Introduction
Welcome to our special January 2010 Horizon Scanning edition.

The health service is about to enter a new era. After years of unprecedented growth, it faces the prospect of unprecedented austerity. The big question is how will the NHS respond? It can certainly hold its head high as the USA seeks to create its own version of our most prized national treasure.

It has been suggested extensively that these difficult times should be used as a catalyst to drive quality and productivity through cost improvement programmes, adopting innovative practices and embracing technology.

We are delighted to be officially partnered with the King’s Fund since summer 2009. We are involved with several seminars and projects with them but for now simply take the opportunity to highlight one of their most recently launched publications *Windmill 2009 – an NHS response to the financial storm*. This paper forms part of the King’s Fund adopted *Quality in a Cold Climate* theme and proffers advice and recommendations for all the different groups in NHS world and how they should co-operate and co-exist to best effect.

Here are some of the key themes of *Windmill 2009*:

- PCTs need SHA support and DH freedom to take a leadership role for the whole of their local health system in developing a response to the financial challenges.
- Commissioners need to improve their understanding of the costs and benefits of local services if they are to reduce spending and drive improvements in productivity.
- Commissioners and providers need to recognise that reducing variations in costs and quality will be necessary but recognise that this is not sufficient alone to deliver the level of savings required.
- Commissioners and providers need to grasp opportunities to work with the independent and third sectors, ensuring innovation and improvement.
- Commissioners need to work closely with local authorities - and ensure the interface between health and care and social care does not become an area of contention rather than achievement.
• Providers need to improve engagement with staff and unions to improve workforce productivity. They also need to communicate with the public, patients and other key representatives.

• Community health providers need to re-invent the model for providing community and home based care working with other providers to improve pathways of care.

• Regulators should work better together to manage performance failures and they should work on regulating care pathways as well as organisations.

• Good performance to be rewarded financially.

• Locally negotiated arrangements are much stronger than those brought about from a “command and control” top down approach.

A number of the sentiments are mirrored in the recently issued five year NHS plan - *NHS 2010 – 2015 From good to great* which promises no top down reorganisations and no DH “blueprints”. However, we may find that the NHS has to re-organise itself in light of the comment from NHS chief executive, Sir David Nicholson, who described the idea of PCTs setting up an array of independent provider arms as “nonsensical” telling acute and community service providers to talk “long and hard” about the benefits of vertical integration.

On a final note - having just enjoyed a festive sub-zero break in the Highlands, I was thinking about how people cope in such adverse climates - it seems that survival during the “cold climate” is about preparation, stamina/training, using the right people and equipment and most importantly believing in what is worth saving and being optimistic that things will get better and easier in due course.

We appreciate the next twelve months (and beyond) look very challenging but we are ready to help you in any way we can - in particular by working alongside you. Wishing all our readers a very Happy New Year and all the best for 2010.

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**NHS Operating Framework 2010/11**

*The NHS Operating Framework 2010/11* (the framework) was published on 16th December 2009. This year is particularly difficult for DH with the prospect of an imminent election and the financial squeeze. It is perhaps unsurprising then that the framework leaves quite a lot to the imagination. For example, the paragraphs on vertical integration and *Transforming Community Services* give much less directional guidance than Sir David Nicholson’s comments reported in the *Health Service Journal* in the week before its release. The attitude to the private sector is also unclear. *NHS as the preferred provider*, described as an “NHS first” approach, is to be clarified in commissioning guidance to be published soon, but it will not “freeze out our partners in other parts of the NHS, the third sector and the independent
sector”. PCTs are also told that the department expects private providers to be included “wherever suitable” in the arrangements PCTs make to ensure patients can exercise their new right to switch provider if waiting times are not achieved.

The framework re-emphasises that the NHS is a national service delivered locally in a way that meets local needs. The argument is made quite forcefully that things have to be this way "it is simply not possible to identify from the centre the kind of quality improvements that are necessary”. This also allows the department to give general instructions without spending any time on how the desired outcomes are to be delivered. Commissioners are told, “to ensure that their providers have sufficient capacity in place to achieve the 31-day standard for radiotherapy by December 2010” without any indication how they might deliver this. The answer perhaps lies in a combination of commissioning and the new standard contracts promised for mid-January, which must be signed by mid-March, but at least this year’s round of contract negotiations is likely to be easier than next year’s, as the framework includes the commitment that from 2011/12 tariff will be the maximum price.

