



Special ‘White Paper’ edition of the Health Legal Update

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INTRODUCTION

Welcome to this special edition of Mills & Reeve’s *Health Legal Update*. Following the publication by the Government last week of the keenly awaited White Paper [Equity and excellence: Liberating the NHS](#) we hope you will find this summary of our initial thoughts on the legal issues and challenges it presents useful.

The Government clearly sets out its vision for the future of the NHS in the White Paper and few would argue with the desirability of the vision to create an NHS centred on patients and carers which achieves outcomes amongst the best in the world and which refuses to accept substandard care.

The challenge that the Government and the NHS as a whole faces is how to achieve that vision in the current financial climate. The White Paper proposes radical changes in the structure of the NHS and makes it clear that despite its promise that funding for the NHS will increase in real terms for each year of the current parliament – there will also be huge cuts to be made – with a commitment to reducing NHS management costs by more than 45 per cent over the next four years.

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Our thoughts on the changes proposed are of course based on the content of the White Paper but we know that there will be further changes, a White Paper on public health later this year, a new legal and financial framework for the funding of adult social care, a new information strategy and a review of arms length bodies, to name but a few and the first three in a series of consultations has already been launched following the publication of the White Paper, [Transparency in outcomes – a framework for the NHS](#), [Increasing democratic legitimacy in health](#) and [Commissioning for patients](#).

However, at this stage there are lots of questions that remain unanswered, for example, even if we just consider for a moment patient related issues – what is going to happen to Priorities and Exceptional Cases? How will that sit with the Cancer Drugs Fund and indeed how will that operate? How will it work with patients registering with any GP? Will patients seek to stay with a practice in an area they perceive to be more generous – will this mean the postcode lottery will get worse? Who will have consultation duties? How will continuing healthcare work? The list goes on and on and that is before we consider any other areas such as employment, real estate and the regulation of primary care performers!

No doubt the answer to these and many more currently unanswered questions will become clear over the passage of time. In the meantime I do hope you will find our thoughts interesting and helpful. We are really interested in your views on the White Paper too – please feel free to email me with your comments [here](#).



Bridget Archibald
Head of Health
01223 222436
bridget.archibald@mills-reeve.com

NHS Commissioning Board

The Government's reforms of the NHS include the creation of an independent NHS Commissioning Board. This is an important new body, which will have a key role both in overseeing the commissioning of NHS services by others and directly commissioning a significant amount of services itself.

The NHS Commissioning Board will have the following five main functions:

- providing national leadership on commissioning for quality improvement;
- promoting and extending patient and public involvement and patient choice;
- ensuring the development of GP commissioning consortia;
- commissioning certain services; and
- allocating and accounting for NHS resources.

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It is clear from the list of main functions that the NHS Commissioning Board has a broad remit and will have a number of important responsibilities. This becomes even clearer when you start to look at the more detailed remit proposed for it. According to the White Paper, this will include:

- primary responsibility for continuity of NHS services (alongside GP consortia);
- a duty to promote equality and tackle health inequalities;
- developing the NHS Outcomes Framework into a more comprehensive system of indicators;
- accounting to the Secretary of State for performance against the NHS Outcomes Framework;
- developing the structure of payment systems for NHS services;
- developing contractual models for commissioners;
- developing commissioning guidelines to standardise good practice;
- establishing a comprehensive system of GP consortia;
- making direct allocations to GP consortia for the 2013/14 financial year onwards;
- holding GP consortia to account for their use of NHS resources and the outcomes they achieve, including taking over the CQC's responsibility for assessing commissioners of NHS services;
- commissioning GP, dental, community pharmacy and primary ophthalmic services, certain national and regional specialised services and maternity services;
- promoting competition;
- working with Monitor to ensure that commissioning is fair and transparent;
- determining data standards for providers;
- accounting to the Secretary of State in relation to remaining within the annual NHS revenue limit; and
- supporting the Secretary of State and new Public Health Service in ensuring that the NHS is resilient and able to mobilise in an emergency.

At this stage, creation of the Board is subject to consultation and the need for legislation. Its formal mandate has not yet been confirmed. However, the above range of activities and responsibilities makes it clear that there is a huge task ahead in getting the Board up and running. The aim is for it be in place as a Special Health Authority from April 2011 and as a Non-Departmental Public Body from April 2012.

