

Get in on the Act

Health and Social Care Act 2012



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1. Summary of the Act

Background

The Health and Social Care Bill was introduced into the House of Commons on 19 January 2011, following the publication of the white paper Equity and excellence: Liberating the NHS in July 2010. The Bill was the largest piece of health legislation since the creation of the NHS. It was subject to 50 days of debate in Committee and on the floor of both Houses. Over 2,000 amendments were agreed.

The LGA played an active role in responding to government consultations on the proposed provisions of the Act, which received Royal Assent in March 2012, and was heavily involved in making representations to Members of the Houses of Commons and Lords during the passage of the legislation. The LGA was successful in securing a number of amendments to the legislation on issues of particular concern to local government.

This publication aims to provide readers with an introduction to the Act and to summarise the main issues and principles enshrined in the supporting regulations and guidance, including the implications for local government. At the time of writing (mid May 2012), regulations, guidance and commencement dates for the provisions in the Act are still awaited. The provisions summarised and discussed below apply to England only, unless otherwise stated.

Summary

The Act is in 12 parts:

Part 1 sets out a framework which confers NHS functions directly on the organisations responsible for exercising those functions, while retaining a general duty on the SoS for Health (SoS) to promote a comprehensive health service. It also gives local government a new set of duties to protect and improve public health. Part 1 also establishes a new non-departmental public body, the NHS Commissioning Board (NHSCB), makes provision for the establishment of Clinical Commissioning Groups (CCGs), contains measures relating to the abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs), and amends the Mental Health Act 1983 and provisions relating to emergency preparedness and pharmaceutical services expenditure.

Part 2 contains provisions relating to the public health service, including the abolition of the Health Protection Agency (HPA), functions in relation to biological substances and radiation protection, the repeal of the AIDS (Control) Act 1987, and co-operation with bodies exercising functions in relation to public health.

Part 3 sets out provisions for regulation of health and adult care services in England and defines the role of Monitor, the sector regulator.

Part 4 amends Chapter 5 of Part 2 of the NHS Act 2006, which makes provision for NHS foundation trusts, removing various restrictions on foundation trusts and their authorisation, removing NHS trusts as a provider model (ie preventing foundation trusts from being returned to NHS trust status) and setting out Monitor's role in relation to arrangements in respect of failing trusts. It also sets out new arrangements for the governance, financing and accounting of foundation trusts.

Part 5 provides for the creation of a new national body, Healthwatch England (HWE), to be established as a statutory committee within the Care Quality Commission (CQC). It also makes provision about Local Healthwatch (LH) organisations in each local authority area. Part 5 also deals with the health scrutiny functions of local authorities and makes provision for the establishment of health and wellbeing boards (HWBs) in each upper tier local authority area, setting out their role. It also provides for foundation trusts and CCGs to be designated as Care Trusts and removes certain restrictions on those to whom the Health Service Ombudsman can report.

Part 6 amends the NHS Act in relation to medical, dental, ophthalmic and pharmaceutical services following the creation of the NHSCB, CCGs and the public health service.

Part 7 makes changes to the regulation of health and social care workers, abolishing the General Social Care Council (GSCC) and transferring some of its functions to the Health Professions Council (HPC). It also abolishes the Office of the Health Professions Adjudicator (OHPA).

Part 8 re-establishes the National Institute for Health and Care Excellence (NICE) as a non-departmental public body and sets out aspects of its role.

Part 9 relates to the publication of information standards and the collection of information from providers of health and social care services.

Part 10 abolishes the Alcohol Education and Research Council, the Appointments Commission, the National Information Governance Board for Health and Social Care, the National Patient Safety Agency and the NHS Institute for Innovation and Improvement.

Part 11 contains miscellaneous provisions, including duties for bodies to co-operate, arrangements with devolved authorities, supervised community treatment and transfer schemes.

Part 12 covers technical matters, including regulatory powers and commencement matters.

Resources

Health and Social Care Act 2012:
<http://tinyurl.com/c9dpdp5>

2. Overview – the key provisions explained

Summary

In providing for new structures and means of commissioning and providing health services, the Act makes changes to a number of existing Acts, most notably the National Health Service Act 2006 (the NHS Act) and the Local Government and Public Involvement in Health Act 2007. Much of the wording of the Act is couched in terms of amendments to previous legislation. The summary and explanation below are largely based on the explanatory notes to the Act provided by the Department of Health and published at <http://tinyurl>.

In the explanations below, all those sections which explicitly refer to local authorities or their staff or services are marked with a pink asterisk.