There is to be no uplift in either tariff or non-tariff prices this year and acute emergency admissions above 2008/9 levels are to be paid at only 30 percent of tariff. There will be no increases in tariff in the following three years either, notwithstanding existing commitments to salary increases. The actual phrase used is that the uplift in tariff in those years will be a “maximum of zero percent”, so that presumably means there could be a reduction. PCTs fare no better. In addition to working to a flat allocation, SHAs are to ensure that PCTs in their region (on a region-wide basis) keep at least two percent of their annual budget (recurring funding) available for the unexpected (only ever committed non-recurrently).

It stands to reason that efficiency savings will be required. With staff costs representing half of the NHS budget it is understandable that there should be focus on efficiency savings here too but there is no intention to revisit existing pay deals. Instead SHAs are tasked with overseeing the start of a reduction of 30 per cent in management and agency costs, of which the majority are expected to be achieved in 2010/11 and 2011/12. Another initiative is that NHS boards should agree targets for reducing staff sickness absence. Success in this area will reduce the need for agency staff and, although the framework is less direct about this, NHS front line staff too. NHS bodies are advised to review “and where possible reduce” their education commitments to be consistent with their future requirements.

The other main themes are early intervention (spend to save), moving services out of an acute setting, integration (within the NHS and between the NHS and local authorities, "It is not a time to police boundaries - we need to break them down”), reducing inequalities and improving patient experience (through its incorporation into tariff). These are also themes in NHS 2010-2015: from good to great, published a few days earlier, and we should see the Framework as the beginning of that journey.

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

2010 promises to be an interesting year for foundation trusts. Unison’s successful judicial review of Monitor’s private charges cap is obviously bad news for those FTs "deriving" more of their income from private charges this year than they did in their reference year. The terms of the judgment mean there is further work for Monitor to do before it can reissue revised rules because the court did not provide sufficiently detailed comment to enable Monitor to just flip a switch. Monitor will be hoping in the meantime that the DH will accelerate its review of the cap and either sweep it away or make it easier to apply in practice.

As a majority of foundation trusts work to the national tariff, there is bound to be some concern about the statements in the NHS Operating Framework that emergency admissions above 2008/9 levels will only be paid at one third of tariff. This is presumably designed to give FTs a financial incentive to find other ways to treat patients where possible and perhaps even to encourage them to take an even greater interest in acquiring community services.

Everyone in the NHS is affected by the financial squeeze but foundation trusts may be able to do something to pass on the pain. Unlike NHS trusts, who are bound by Agenda for Change (AfC), foundation trusts are free to agree terms and conditions (including pay) with their staff, subject to not infringing the staff’s legal rights under their contracts of employment. So far only one foundation trust has publicly broken with AfC and that was with a view to giving their staff better terms. It remains to be seen whether any foundation trusts will be brave enough to seek to pay their staff less - or even suggest it as a voluntary measure as an alternative to wider redundancies - in the same way that businesses in the private sector have been doing for the last year or so.

This year should also bring more opportunities for vertical integration and mergers with foundation trusts. The operating framework promises to streamline the existing process which takes much too long if the NHS is to deliver the required improvements. Whilst the push for intra-NHS transactions does not leap out of the document, the essential components are there and Sir David Nicholson is known to be a fan of integration.

With so much going on, politically and in the economy, this is not a great time to be between leaders. Whilst both of the major parties are in favour of foundation trusts, both are hinting that the model may need refining. It is understandable in that climate that so much attention is focused on the appointment of a successor to Bill Moyes and it would be best to have that sorted out before Bill retires at the end of January.

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

Pharmacy regulations

An advisory group on the NHS (Pharmaceutical Services) Regulations chaired by Paul Burns, has worked throughout the second half of 2009 on the revised framework for the delivery of pharmacy services.
The main changes will:

- require PCTs to develop and publish pharmaceutical needs assessments (PNAs);
- then use the PNAs as the basis for determining entry to NHS pharmaceutical services provision; and
- introduce new quality requirement for contractors.

The draft *National Health Service (Pharmaceutical Services)(Amendment) Regulations 2010*, together with draft guidance and consultation “impact assessment” is now out for consultation until the 28 February 2010.