In the meantime, there are some interesting questions surrounding the Board's proposed role, for example, in relation to the services it will directly commission. While the White Paper states that the Board will not manage providers, it seems inevitable that it will be involved in managing GPs, dentists, pharmacists etc if it is to commission those services. PCTs currently undertake a vast amount of work managing the performance of those providers, both through compliance with their contract terms and performers list management. It is an enormous responsibility for one Board to

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commission all primary care “family health” services for the whole of England and it is not yet clear on what basis this will work.

The White Paper also states that GP consortia will have “influence and involvement” in relation to services commissioned by the NHS Commissioning Board. It will be interesting to see what this role will look like, as the services commissioned by the Board are ones that it was not felt appropriate for GP consortia to commission themselves. This would suggest that their influence and involvement over those commissioning decisions should be limited.

For further information or advice please contact [Fiona Boyse](#) on 0121 456 8302.

GP Commissioning

The White Paper puts GPs and primary care at the heart of the reform agenda of the NHS. However, GP commissioning is such a radical change that much of the statutory and contractual framework currently governing commissioning in the NHS will need amending to accommodate these major reforms. Also, areas of law that previously did not apply to GPs will now be relevant as GP consortia will be carrying out public functions with responsibility for public money. These include the following:

Organisational form

It is just not clear from the White Paper if GP consortia will be statutory bodies or private entities. The White Paper says: “We envisage putting GP commissioning on a statutory basis with powers and duties set out in primary and secondary legislation.” This is not going so far as saying GP consortia will themselves be statutory bodies – just that the activity of GP commissioning will be on a statutory basis and the powers and duties of GP consortia will be set out in legislation.

Similarly “Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality” which seems to suggest that practices can choose their own legal form or it could be read that it is the management structure of collaborative working amongst practices that can be implemented flexibly.

No doubt what evolves will depend on public opinion and Parliament – certainly concern is being expressed in various quarters that GP consortia amounts to the denationalisation of the NHS.

Accountability

There are a number of interwoven issues here. How will GP consortia be held to account? What flexibilities will be put in place to enable GP consortia to innovate? How will financial risk be managed? Will there be any reward for GP consortia for exceeding outcomes?

The White Paper majors on three areas here:

- an accountable officer within each GP consortia;
- that accountability will be outcome based; and
- that GP consortia will not be bailed out – suggesting there will be a failure regime.

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A robust accountability framework will be central to the Government's plans and to GP consortia being acceptable to Parliament. At the same time it is questionable how much risk GP consortia will really be prepared to take on. What will be important, and challenging, will be to ensure the accountability framework does not stifle innovation.

We have all heard a great deal in recent years about how autonomy of commissioning bodies has led to different commissioning decisions across the UK. With an increased number of commissioning bodies, this increases the likelihood of different approaches to prioritisation of treatments and funding decisions, which could lead to an increased perception of the existence of the postcode lottery and an increase in the number of judicial reviews sought by patients. A key question for GP consortia will be the extent to which it is appropriate to work together and the extent to which local health needs can only be addressed through commissioning on a locality basis.

The White Paper also introduces a new dimension to this. As patients are to be allowed to register with any GP practice, regardless of where they live, there may also be scope for patients to transfer to another practice if that practice offers a drug or treatment that is not currently available to that patient.

An important consideration in all of this will be what will happen to the current panels to consider individual funding requests and the policies that underpin them, some of which are regionally based. Meanwhile, GP consortia need to think about how the balancing act between commissioning for local need and consistency in decision making is achieved.

Procurement and contestability

Ordinarily the public procurement rules only apply to central and public sector bodies. If GP consortia become statutory bodies then they will be caught by the rules. However, even if GP consortia remain private sector bodies, procurement rules will still apply as they are spending public money and carrying out public functions.

Similarly the White Paper is clear that the contestability agenda will continue. The "dying" concept of the NHS as preferred provider has been finally laid to rest and the White Paper says "providers will compete to provide services". What does this mean for GP consortia?

When considering purchasing any services to support their commissioning functions, GP consortia will need to take account of the procurement rules. If, for example, they want to enter into a long term high value contract with an external organisation to provide commissioning support, they will need to tender these services. Large contracts for health services where there could be interest outside the UK will also need tendering.

There is likely to be updated guidance on commissioning health services that will provide a framework to GP consortia for deciding on whether or not to run a competitive tender which is similar to the current PCT procurement guide.