Part 1 – The health service in England

Section 1*: amends section 1 of the NHS Act, which contains the Secretary of State's (SoS) duty to promote a comprehensive health service designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of mental and physical illness.

Subsection (1) retains the duty on the SoS to promote a comprehensive health service. This is the core duty, dating back to the founding NHS Act of 1946, which makes the SoS accountable for the health service.

The Act inserts the words 'physical and mental' in front of 'illness' when outlining the SoS's duty which thereby addresses mental as well as physical illness.

The functions of commissioning services and the provision of services will no longer be delegated by the SoS, but will be directly conferred on the organisations responsible for performing them. The SoS's role is to ensure that these functions are being carried out effectively; he or she retains ultimate responsibility for securing the provision of services through the exercise of his or her functions, such as his or her powers to set objectives for the NHSCB (through the mandate to the NHSCB), to oversee the effective operation of the health service and to intervene in the event of significant failure.

The SoS and local authorities will have powers both to commission and to provide public health services.

The Act maintains the principle that health services must be free of charge unless charges are specifically provided for in legislation. This includes all services commissioned by the NHSCB, CCGs, and, in relation to public health, local authorities.

Section 2 creates a duty on the SoS to act with a view to securing continuous improvement in the quality of individuals' healthcare. In discharging this duty, he or she must have regard to the NICE quality standards and must focus on outcomes, particularly on effectiveness, safety and patient experience. This duty is also placed on the NHSCB and CCGs.

Section 3 places a duty on the SoS to have regard to the NHS Constitution when exercising his or her functions.

Section 4 introduces a new duty on the SoS to have regard to the need to reduce health inequalities in relation to access and outcomes. Later sections of the Act place equivalent duties on the NHSCB and CCGs, both of which are also required to produce commissioning plans setting out proposals to reduce health inequalities. All those with this duty must assess their effectiveness in annual reports and the NHSCB must annually assess the performance of CCGs in relation to reducing health inequalities.

Section 5 requires the SoS and the NHSCB to promote autonomy in the health service. This is intended to enshrine the principle outlined in 'Equity and Excellence: Liberating the NHS' of "maximising the autonomy of individual commissioners and providers and minimising the obligations placed upon them, in a way that is consistent with the effective operation of a comprehensive health service".

Section 6 places a duty on the SoS to promote research (similar duties are placed on the NHSCB and CCGs in later sections).

Section 7 places a duty on the SoS and a duty to co-operate on commissioners and providers to ensure an effective system for education and training for health and allied professionals.

Section 8 imposes a duty on the SoS to report on and review the treatment of providers of NHS services.

Section 9 establishes the NHSCB as a non-departmental public body to hold CCGs to account and to promote a comprehensive health service, with the exception of public health functions. NHSCB's commissioning functions are conferred by provisions elsewhere in the Act.

Section 10 establishes CCGs.

Section 11 places a duty on the SoS to protect health and to consult the Health and Safety Executive as appropriate.

Section 12* concerns the duties and powers of the SoS and of local authorities in relation to the improvement of public health. It gives upper tier and unitary local authorities a duty to take appropriate steps to improve the health of the people in their areas. Some of the steps local authorities might take are listed, including providing information and advice, providing facilities for the prevention or treatment of illness, providing financial incentives to encourage individuals to adopt healthier lifestyles and providing assistance to help individuals minimise risks to health arising from their accommodation or environment. Local authority actions could also include making grants and lending money to organisations or individuals.

Section 13 confers a duty on CCGs to commission health services (except those commissioned by the NHSCB) for all those for whom they have responsibility – ie those who are provided with primary medical care by the CCG and those who are resident in the area.

Section 14 confers powers on CCGs to commission physical and mental health services of prevention, diagnosis and treatment of the people for whom they have responsibility.

Section 15 gives the SoS a regulation-making power to require the NHSCB to commission certain services, including primary medical, dental, ophthalmic and pharmaceutical services, health services for the armed services and for people in prison and some specialised services which are currently commissioned by Strategic Health Authorities (because of issues such as low volume or high cost).

Section 16 removes the duty from the SoS to provide high security psychiatric services and transfers it to the NHSCB.

Section 17*: transfers responsibility for certain public health activities to local authorities, including medical inspection, treatment, weighing and measuring of school children, and the transfer of the school nursing service. It also confers a duty on the SoS to arrange for screening and supply of blood and human tissues. It also transfers the wheelchair service to CCGs.

This section also provides for the NHSCB, CCGs and local authorities – the latter with respect only to public health – to conduct, commission or fund health-related research.

Section 18* gives the SoS powers to make regulations requiring local authorities to carry out public health functions and makes the local authority liable for acts or omissions of the authority when exercising such functions.