We anticipate a busy time for all those involved in the commissioning of pharmacy services over the next 12-18 months as PCTs gear up for the requirements of the new system that will be put in place.

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

**Procurement**

The development of procurement law and policy continues apace. As we move into 2010, the implementation of the Remedies Directive in December 2009 will be at the forefront of procurement and NHS organisations will need to ensure that they are complying with the new rules. Whilst the amended requirements around contract award information and the standstill period should prove fairly straightforward to implement, the most interesting and important development is the introduction of the new remedy of ineffectiveness.

The new remedy means that the courts now have the power, in certain circumstances, to set aside contracts which have already been entered into. If there has been no notification of the contract award, the period for bringing a claim is six months from commencement of the contract. Clearly this remedy carries serious implications. It will therefore be interesting to see how quickly a case on ineffectiveness reaches the courts and whether this remedy will be applied frequently in practice.

Within the NHS, revised versions of the PCT procurement guide and the principles and rules for co-operation and competition are expected early in 2010. These will clarify the latest policy requirements set down by DH in relation to procurement.

This year we will also see the new regional commercial support units becoming fully operational. These effectively replace the NHS Purchasing and Supply Agency and are intended to support NHS procurement and competition, in line with policy objectives such as World Class Commissioning. It will be interesting to see how their role develops.

Finally, I am delighted to announce that we have recently launched the Mills & Reeve Procurement Portal, which includes downloadable document templates, tools and over 100 frequently asked questions. This can be accessed at www.mrprocurement.com.
Employment

The implementation of the Equality Bill which, if all goes to plan, will start in October is likely to be the most important new legal development of 2010 in the employment field. For many public sector organisations, including NHS trusts and foundation trusts, PCTs and SHAs this means expanding the range of the existing equality duties across all the main protected characteristics, as well as dealing with some adjustments to generic discrimination law. The latter changes are likely to be implemented in October 2010. The Government has targeted April 2011 for the new public sector duties to come into force.

Among the other changes already announced, the planned introduction of the new “fit-note” regime in April 2010 stands out. Last May the Department for Work and Pensions (DWP) consulted on draft regulations which will introduce a new sick certificate regime for social security and statutory sick pay purposes, with the aim of giving better information to employers and helping people on sick leave return to work sooner. The NHS will clearly have a major role to play in rolling out this new regime but no further information on implementation has been forthcoming, at least publically, from the DWP.

Turning to case law developments expected in 2010 two appeals in the pipeline are likely to be particularly significant. The progress of Rose Gibb’s appeal against the High Court’s decision that her NHS trust employer had no power to make her termination payment, will be watched anxiously by many public sector employers. The Court of Appeal is due to hear the appeal in March. Another case to watch is G v X and Y. It raises a number of important issues about the conduct of disciplinary procedures by public sector bodies and has already been heard by the Court of Appeal. Its decision is likely to be published early next year. This case assumes added importance because the Court of Appeal’s decision in Kulkarni will not, we now understand, be appealed to the Supreme Court.

Interesting though all these developments are, it is arguable that they will be overshadowed by the steps that NHS employers will need to take next year to adjust to the public sector spending squeeze. Leading the NHS workforce through to recovery, recently published by the NHS Employers’ Organisation, points out that times are going to be particularly challenging on the employment front given the agreement to honour the Agenda for Change pay award for 2010/2011. Something has to give, and a number of options, short of “slash and burn” are explored. Of the suggested strategies, achieving savings through mergers and targeting levels of sickness absence are likely to be particularly challenging for HR managers.

For further information or advice please contact Jog Hundle on 0121 456 8206 or Stuart Craig on 01223 222280.
Patient matters: mental health

Community treatment orders (CTOs)

The amendments to the Mental Health Act 1983 have now been in force for just over 12 months. Most organisations should be familiar with the key changes. We anticipate that there will still be difficult issues arising around CTOs.

Some of the key points to keep an eye out for are:

- If the responsible clinician (RC) and approved mental health professionals (AMHP) agree that the patient should be discharged onto supervised community treatment (SCT) they should complete the relevant statutory form (CTO1) and send it to the hospital managers. It is important that the three parts of the form are completed in chronological order, as the RC cannot exercise his power to make a CTO until the AMHP has confirmed in writing that they agree with the application. The RC cannot therefore complete part three of the form before the AMHP has completed part two.