GP Consortia need to consider how they will develop or source expertise to run procurements.

Early implementers of GP commissioning

Change will take time. Meanwhile, pilot projects will need to be structured in such a way as to ensure compliance with current statutory and policy framework yet is sufficiently flexible to adapt to the rapid pace of change!

For further information or advice please contact [Gill Thomas](#) on 01223 222237.

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Transforming Community Services

The Revision to the Operating Framework stated that the separation of PCT commissioning from provision was a priority and that PCTs should divest their directly-provided community services by April 2011. This is confirmed in the White Paper. Also, by the end of 2010, Strategic Health Authorities will separate their commissioning and provider oversight functions.

The White Paper outlines that it is the Government's ambition to "create the largest and most vibrant social enterprise sector in the world". Elsewhere in this update we mention the additional freedoms for foundation trusts that are outlined in the White Paper. The White Paper states that in future "all community services will be provided by foundation trusts or other types of provider". There will be a new category of "employee-led foundation trusts", which may be an attractive option for provider arms that were considering other forms of social enterprise.

The White Paper contemplates that other types of provider will be able to enter the market for community services relatively easily and quite soon, because community services are to be moved, as soon as possible, to an "any willing provider" approach. How quickly this will be achieved in practice will depend on whether the initial community services contract is a block contract or dependent on activity. Looking forward, GP consortia will gradually take responsibility for commissioning community services. It is envisaged that GP consortia will have full responsibility for commissioning in 2012/13 and full financial responsibility from April 2013.

The development of currencies and tariffs for community services will now be accelerated and Payment by Results (presumably with outcome-based adjusters) will be extended to community services with effect from April 2012.

The extension of Payment by Results to community services will not, on its own, ensure a fair playing field. For example, costs of pension provision and compliance with regulation will impact upon operating costs. In relation to the latter, all providers (including those providing community services) will be inspected/licensed by CQC and Monitor. The extent to which pension provision remains a problem will depend on the independent review of public pensions that Lord John Hutton will chair.

Patient choice is also essential and one of the areas of focus in relation to community services is availability and accessibility of information and decision aids.

It was previous policy that transfers of community service businesses would be "asset-light" and that PCTs would retain the property required for the provision of those services. However, the White Paper confirms that PCTs will be abolished from April 2013, following the establishment of the NHS Commissioning Board and the network of GP consortia. It is unclear who will hold PCTs' property interests following their abolition and whether that will affect the policy on asset-light transfers. Having said that, any transfer of assets may hinder entry of other providers into the market which could then prevent a fair playing field.

For further information or advice please contact [Jonathan Hayden](#) on 0121 456 8238 or [Tim Winn](#) on 0121 456 8355.

Changing role for Monitor

The White Paper proposes that Monitor will become the economic regulator for publicly-funded healthcare from April 2013. For those unfamiliar with the term "economic regulator" the paper offers OFCOM (the communications and broadcasting regulator) and OFGEM (the gas and electricity regulator) as examples of economic regulators – the others in the UK being Ofwat (water), Postcomm (postal services) and ORR (rail regulation).

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Economic regulators take responsibility for the whole of their sector (“economy”), which means Monitor will be responsible for regulation of conduct, competition and pricing in publicly-funded health and social care, but also making sure that services are available. This is one of the key features of economic regulators in the UK and why Government only creates them for services regarded as essential. As Monitor is to be responsible for regulating competition, we assume this means that the Co-operation and Competition Panel will be rolled into Monitor, although that is not specifically mentioned in the White Paper.

The White Paper says Monitor will also have responsibility for regulating competition across the whole of health and social care, which makes sense because it may not be practically possible always to draw the line between health and social care or to regulate competition amongst NHS-funded care in isolation from privately funded care because of the opportunities for cross-subsidy and other anti-competitive conduct. Cross-subsidy is currently in the news as Sky attempts to take BT to task (via OFCOM) for selling Sky Sports channels at below Sky’s wholesale price (BT not only makes no margin, but actually loses 1p on every Sky Sports package it sells).

Monitor will also have a role in relation to GP consortia, because their actions (conduct) as commissioners may also have an impact on competition in the market in NHS-funded health care.

