also within its remit.

- **National Information Governance Board for Health and Social Care:** Statutory functions to be transferred to the CQC and certain advisory functions will sit within the DH or other bodies.

- **NHS Institute for Innovation and Improvement:** Role transfers to the Board which has a duty to promote (and can offer prizes for) innovation.

- **National Patient Safety Agency:** The National Reporting and Learning System which was hosted by NPSA has a two year stint at Imperial College Hospital NHS Trust, while a tender process is scoped and developed by the Board. NPSA’s responsibilities concerning patient safety will transfer to the Board.

- **Office of Health Professions Adjudicator:** It was never fully operational. The intention had been that it would be a new independent body set up under the *Health and Social Care Act 2008* to take decisions on fitness to practise cases instead of the General Medical Council and, going forward, the General Optical Council.

For further information or advice please contact Rona McPherson on 01223 222299 or Tim Winn on 0121 456 8355.

**Primary care services**

**General Dental Services (GDS) and Personal Dental Services (PDS)**

The rules on those eligible to enter into GDS contracts and PDS agreements have widened. GDS contracts can now also be held by a limited liability partnership so long as at least one member is a dental practitioner. There are also new requirements regarding partnerships to ensure the dental practitioner is an active and not a sleeping partner. PDS agreements can be held by limited liability partnerships so long as certain criteria are met which are similar to those for GDS contracts, and those entitled to hold shares in a company limited by shares has been widened. Once this section has been enacted commissioners will need to update their checklists of eligibility to hold GDS contracts and PDS agreements to ensure compliance with the new rules.

**Pharmacy matters**

Decisions relating to the right to be included on a pharmaceutical list in order to provide pharmaceutical services will be taken by the Board. Appeals against the Board’s determination will be heard by the First Tier Tribunal (FTT).
only if they are on “fitness to practise” grounds. If the FTT allows the appeal, the matter is then remitted to the Board. The FTT will not re-determine the application. Appeals on other grounds will be determined by the Secretary of State (delegated to the NHS Litigation Authority).

There will be a performers list for local pharmaceutical service performers and those who assist pharmaceutical contractors in the provision of pharmaceutical services. This will bring pharmacists in line with other primary care performers. We await the detail surrounding the management of the performers list, but we know that there will be a national list which will be managed locally.

For further information or advice please contact Dawn Brathwaite on 0121 456 8224.

National Institute for Health and Care Excellence (NICE)

Although Schedule 16 of the Act deals in detail with the constitution of NICE, the bulk of the provisions relating to its future activities are to be found in Part 8 of the Act. This will re-establish NICE, currently a special health authority, as a non-departmental public body corporate called the National Institute for Health and Social Care Excellence but still known, for short, as NICE.

As its new name indicates, the principal change will see NICE exercising its functions in relation to social care in England, as well as healthcare.

In exercising its functions, NICE must therefore have regard to:

- the broad cost-benefit balance of the provision of health services or social care;
- the degree of need of persons for health or social care; and
- the desirability of promoting innovation in the provision of health or social care.

NICE’s output, as now, will divide into the development of quality standards (aspirational markers of high quality, cost effective patient care) and the provision of guidance, recommendations, advice and information. Henceforth, however, quality standards relating to NHS services (including section 117 Mental Health Act 1983 aftercare) will be commissioned by the Board and those relating to public health or social care by the Secretary of State. In cross-over areas, there may be a joint commission.

Both the Secretary of State (new s1A NHS Act 2006) and the Board (new s13E NHS Act 2006) must, with a view to securing continuous improvement in the quality of health services, have regard to the quality standards prepared by NICE. NICE, in turn, will be obliged to have regard to the provisions of the NHS Constitution and will be subject to the public sector equality duty.

Under regulations to be made, NICE will be empowered to provide guidance, recommendations, advice and information with regard to NHS services, public health and social care; to the NHS, local authorities and other organisations in the public, private, voluntary or community sectors. Compliance with guidance in specific cases will be required, to replicate the provisions of the current funding direction for technology appraisal guidance. NICE will continue its delivery of education, training and development on evidence-based therapeutics and medicines management and extend this delivery into the field of social care.

The Board may direct NICE to exercise any of its functions relating to the preparation of commissioning guidance which the Board must publish under s14Z8 NHS Act 2006. Commissioning guidance will provide CCGs with practical advice on contracting for the provision of health services with a view to the improvement of quality.
The new statutory framework will provide NICE with the opportunity to re-dress its shop window with yet further emphasis on quality. With its remit extended to encompass social care, however, one wonders what impact this will inevitably have on the timely production of its guidance. Also, with local authorities having to make cuts left right and centre, there will surely be an inevitable tension between the aspirations set by the social care quality standards and the budgets which must seek to fund them.

For further information or advice please contact Jane Williams on 0121 456 8421.

Information governance

We have been warned

There are two main points arising from the reforms and the Act:

- CCGs will be corporate bodies and subject to all the rigour of information governance which will be monitored (and enforced) by the Information Commissioner and the CQC.