- The RC must specify on the form the date the CTO is to be made. It is authority for the SCT to begin and can be a short while after the date on which the form is signed to allow time for arrangements to be put in place for the patient’s discharge. It can also be the date on which the RC completes part three of the form, but it cannot predate this.

- It is also important to remember that CTO documentation cannot be rectified. It has to be right first time, or there should be sufficient time to allow for full scrutiny of the documents before the effective date, so that the forms can be filled out again if there are any significant defects.

New Horizons

New Horizons is a cross-government programme of action to help improve everyone’s mental well-being and the services that provide mental health care. Its twin aims are to improve the mental health and well being of the population and improve the quality and accessibility of services for people with poor mental health.

With over 120 recommendations there is a lot to digest in this shared vision for mental health. We look forward to working with our clients across the public, private and third sector to support them in whatever way we can to implement the action points with regard to prevention of mental ill health, promotion of mental health, early intervention, tackling stigma, strengthening transitions, personalised care and innovation.


For further information or advice please contact Jill Mason on 0121 456 8367.
Patient matters: Continuing Healthcare

Direct payments
The consultation in respect of direct payments closes on 8 January 2010. Pilot sites will be up and running in respect of direct payments so it will be interesting to learn how they are progressing.

Controlling costs
In the meantime PCTs, in the current climate, will need to focus on how best to control their continuing healthcare budgets. Ways of doing this will be to review current cases to make sure that the PCT is the responsible commissioner, to check whether an insurer ought to be paying for care costs rather than the PCT and to consider carefully the cost differentials between domiciliary care and nursing home costs.

For further information or advice please contact Jill Mason on 0121 456 8367.

Patient matters: Mental Capacity Act (MCA)

Code of Practice
Although the MCA has now been in force for some time, the queries we sometimes receive from clients reveal that it is not yet fully understood. It is important to bear in mind that healthcare professionals have a statutory duty to have regard to the code of practice which accompanies the Act.

Deprivation of Liberty Safeguards (DOLS)
In April 2010, the DOLS amendments to the MCA will have been in force for 12 months. The recent case of GJ has clarified the law relating to whether the Mental Health Act (MHA) or the MCA should be used, giving priority to the MHA. We can expect further case law in 2010 clarifying issues around DOLS.

Assisted suicide
The DPP published his interim policy on assisted suicide in September 2009. The consultation relating to this has just closed and a final policy is expected in Spring 2010.

Consultation
The Government is also starting to consult on various aspects of the Act. A Ministry of Justice consultation proposes amendments to secondary legislation to ensure the Mental Capacity Act 2005 meet its aims and objectives. The first step in this process was the Reviewing the Mental Capacity Act 2005: forms, supervision and fees, which saw large-scale changes being implemented from April 2009.

The current consultation addresses identified areas of legislation and policy that in practice have not worked as well as otherwise intended. Views are sought on: reducing the security bond discovery period after the client’s death from seven to two years; expanding the list of benefits that would qualify a customer for exemption from payment of Office of the Public Guardian (OPG) fees; fees associated with the introduction of attorney supervision to lasting powers of attorneys (LPA); and fees association with an optional checking service for LPA.
applications. The OPG intends to implement the proposals on April 1, 2010. Comments should be submitted by March 9, 2010.

For further information or advice please contact Jill Mason on 0121 456 8367.

**Patient matters: priorities**

**Specialised commissioning**

We will wait with interest to see the outcome of the consultation on strengthening the existing arrangements for commissioning services for extremely rare conditions on a national level. The consultation is due to close on 19 February 2010. A single expert advisory group (the National Commissioning Advisory Group) has been proposed.

**Pilots**

February will be a busy month.

The National Institute for Clinical Excellence (NICE) is currently permitting patients with rare illnesses to take new drugs before they have been evaluated by the agency under a pilot scheme. The scheme, Innovation Pass, allows drug manufacturers to collate evidence on the benefits of the drugs, which will then be used by NICE to decide whether they are cost-effective enough to be available on the NHS. The pilot will run until February 2010.

For further information or advice please contact Jill Mason on 0121 456 8367.