As the economic regulator, Monitor will license only those providers that are financially viable. The White Paper also raises the possibility of a levy on providers to fund Monitor’s intervention to support essential services without recourse to public funds. Monitor will also be responsible for the “rules-based special administration regime” – on which further details are imminent – which we assume will set out the circumstances in which Monitor may take control of failing providers to maintain essential services.

It should be noted that Monitor is one of two regulators for healthcare, the other being CQC, and providers will need to be licensed by both of them before they are allowed to supply publicly-funded healthcare. These proposals are subject to consultation.

For further information or advice please contact [Tim Winn](#) on 0121 456 8355 or [Jonathan Hayden](#) on 0121 456 8238.

The future of the CQC

The Care Quality Commission will continue as the licensing body for publicly and privately funded health and social care on grounds of safety and quality. The CQC will be able to respond to any information it receives from any source, including local HealthWatch (the successor to LINKs) to justify an investigation. Indeed the head office of HealthWatch will be located within the CQC.

However, although the CQC will be responsible (with Monitor) for the joint licensing of providers, it will no longer be responsible for evaluating NHS commissioners (including GP commissioning consortia), which will be the sole responsibility of the new NHS Commissioning Board (from 2012).

Under the White Paper’s proposals, the Care Quality Commission will become “an effective quality inspectorate”. This inevitably means a change from the current system which places much reliance on self-certification and limited spot checks. In order to achieve this change in emphasis (from regulator to inspectorate) visits from the CQC and more extensive audits will become the norm. The CQC’s approach will continue to be “risk-based”, which means the CQC will continue to devote more of its time and attention to providers with known problems.

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For further information or advice please contact [Tim Winn](#) on 0121 456 8355 or [Jonathan Hayden](#) on 0121 456 8238.

The future of foundation trusts

The proposals in the White Paper include consultation on legislation to repeal the private charges cap, facilitate mergers between foundation trusts and, perhaps even more radically, allow foundation trusts to move beyond healthcare to additional purposes. Consistent with viewing foundation trusts as “social enterprises”, the Government also proposes to consult on allowing greater flexibility to foundation trusts in how they are governed, provided that, as now, they remain not-for-profit organisations. Taken together, these proposals would allow foundation trusts to compete on a much more even footing with the private sector, although not entirely on a par because (without more) they will not be able to pay dividends to investors or offer their assets as security to raise further capital. The changes could also allow the creation of hybrid organisations with multiple purposes, such as social care, research and education, which may for example, pave the way for local authority and university-led foundation trusts.

We would expect changes like these would make it easier for aspirant foundation trusts to find a solution that works for their organisation, making foundation trusts even more attractive. That is important because the White Paper states categorically that all NHS trusts are to be or be “part of” foundation trusts by 2013/14, with the support of a new unit within the Department of Health. To emphasize the finality, the White Paper proposes to repeal the NHS trust legislation in due course – so that it will not be possible to be an NHS trust. Before this happens, those NHS trusts that cannot find a path to foundation trust will have been put into administration under the Health Act 2009 provisions, the implication being that their essential services will be transferred to another (foundation trust) provider.

The White Paper also expressly states that the de-authorisation regime for foundation trusts will be repealed, which makes sense because de-authorised foundation trusts become NHS trusts. These proposals not only provide a real deadline for NHS trusts to become or join in with foundation trusts, they also mean there is no way back for failed NHS foundation trusts.

For future failures, the White Paper contemplates a “special administration” regime which it places firmly in Monitor’s hands as the economic regulator. The accompanying analytical strategy refers to this as “the special administration and insolvency regime” although it is not clear whether this is a return to the idea that there should be no safety net. Foundation trusts will be wary of these proposals and will want to understand how they will work in practice.

The White Paper states that these proposals will be subject to consultation.

For further information or advice please contact [Tim Winn](#) on 0121 456 8355 or [Jonathan Hayden](#) on 0121 456 8238.

The estate of things to come...

Fresh on the heels of the Commissioners’ Investment and Asset Management Strategy (CIAMs) work and Transforming Community Services, a brand new look is now required at NHS Estate following receipt of the Secretary of State’s vision for the future of health service delivery and commissioning.

This article focuses on the impact on primary and community estate and considers the position in relation to both administrative offices/HQs and operational premises.