- Information (analysis and sharing) will be key to the provision and monitoring of health and care services and patient choice.

"Each CCG will be accountable for ensuring that it has adequate IG measures in place covering all aspects of information handling…" DH, 26 October 2011.

Nothing in the Act changes this and it applies to all health care bodies. There is, however, an emphasis on the secondary uses of data and information sharing.

Interestingly, information from the department (and not within the Act) is clear that the Government has still to do a lot of “thinking” as to how the NHS uses information in the future and to put “flesh” on the “bones” of departmental pronouncements. The department is promising a lot of work and consultation in 2012 is still to be done and we can expect an updated policy document in the next few months.

With potential consequences of breach including damage and distress to patients and service users, Information Commissioner Office (ICO) penalties of up to £500,000 and complaints and legal proceedings against both the organisation and individual staff members, it is vital that all organisations involved in data handling are aware of both their current and continuing responsibilities throughout the transition process.

It was perhaps, wishful thinking to expect to find a section entitled “information governance” within the Act. Instead, we are left with having to piece together the position from various provisions which relate to this area. In summary, the key changes/references to information governance are as follows:

- The Board will have a duty to publish information governance requirements regarding patient information/information generated in the course of provision of healthcare services.

- CCGs and the Board are to be recognised as public authorities for the purposes of the Freedom of Information Act 2000.

- The SoS/the Board are to set information standards for health services and adult social care in England. These standards can include technical, data or information governance standards and are to be followed by the SoS; the Board; public bodies exercising functions in connection with health services or adult social care; and anyone providing publicly funded health services or adult social care commissioned by or on
behalf of a public body. Take note that Version 10 of the information governance toolkit is due for release this month.

- The Health and Social Care Information Centre (HSCI) will become a non-departmental public body with the aim of becoming the leading source of (and analysis of) data relating to health, public health and social care for the national transparency agenda. In collating such information, the HSCI must have regard to:
  - limits on the information they can request, especially when such information is deemed confidential in nature; and
  - legislation on disclosure to which they remain subject despite having an exemption from duties of confidentiality.

The SoS appears to have wide ranging powers to require the collection of information, but it seems the purpose is to supply information to bodies for the management and regulation of health care and to the public for the purpose of patient choice, etc. Having said that, it appears that patient identifiable information may be capable of collection and sharing in some cases subject to some safeguards:

- Nothing within the Act stops the HSCI from disseminating information in accordance with other legislation.
- The National Information Governance Board is abolished. The functions (including applications/consultation under S251 of the NHS Act 2006 to permit confidential information to be shared in certain circumstances without consent).
- The CQC is to monitor and seek to improve the practice of providers in connection with the processing of information.

Notwithstanding the above changes and references to the need for greater information sharing across the NHS, the principal legislation in this area such as the Data Protection Act 1998 and Freedom of Information Act 2000, remains capable of overriding any powers in respect of the dissemination of information. For this reason organisations must take care not to fall into the trap of side-lining information governance.

For immediate guidance on the duties and responsibilities of organisations during the transition period, please see:

- The National Information Governance Board: Guidance for Transition
- NHS Information Governance: Effective Management of Records, during a period of transition or organisational change
- DH Responses to the NHS Future Forum’s second report: 10 January 2012
- CCG Authorisation: Draft Applicants’ Guide.
- NHS Information Strategy
We will be setting out more detail and help for NHS bodies, new and old and in particular keep your eyes peeled for our future publications *Information Governance: dealing with transition*, a series of three updates which will cover:

- how organisations should prepare for when they take responsibility;
- information governance in the interim; and
- handling information governance post-transition.

For further information or advice please contact Stuart Knowles on 0121 456 8461 or Lorna Shastri-Hurst on 0121 456 8400.

**Patient matters**

**Mental health matters: Mental Capacity Act and Health Act - what has changed?**

Predicted changes in numbering aside, the provisions in the Act relating to the Mental Capacity Act 2005 and Mental Health Act 1983 remain largely unchanged from the position as set out in the Bill, and previously reported on in our *February 2011 Health Legal Update Special Edition*.

These changes will not take effect until the SoS makes an order to that effect.

To help refresh our memories, the main changes are as follows:

**Mental Capacity Act: Independent Mental Health Advocates (IMHA)**

The amendment to section 35 Mental Capacity Act is introduced. The term “responsible authority” replaces “appropriate authority”, with section 35(6A) providing that the local authority is the responsible authority with regard to the provision of IMCAs.

**DOLS**

Schedule A1 to the Mental Capacity Act 2005 is amended so that the relevant supervisory body becomes a local authority, rather than a primary care trust in respect of cases where the managing authority is a hospital.

**Mental health high security services – Section 16**

The duty to provide high security services is transferred from the SoS to the Board. Providers have to be approved by the SoS who will still have power to issue directions to the provider and indeed to the Board.

See page 18 of the explanatory notes.

**Mental Health Act 1983**

Sections 38 – 45 confirm various amendments to the Mental Health Act. The explanatory notes cover this at pages 57-61 and 192 – 194.