**Patient matters: swine flu**

NHS staff and critical care staff in particular may be concerned that, if a pandemic does arise, they will face risks as a result of seeking to discharge their professional responsibilities. Their concerns are likely to centre around:

- criminal prosecutions for murder, manslaughter or neglect;
- reference to professional bodies;
- civil action for negligence; or
- complaints.

If there is a swine flu pandemic which puts particular strains on NHS staff and resources, provided staff work within national guidance they should not face any additional legal risks when carrying out their roles.

The relevant guidance is:

- [Ethical considerations in developing a public health response to pandemic influenza](#) (WHO 2007).
- [Responding to pandemic Influenza: the ethical framework for policy and planning](#) (Committee on the Ethical Aspects of Pandemic Influenza 2007).
- [Guidance on infection control](#) (Health Protection Agency).
• **Critical care strategy: managing the H1N1 flu pandemic** (September 2009).

• **GMC swine flu guidance** (February 2009).

Hopefully the projected numbers will not actually materialise.

For further information or advice please contact Jill Mason on 0121 456 8367.

**Patient matters: children’s law**

This has been a high profile area in 2009 and health visitors, paediatricians and anyone involved in caring for the health of children is probably hoping that 2010 will be a quieter year.

We anticipate issues relating to inter-agency working and investment in the workforce following the Lord Laming review.

Publicity in children's cases will be likely to remain high on the agenda with changes to the Family Proceedings Rules and coverage of high interest cases such as the Baby OT and Baby RB cases.

For further information or advice please contact Jill Mason on 0121 456 8367.

**Patient matters: personal care at home**

The Personal Care at Home Bill (which will shortly begin its Parliamentary stages) will amend the Community Care (Delayed Discharges etc) Act 2003 and will allow councils to provide personal care at home free of charge in certain circumstances to people with the highest needs. It is anticipated that the new arrangements will be in place from October 2010.

The consultation on the proposals is now underway and closes on the 23 February 2010 although responses are invited, if possible, by the 26 January 2010.

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

**Regulatory matters: performers lists – new appeal process**

The Family Health Services Appeal Authority (FHSAA) is expected to transfer from 18 January 2010 into the Health, Education and Social Care Chamber of the First-tier Tribunal. The FHSAA's new title:description is likely therefore to be First Tier Tribunal (Primary Health Lists).

The First-tier Tribunal is a relatively new generic tribunal established under the Tribunals, Court and Enforcement Act 2007. Most tribunals are currently being combined into the First-tier Tribunal. Appeals from the First-tier tribunal lie to the Upper Tribunal.

The First–tier Tribunal is divided into five Chambers:
• General Regulatory Chamber;
• Social Entitlement Chamber;
• Health, Education and Social Care Chamber;
• Tax Chamber; and
• War Pensions and Armed Forces Chamber.

Watch out for the new procedural rules – due out any time now.

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

Property management and investment
The King’s Funds concept of quality in a cold climate is also particularly relevant to the way the NHS should enhance, protect and maximise the use and value of its estate. The need for estate planning to follow service need has never been so strong and other future challenges include the increased emphasis on carbon trimming, of maximising facility usage to cut overheads.

We are advised that neither current nor future governments plan to re-organise the NHS but what is inevitable is that technology and methodology will continuously evolve and as more home telecare and treatment and more services move from acute to community settings this will have an impact on the use of existing facilities and the appetite for more.

Where NHS organisations need to procure new facilities the economic climate will put unprecedented pressure on the correct tools and structures being used for such procurement:
• The Conservatives have said that they will place more risk on the private sector in PFI – the challenge will be to do this without increasing the cost of so doing at the door of the public sector at a time when all costs will be scrutinised more than ever.
• Ways of maximising income and capital from NHS estate through planning applications, site assembly, third party income (from public and private occupiers) will become more important than ever.
• Use of the Express LIFT panel will be rightly encouraged for development programmes but should be avoided for one-off projects which may not provide best value.
• Existing LIFT partnering arrangements have the potential to provide good opportunities for NHS participants provided firstly they are strong in the Strategic Partnering Board Room and secondly they performance check existing schemes and supply chains.
• We are already working on a development which utilises a charitable entity as project company and foresee that this will provide a neat solution not only for some of those one-off projects but may also be adapted for much wider application to hold and manage community NHS estate. More on this to follow later in 2010.
For further information, advice or details about the development and use of charitable structures please contact Michael Whatley on 0121 456 8291.

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