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If primary care trusts (PCTs) and strategic health authorities (SHAs) are going to be disbanded, those entities will no doubt be pulling back immediately from any proposed long term commitments to buy or take on long term leases for administration or HQ premises to avoid being left with surplus interests in 2012/13. Where these premises are already owned or leased they may represent part of the NHS “family silver” but more typically be leased and likely to be unattractive to the new GP consortia who will either have their own premises or will not need buildings of the same size or in that location.

Even if the surplus interest has a substantive value it may be difficult to dispose of unless the commercial property market picks up. In some areas PCTs have taken over premises in locations where there are few other organisations of the size and scale to take the space. Who will be responsible for residual liabilities such as outstanding rents on the residue of a leasehold term will be clearer in due course – in our view it is more likely to go “up” to the National/Regional Commissioning Boards rather than “down/across” to the GP consortia bodies. Where premises are going to be surplus, PCTs should start negotiations earlier rather than later.

In relation to operational estate there are many different types of ownership ranging from PCT owned, GP owned, 3PD, NHS LIFT and PFI. Each of these types of ownership will have its own issues in relation to the changes.

However, we envisage that PCTs will find the information collected during CIAMs very helpful in future planning.

In some areas PCT provider staff are to be transferred to foundation trusts – as there is still a principle of retaining the estate with the commissioner it is perhaps less likely that the estate will go with them otherwise this may jeopardise the choice agenda.

Whether transferring HQ/administrative offices or operational estate these are key issues to be addressed as will be the covenant strength of and the attractiveness or otherwise of the GP consortia to commercial landlords. Much will depend on their legal structure but it looks unlikely that they will have the same NHS back up cover that PCT covenants do – this may make such landlords reluctant to consent to assignment unless the Secretary of State for Health (SSH) provides a covenant (along the same lines as the deeds of safeguard given by the SSH to provide further reassurance for foundation trusts in PFI deals). Alternatively it could be effected by outgoing PCTs providing authorised guarantee agreements backed by the SSH.

As the guidance appears and there is more direction of travel we will provide further updates and try and answer more of the many questions. This autumn we plan to host seminars from each of our main offices where we will be examining the future structures and management of NHS estate. To register your interest in attending please email your details to events@mills-reeve.com stating that you are interested in attending one of our management of NHS estate seminars.

For further information or advice please contact [Michael Whatley](#) on 0121 456 8291.

NHS Local Improvement Finance Trust (LIFT)

One particular area where a number of questions arise relates to the future of the LIFT programme. Certainly to date the Government seems to have been very supportive of it describing it as one of the best examples of joint public private working. The White Paper proposals present further opportunities for pro-active and effective LIFT Companies.

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In relation to the PCT's role as participant there are a limited number of statutory bodies to whom they can assign the benefit of the Strategic Partnering Agreement. Two of these options have gone as primary care trusts and strategic health authorities are not going to exist in the future. One option is to transfer to "any person/party replacing any of the above" which could lead to some interesting discussions as the PCT's functions are being passed to a number of different entities (eg, local authorities, commissioning boards and GP consortia). In relation to the obligations to pay the Lease Plus and Land Retained Payments two related things need to be borne in mind. First, the funders of LIFT projects have a number of controls over the LIFT projects and documents through their security documents and, second, any transfer of these obligations to a third party would need to be negotiated with LIFT Co and its funders.

The LIFT shareholders agreement provides that the respective 20 per cent shares that are owned by PCTs and Community Health Partnerships (the Department of Health wholly owned company that initiated and promotes LIFT) can only be sold to the private sector partner (who holds 60 per cent) once they have been first offered to the other public sector shareholder (and other PCTs where there are more than one PCT Shareholder).

The other possibility is that there is a Transfer Order – transferring PCTs' interests to whichever statutory body takes over the PCTs' functions. As most LIFT property relates to primary and community care services it is possible that PCTs' interests in LIFT projects (shareholdings, Lease Plus and Land Retained Agreements) are transferred to the National/Regional Commissioning Boards who will be commissioning primary care in the future. This would follow on from the earlier DH guidance that the estate should remain with the commissioner. Then as well as commissioning primary care from GPs (in their capacity as providers) the boards could also become their landlords.

Another option would be for those GP consortia whose constituent practices lease parts of LIFT buildings from PCTs to take on the role of head tenant under Lease Plus Agreements and maybe to acquire shareholdings in the Lift Companies. This would take us back to the original LIFT "vision" which saw GPs as key stakeholders and shareholders.

