What does the Health and Social Care Act mean?

In July 2010 Andrew Lansley MP, the Secretary of State for Health, published his plans for NHS reform in the White Paper, *Equity and Excellence: liberating the NHS*. The Health and Social Care Bill, introduced in July 2011, completed its passage through the Houses of Parliament and was granted Royal Assent to become the Health and Social Care Act in April 2012.

**New commissioning framework**

The act creates an entirely new commissioning framework for the provision of health care in England. This new framework also has implications for the provision of social care and public health.

Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) are to be dissolved by April 2013 with new local clinical commissioning groups (CCGs) and an NHS Commissioning Board established to take over their duties.

**NHS Commissioning Board**

The new NHS Commissioning Board, formed by the act, is an independent body which will play a pivotal role in the new NHS. It will provide the top level commissioning and managerial guidance for the NHS in England once PCTs and SHAs have been dissolved. The NHS Commissioning Board currently exists in shadow form as a special health authority and will fully take up its role in October 2012.

The Secretary of State will produce an annual mandate of services which must be provided by the NHS, and the board will be responsible, via its overseeing of local service commissioning, for delivering this.

A nurse director, Jane Cummings, has recently been appointed Chief Nursing Officer on the NHS Commissioning Board.

**Clinical commissioning groups (CCGs)**

The act formally creates CCGs, but they have been in operation across the country in shadow form to PCTs, as ‘pathfinders’, since the bill was first introduced in January 2011. All GP practices will have to become members of a CCG. They will take over local service commissioning for the majority of services from PCTs although some services, such as maternity, will remain at a national level with the NHS Commissioning Board.

Every CCG will have a governing body, which will have a chair and will have to include an accountable officer, a finance officer, a registered nurse, a secondary clinician and two lay people.

CCGs will be financially accountable to the NHS Commissioning Board. The NHS Commissioning Board will also have responsibility for authorising all CCGs. This means approving them as fit and ready to take on the commissioning role. The authorisation process also requires that CCGs seek approval from their local authorities via their Health and Wellbeing Boards, and their respective Local Involvement Networks, or after April 2013 their Local Healthwatch.

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The RCN fought hard to secure a nurse position on the governing body of CCGs but we have become concerned with how this is being implemented. Information gathered at regional and national levels continues to indicate that in many areas junior nurses without the requisite skills are being appointed into token roles while experienced senior nurses currently working in PCTs and other areas are being overlooked.

Many CCG lead nurse roles are only being advertised on a sessional basis for a few hours a week and those in post are not being included in CCG development work. There are also significant variations in the interpretation of conflict of interest rules which are acting as barriers that block senior level nursing involvement with CCGs.

**Clinical senates and strategic networks**

CCGs are expected to seek relevant advice from clinicians, patients, the third sector and others for the development of services. For this purpose CCGs may approach new bodies such as clinical senates and strategic clinical networks, which hold sector, service and disease specific expertise. It is expected that clinical senates will inform any significant decisions such as regional and national service reconfiguration.

At present, it is unclear what the nursing role will be in relation to clinical senates and networks. The RCN is working with the Government to ensure there is appropriate representation and nursing input into the work of these bodies.

**Local government involvement**

The act creates new health and social care co-ordination bodies, called Health and Wellbeing Boards (HWBs). These bodies will bring together representatives from across the NHS, public health, adult social care and children’s services, as well as elected representatives and representatives from the Local Healthwatch (LHW), to jointly plan how they can best meet local health and social care needs.

HWBs will produce a health and wellbeing strategy which will feed into CCG planning. If the HWB does not feel that a CCG has taken this strategy into account they can report them to the NHS Commissioning Board.

The HWB will be a committee that sits within the local authority. Membership of the board will be determined by the local authority, but as a minimum they must include:

- one local elected representative
- a representative of local HealthWatch organisation
- a representative of each local CCG
- the local authority director for adult social services
- the local authority director for children’s services
- the director of public health for the local authority.

**Public health**

Local public health services will now be commissioned by local authorities rather than the NHS. This will involve a transfer of a ringfenced budget of around £4bn, and the transfer of around 5,000 staff. The act stipulates that all local authorities must appoint a director of public health. Staff will be protected by TUPE (Transfer of Undertakings (Protection of Employment)) arrangements, but there is much uncertainty currently around which services local authorities will retain and deliver.

The RCN continues to be involved in discussions with the Department of Health and employers to guarantee the fair transfer of staff by maintaining current NHS terms and conditions. So far we have been successful in maintaining access to the NHS pension scheme for those staff transferred from NHS to local authority employment. However, concerns remain about the terms and conditions of newly-appointed staff.
Public Health England, a new statutory body with responsibility for oversight and strategic planning of public health services, will be established from April 2013. It will incorporate the responsibilities of bodies such as the Health Protection Agency and the National Treatment Agency for Substance Misuse, which have been abolished.

Community and voluntary sector involvement

Local Involvement Networks (LINks) will be replaced by new bodies called Local Healthwatch (LHW), to be established by April 2013. LHW will be similar in operation to LINks, but will have additional functions, and may also be contracted to deliver the advocacy and complaints services currently carried out by PCT Patient Advice and Liaison Services (PALS), which are to be abolished. As noted, LHW will have a seat on the Health and Wellbeing Board, and may also develop structured relationships with local CCGs.