In summary:

- **S12(2) and approved clinician approvals – Section 38**: New sections 12ZA, ZB and ZC are added to the Mental Health Act enabling the SoS to agree with another person that they can exercise the approval function concurrently with the SoS, and require the Board or a special health authority to exercise the approval function concurrently with the SoS or another person. The SoS retains the power to cancel the authority at any time as well as to issue directions regarding how the power should be used.
Discharge of patient and transfers to and from hospitals – Sections 39 and 42: Sections 23 and 123 of the MHA 1983 will be deleted, along with consequent amendments to reflect the removal of authority for the SoS to engage in these areas.

Pocket money for in-patients – Section 41: The power of the SoS to provide pocket money to patients without other resources is removed.

IMHAs – Section 43: The duty of the SoS to make arrangements for IMHAs is transferred to local social services authorities and will become a social services function through amendments to Schedule 1 of the Local Authority Social Services Act 1970.

Patient’s correspondence – Section 44: The SoS is no longer to be involved in requests from individuals to withhold outgoing post.

Notification of hospitals having arrangements for special cases – Section 45: The duty to notify the local authority about arrangements in respect of urgent cases or the provision of accommodation suitable for children with a mental disorder is transferred from primary care trusts to CCGs.

Approved Mental Health Professionals (AMHPs) – Section 217: Section 114ZA is inserted into the MHA 1983 to reflect the fact that the Health and Care Professions Council in England are to be able to approve courses for AMHPs. Knock on amendments to various statutes are confirmed.

Supervised Community Treatment – Section 299: Section 64C(4A) is inserted meaning that if an approved clinician (AC) has certified that a patient has capacity to consent to treatment and has consented then there is no need for a second opinion appointed doctor (SOAD) to be involved too. It remains important to note that:

- this new rule will not apply to electro-convulsive therapy for under 18s;
- if a patient either loses capacity or withdraws consent, the AC’s certificate will no longer be valid; and
- in the above scenario treatment can continue whilst a SOAD certificate is sought if the AC thinks that to stop would cause serious suffering.

In light of this there will be knock on amendments to the forms required, to s17B in respect of recall for examination and s62A in respect of treatment following recall.

Other sections: Further amendments to the Mental Health Act to reflect the abolition of primary care trusts and strategic health authorities are listed at Schedule 5 of the Act.

Aftercare Services arising from Section 117 of the Mental Health Act 1983 - There will be no amendment after all.

As readers will know, section 117 of the Mental Health Act creates a joint duty on primary care trusts and local authorities to provide, in co-operation with relevant voluntary agencies, aftercare services to patients who were previously subject to Sections 3, 37, 45A, 47 or 48 of the Act. This duty continues until such time as both the primary care trusts and the local authorities are satisfied that the person is no longer in need of such services.
This is a freestanding duty for which no charges can be made to the service user.

It is for the primary care trusts and the local authorities to agree a joint policy by which they will decide how the package is funded. This agreement can vary from region to region and if often subject to local dispute.

The Law Commission previously recommended that section 117 be amended to state that primary care trusts should provide health care and local authorities should provide social care. Their view was that this reflected what was already happening in practice but it would also provide clarity in terms of funding responsibilities.

The original draft of the Bill sought to amend section 117 and specify that PCTs should only provide those services which fall under section 3 of the NHS Act (ie, health services). Such an amendment would have brought about the clarity sought from the Law Commission in respect of funding responsibilities. However, there were numerous campaigns against such a change championed by Lord Patel of Bradford in the House of Lords. He raised concerns that the amendment would remove the duty to co-operate and, he argued, lead to a situation where service users could be charged for aftercare services. Although the latter was denied by the Government, after much debate, Lord Patel's submissions were accepted and Section 117 will remain more or less unchanged.

Although it is extremely important to ensure that service users are not denied aftercare services, the rejection of the proposed changes may be of some disappointment to those primary care trusts and the local authorities who were hoping to receive some clarity as to the division of funding in such cases.

Summary
As will be clear from the above, many of the changes introduced reflect the organisational change within the NHS and the desire of the SoS to step-back from front-line involvement.

However it is important, in particular, CCGs in respect of s117 Mental Health Act and ACs in respect of s17B, s62 and s64 ensure that they fully understand their powers and responsibilities.

NHS Continuing Healthcare (CHC)
Unfortunately there is no more detail in the Act than there was in the Bill.

We are told by paragraph 176 of the explanatory notes, despite the fact that s20 of the Act does not refer to CHC per se it is intended to allow the continuation of existing arrangements for CHC.

There will be a new Section 6 E in the NHS Act which will provide for standing rules to be made imposing requirements on the Board or CCGs. These will be imposed by regulations.

Complaints
As proposed in the Bill, the Health Service Ombudsman will be able to share complaints investigation reports and statements of reasons with such organisations as they think appropriate.

For further information or advice please contact Jill Mason on 0121 456 8367, Jill Weston on 0121 456 8450, Lucy Johnston on 01223 222366 or Laura Jolley on 01223 222448.