For further information or advice on existing LIFT arrangements please contact [Bridget Archibald](#) on 01223 222436.

Employment issues

The White Paper says that "Liberating the NHS involves change at every level of the NHS" and looking at the proposals it is abundantly clear that there will need to be a major workforce programme in order to deal with the significant workforce challenges ahead.

These are the specific and key workforce issues that are directly referred to in the White Paper:

Staffing levels – The White Paper makes an explicit statement that "the NHS will employ fewer staff at the end of this Parliament" and makes clear that the workforce will be "rebalanced" towards clinical staffing and front-line support. This commitment to reducing staff numbers and the reorganisation involving the proposed abolition of primary care trusts and strategic health authorities indicates that there will be significant redundancies (for which a figure of £1.7 billion has reportedly been set aside) and no repeat of the employment guarantee and extensive "slotting in" to roles which occurred following the Commissioning A Patient Led NHS (CPLNHS) reorganisation.

Employee led organisations – The White Paper states that staff will have an opportunity to turn the organisations that employ them into employee-led social enterprises. So far social enterprises have not seemed particularly attractive to

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employees and take-up has been slow. Whether employees will see any advantages in this model will depend on the precise proposals which emerge.

Pay levels – The policies announced in the Budget on 22 June 2010 around pay restraint and the inclusion of the NHS in the two-year public sector pay freeze from 2011/12 are reiterated. The pay review bodies will be asked to make recommendations on pay for staff earning under £21,000.

Pay bargaining – Perhaps one of the most fundamental changes proposed is that, going forward, the White Paper makes clear that the Government wants pay decisions to be led by employers, rather than being imposed by the Government, saying that in future all individual employers will have the right to determine pay for their own staff. This is clearly a major attack on collective bargaining which has always existed in the NHS. Recognising this, there is an acknowledgement in the White Paper that many organisations will want to continue to use national contracts as a basis for their local terms and conditions, although that falls short of a commitment to anything specific. Predictably the proposals have angered public sector unions who have interpreted the proposal as undermining their influence in national pay bargaining. TUC general secretary Brendan Barber said: “The Government will bite off more than it can chew if it gets rid of national pay bargaining in the NHS. It would mean a pay bureaucracy in every hospital and GP’s surgery, would hit lower-paid workers in the less prosperous parts of the economy the hardest, make the north/south divide even bigger and, if past experience is anything to go by, would see those at the top of organisations paying themselves even more.”

Pensions – The Government will consider the outcome of the review of public sector pensions being carried out by Lord Hutton and says it is committed to ensuring that pension solutions are found that are fair to the workforce in the health service and fair to the taxpayer. The express reference to issues such as access, the impact on labour market mobility between the public and private sectors and the extent to which pensions may act as a barrier to greater plurality of provision of public services mean it would be surprising if the status quo remains an option. As a minimum this may see a change in the current policy of requiring a private sector provider to establish a broadly comparable pension scheme.

Efficiency – The White Paper reiterates the continuing drive for efficiency savings and states that the existing quality, innovation, productivity and prevention (QIPP) initiative will continue with greater urgency. Achieving those efficiencies in the context of such a major restructure will prove a formidable challenge. Research by the right-of-centre think-tank Civitas has found that, as with any major organisational change, restructures in the NHS are followed by a performance dip. Even after comparatively minor changes, it has previously taken NHS organisations three years for their performance to get back to where it was before the restructures were carried out.

Leaving aside the specifics, it is the big picture that is likely to present the most significant workforce challenges. In September 2009 there were 3,713 non-clinical staff in SHAs and 64,768 in PCTs. These employees now face uncertain personal futures, whilst simultaneously being key to the successful implementation of many of the reforms that have been set out in the White Paper.

Although the White Paper acknowledges that “the need for good managers performing essential functions, such as managing finance and contracts will remain” and says that there will be “opportunities for managers to start new roles ... supporting GP consortia, and within the NHS Commissioning Board” there is no detail about the mechanism by which staff might move from one organisation to another, the effect of any move on them and in particular whether TUPE or TUPE principles might apply.