At the national level, a new organisation will be created called Healthwatch England (HWE), from October 2012. This organisation will be hosted by the Care Quality Commission (CQC), and will be connected to LHWs in order to encourage a flow of information and intelligence, so that local issues can be given national inspection where it is felt necessary. HWE will also offer support and advice to LHWs, to aid them in their development and in carrying out their duties.
Regulators: Monitor and the CQC

Monitor

Monitor, the current regulator of foundation trusts, will have its role extended to act as the economic regulator of the new system. All providers of NHS services, which is expected to include an increased number of private providers, will have to achieve a license from Monitor in order to bid for and provide services.

Monitor’s role was one of the most contentious issues debated during the bill’s passage, as it was originally proposed that its sole duty would be to promote competition between service providers. Following intensive lobbying, the act now gives Monitor a duty to ‘prevent anti-competitive behaviour’. Monitor will be responsible for overseeing competition within the procurement system, and will hold dual power for this with the Office of Fair Trading. Monitor and the NHS Commissioning Board will also set out guidance on how competition should be applied across services.

Monitor will set the national tariff, or pricing, of services. It will also set the parameters for which negotiation and competition around price can occur in order to ensure that the decision to award a contract providing NHS services is not solely made around the cost of a service.

Monitor will assess the financial viability of providers and will step in when a provider triggers the system wide failure regime. It has the power to appoint administrators and temporary management of failing providers. Monitor will also hold CCGs to account in regard to the financial viability of their chosen providers.

Care Quality Commission

The CQC will maintain its role as the independent regulator of all health and social care settings. However, it has had its responsibility for assessing commissioners reallocated to the NHS Commissioning Board. The CQC will register all providers and assess their viability to provide high-quality and safe NHS services.

The CQC’s role is separate from that of Monitor as its focus is upon the quality of service provided. It will maintain its inspectorate role of all care settings.

NICE (National Institute for Health and Clinical Excellence)

NICE will become an independent, non-departmental public body. It will, however, maintain its role of assessing the clinical and financial viability of treatment and services. NICE will change its name to the National Institute of Care Excellence to reflect having its remit extending to cover social care.

Private income cap

The act replaces the current arrangements concerning what percentage of an NHS foundation trust’s income can be generated from treating private paying patients. Previously, income generated by foundation trusts was capped, on average at around 2-4 per cent with some exceptional cases such as the Royal Marsden and Moorfields Eye Hospital. The cap, from 2014, will be raised to a possible 49 per cent of a foundation trust’s total income, far more than has ever been previously permitted.

The RCN has repeatedly raised concerns about this change. The RCN believes that it will be to the detriment of NHS patients with more profitable private patients pushing NHS patients to the back of the queue for services leading to increased waiting times and a two-tier health service. The RCN also believes that for many foundation trusts, achieving an increase of income from private patients will be impossible but many foundation trusts will waste valuable resources, which should be spent on frontline care, in attempting to do so.
As we move towards the 2014 date of implementation, the RCN will monitor foundation trust behaviour and raise concerns, where necessary, about the adverse effects of this policy change.

**Education and training**

The act stipulates that the Secretary of State will have a duty to ensure that there is an effective system for the planning and delivery of education and training. The Government will publish draft legislation and further guidance regarding medical education and training during the forthcoming parliamentary session. This will most probably form part of the draft Care and Support Bill announced in the Queen’s speech (May 2012).

Current NHS Confederation Chair, Sir Keith Pearson, will chair Health Education England (HEE), the new body responsible for overseeing the education of health professionals. HEE will be established in June 2012, and is intended to provide national leadership to the new system of health care education and training. It will bring together the roles of current bodies Medical Education England, Allied Health Professional Advisory Board and the Nursing and Midwifery Professional Advisory Board.

HEE will play a major role in supporting Local Education and Training Boards (LETBs) which are expected to take over the education and training roles of SHAs and postgraduate deaneries.

**Regulation of health care support workers**

The act grants powers for a voluntary register of all health care support workers with statutory minimum training and core competencies attached. The Council for Healthcare and Regulatory Excellence (CHRE) will set standards and quality assure any voluntary registers (there is no requirement for there to be a single register).

The RCN lobbied hard to try to change this section of the bill to provide for a mandatory register for all health care support workers (HCSW) working in care settings whose work is delegated to them by a registered nurse. Though widespread support for this amendment was achieved it was defeated by the Government.

The RCN remains convinced that a mandatory register will help to ensure that the HCSW workforce is fit for purpose and able to deliver high-quality care. Regulation and registration will also grant recognition of the increasingly complex and vital role that HCSW play in today’s NHS and social care settings. The RCN will continue to lobby the Government for a change to the legislation and a move towards mandatory regulation.

**Key dates**

- Now until Dec 2012 – authorisation process for CCGs begins – 35 CCGs have been identified to be in the first wave of authorisation
- June 2012 – Health Education England established as a special health authority
- Oct 2012 – NHS Commissioning Board to be fully established as an independent body
- Oct 2012 – Monitor starts its new economic regulator role
- April 2013 – SHAs and PCTs to be abolished
- April 2013 – Public Health England established
- April 2013 – Full system of CCGs established
- April 2014 – Target date for all remaining NHS Trusts to have authorisation as foundation trusts.

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