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Given the radically different nature of the undertakings envisaged by the White Paper from those which presently exist, as well as the way that commissioning staff are typically organised, attempting to apply TUPE and the automatic transfer principles could be complex and fraught with difficulty. David Nicholson's letter sent to all chief executives on 13 July 2010 makes reference to a forthcoming "agreed human resources framework" which will hopefully provide clarification, but the framework will have to recognise that there is a fundamental difference between a reorganisation of public sector employers and a reorganisation which involves fewer public sector jobs and a transfer of functions to the private, GP, sector where there may be different needs and priorities.

Much greater clarity will have to be provided in the near future about this key issue as David Nicholson's letter also makes clear that all staff affected by change should have an initial interview with their line manager to discuss the situation by the end of September 2010.

For further information or advice please contact [Stuart Craig](#) on 01223 222280 or [Martin Brewer](#) on 0121 456 8357.

Patient involvement/HealthWatch

The foreword is always a good place to start in any document. The foreword to the White Paper really sets the scene and emphasises that the Government intends to make the NHS more accountable to patients and that patients will be at the heart of everything it does. This is to mean that patients will have more choice and control helped by easy access to the information they need. They are to be in charge of making decisions about their care. This is expanded on in Chapter 2 entitled "Putting Patients and the Public First" which is broken down into the following four sections:

Sharing decision making – nothing about me without me

The new NHS Commissioning Board is to champion patient and carer involvement and the Secretary of State will hold it to account for progress.

The Government lists several reasons for this, namely that evidence has shown that involvement improves health outcomes, increases satisfaction and increases adherence to treatment and it can also bring about significant reductions in cost as well as improve the management of long term conditions. Further comments on the Commissioning Board are included above.

An NHS information revolution

There is a lot to take on board here and my colleague Stuart Knowles gives his thoughts on the proposals further on in this update but, in short, the Government's aim is to give people access to comprehensive, trustworthy and easy to understand information. The White Paper talks of enabling patients to communicate with their clinicians online and wider use of tools such as Patient Reported Outcome Measures, patient experience data and real time feedback. Again they refer to evidence – this time that better information creates a drive for improvement in providers.

Quality Accounts are to be revised and extended and more information is to be provided about commissioning. The Government wants patients to have control of their health records and there is mention of patients downloading records. Information on safety, effectiveness and experience is to be published about providers. Again the NHS Commissioning Board will have a role determining data standards to promote compatibility, to clarify legal ownership and responsibilities of organisations who manage health data. An information strategy is to be published in the autumn.

Increased choice and control

Choice is to be about not just where you go as a patient and when but about a fundamental control of the circumstances of the treatment and care you receive. The Government lists 11 things it will do to increase choice and

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control including consulting on choice of treatment later this year and giving patients the right to register with any GP practice with an open list. There is an emphasis on the concept of “any willing provider” in this section. In addition the Government wants to encourage more pilots to come forward to explore personal health budgets. Once again the NHS Commissioning Board is to develop an implementation plan.

Patient and public voice

The Health Bill is to create HealthWatch England. It will be within the CQC. Local Involvement Networks (LINKs) will become the local HealthWatch. There are four local and four national roles listed for HealthWatch. Nationally HealthWatch will have the power to propose CQC investigations of poor services and local HealthWatch will also have the power to report concerns about the quality of providers.

For further information or advice please contact [Jill Mason](#) on 0121 456 8367.

Information governance – get your information governance and data security right or pay the price!

Information may not be the first thing on the mind of NHS managers and those establishing GP consortia, but, be under no mistake it is high on the agenda of the coalition government and it is your responsibility to understand and get the law right.

Just a quick look at the first few pages of the White Paper tells the story. It talks about an “information revolution” in the NHS which is seen as part of giving patients “control” and is referred to as the mainstay of accountability. The paper proposes patients’ communication with the NHS and much more information being available online. Be under no mistake, commissioning decisions and the information upon which they are based will be open to public scrutiny with all this information being put in the public domain. The Government is looking to establish a “Health and Social Care Information Centre” and the new NHS Commissioning Board is to be charged with the job of setting standards for data management.

The devil will be in the detail of course and the legal ownership of information and the management responsibilities of the new organisations will require primary legislation. We will therefore need to wait for the Department of Health to have thought through the issues and publish its information strategy before reaching firm views on the changes proposed, but at this stage there are already two striking points to consider.

First, the Government has made it clear that freedom of information is a major issue and will be extended. There is no doubt that it will cover all organisations within the NHS and is very likely to be extended to cover private sector organisations, or those not directly employed by the NHS, that deliver service to or on behalf of the NHS. David Cameron has made it clear that the coalition is determined to “rip off the cloak of secrecy” around public services.

Second, the Government and the Information Commissioner are determined to make sure that data security (in all its forms, paper records, IT etc) is of paramount importance. David Cameron will be determined not to take the blame and embarrassment for lost data on the scale said to have been lost by HM Revenue and Customs in 2007. The regulatory processes are now in place to make data security the responsibility of NHS managers directly.

The Government is actively considering the revised e-privacy directive which will come into force shortly with its main aim of protecting individual privacy and enhanced information security. There will be even stronger regulatory powers to be used against those who breach data security and a legal obligation to notify the Information Commissioner of any

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security breach. No one can then doubt the force of the power of his office when that happens. (Did you know that the Information Commissioner is seeking to amend the law to imprison people for some data “security” offences?)

It will take no more than a moment’s thought for all those involved in GP commissioning to realise that the quantity and quality of sensitive personal information which they will hold will mean they are at a real risk if adequate information governance and data security measures are not in place from the very start.

The action required

Although we will have to wait for the creation of the Health and Social Care Information Centre and the standards set out by the NHS Commissioning Board on data management and (of course) security, there is action that any fledgling GP Commissioner (as well as all other NHS bodies) must put in hand now. At the very least we suggest you consider and seek help on the following issues:

- developing an information governance business case (an action devised this year and actively promoted by the Information Commissioner);
- applying “privacy by design” to the new structures and making sure data security is built into the “fabric” of the new organisation and not an after-thought;
- dealing with the implementation of the revised e-privacy directive, and especially data security;
- putting in place proper information sharing including protocols with other public bodies. Consider, for example, other NHS bodies and local authorities;
- establishing robust contractual arrangements on the information standards of suppliers and third parties and auditing compliance;
- dealing with the prospect of enforced audits and the other regulatory powers of the ICO;
- putting in place proper policies and practice to ensure you have proper information governance procedures and setting up external audit to provide assurance that they actually work and comply;
- establishing a proper publication scheme in line with the requirements of the Information Commissioner and putting in place proper procedures to make information public as will be required by the Government;
- adopting and using privacy impact assessments, and
- consider making personal information promises.

It might seem like a daunting action plan, and hopefully the Government will, in time, address some of these issues when it considers the detail as to how it will put into practice its stated ambitions for the NHS.

In the meantime, the earlier GP commissioners and others make a start on these matters the easier they will be. Addressing information governance after a new organisation has been created will be an extremely complex and difficult task to do properly.

For further information or advice please contact [Stuart Knowles](#) on 0121 456 8461.

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Public health and social care

Improving public health, tackling health inequalities and reforming adult social care will be the strategic focus of the DH as the NHS is liberated. We await the details to be set out in the public health White Paper this year, but the headlines have been signalled.

We can expect to see the creation of a new Public Health Service. Its remit will be largely as follows:

- integration of existing health improvement and protection bodies and functions;
- increased emphasis on research, analysis and evaluation;
- responsibility for vaccination and screening programmes; and
- appointment (jointly with the local authority) of the Director of Public Health.

Local authorities will have an enlarged role. They will have responsibility for local health improvement and the department will set a ring-fenced public health budget for this. "Health and wellbeing boards" will drive local strategy – joining up the commissioning of local NHS services, social care (adult and children) and health improvement. This is a sea change.

We can expect to see closer alignment of health and social care, including funding, to secure better outcomes for individuals. Partnership arrangements will be easier to be put in place. We can expect to see greater use of personal health budgets, with the hint that there may be a right to a personal health budget in the area of NHS continuing healthcare in the future. The funding of long term care continues to be a priority and a commission has been established to report within a year.

Some PCTs are already looking at ways of working more closely with their local authorities. Patients, who previously received direct payments and managed their care package independently, struggle when they become eligible for NHS continuing healthcare and their care decisions are managed by someone else. The personal health budgets would be welcomed by them but these can be operationally very complex.

For further information or advice please contact [Dawn Brathwaite](#) on 0121 456 8224.



Jacqueline Haines
Senior Solicitor and HLU Editor
for Mills & Reeve LLP
+44(0)121 456 8404
jacqueline.haines@mills-reeve.com

www.mills-reeve.com T +44(0)844 561 0011

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