Section 19 gives the SoS powers to direct the NHSCB and CCGs in respect of EU obligations connected to the health service.

Section 20 gives the SoS powers to regulate the NHSCB and CCGs in relation to how they carry out their functions, including the drafting of commissioning contracts.

Section 21 relates to the powers of the SoS to direct Special Health Authorities to exercise certain functions.

Section 22: gives the SoS powers to delegate by arrangement public health functions and any liabilities incurred to the NHSCB, CCGs or local government. The section also allows for the SoS to provide funding to the NHSCB and CCGs (but does not refer to funding for local government) in related to the delegated function.

Section 23 requires the SoS to publish and lay before Parliament an annual ‘Mandate’ or set of objectives to the NHSCB. It also introduces duties on the NHSCB in relation to: effectiveness and efficiency; quality of services; promoting autonomy; reducing inequalities; promoting patient involvement and choice; promoting innovation; research; education and training; having regard to the impact of services in relation to borders with Scotland and Wales; patient safety; and information. It prohibits the NHSCB from pursuing policies designed to increase or decrease the market share of any particular type of healthcare provider (for example private sector or third sector providers).

Section 24 sets out how the SoS will fund the NHSCB and its general financial duties.

Section 25 gives details of the duties of the NHSCB in relation to CCGs, including its duties in relation to authorising, merging or dissolving CCGs and for the publication of constitutions, governance arrangements and accountability.

Section 26* sets out the general duties and powers of CCGs, which reflect those of the NHSCB set out in section 23. These include duties to address health inequalities and to promote integration. It also makes provisions with regard to CCGs’ commissioning plans, including public consultation and consultation with HWBs which must be consulted on whether CCGs have adequately taken account of the latest joint health and wellbeing strategy. It provides for HWBs to report to the NHSCB their views on the latter.

Section 27 sets out the financial arrangements for CCGs, including their duty to break even on their commissioning budget and the power of the NHSCB to reward quality of performance of CCGs.

Section 28 requires all GP practices to be members of CCGs.

Section 29* enables the transfer to local authorities of PCTs’ existing functions around dental public health, and extends to local authorities a duty to help “secure and maintain” (NHS Act 2006) the health of the prison population. An amendment to the earlier legislation also enables the SoS to make regulations enabling a local authority and the prison service to delegate their prison health functions to each other.

Section 30*: requires local authorities and the SoS, acting jointly, to appoint directors of public health (DsPH). The section also defines the responsibilities of DsPH as including:

- a) the new health improvement duties that this Act places on local authorities
- b) the exercise of any public health functions of the SoS which he or she requires the local authority to exercise by regulations under section 6C of the NHS Act 2006 (this relates to functions outside England)
- c) any public health activity undertaken by the local authority under arrangements with the SoS
- d) local authority functions in relation to planning for, and responding to, emergencies that present a risk to public health

- e) the local authority role in co-operating with police, probation and prison services in relation to assessing risks of violent or sexual offenders
- f) other public health functions that the SoS may specify in regulations (eg functions in relation to making representations about the grant of a licence to use premises for the supply of alcohol).

The section stipulates that DsPH will be local authority employees who may be dismissed by local authorities after consultation with the SoS. Where the SoS considers a DPH has failed or might have failed to carry out certain aspects of his or her health responsibilities then the SoS may require the local authority to take certain actions.

Section 31* requires local authorities to have regard to documents that the SoS publishes when exercising their public health functions, for example, the public health outcomes framework. The section also permits the SoS to issue guidance to local authorities about the staff they employ to exercise their public health functions. The section also requires DsPH to produce, and local authorities to publish, annual reports.

Section 32* gives the SoS powers to set up complaints procedures and mechanisms for dealing with them.

Section 33 abolishes SHAs. It is intended that they should be abolished on 1 April 2013.

Section 34* abolishes PCTs (intended to take place on 1st April 2013) and transfers their responsibilities for local health improvement to local authorities.

Sections 35-37* amends Part 3 of the Water Industry Act 1991 (fluoridation), as amended by the Water Act 2003 to provide for the SoS to make arrangements with a water undertaker to fluoridate a water supply, only following a proposal from, and consultation and decision by, the relevant upper tier or unitary local authority. There are also provisions for cross-border co-operation between England and Wales on fluoridation and on monitoring the effect of fluoridation schemes on the health of the population.

Previous legislation is amended to enable a local authority or group of local authorities to make a fluoridation proposal to the SoS. Procedures are set out in relation to consultation and decision making and the variation and termination of fluoridation schemes. Transition arrangements are set out for existing fluoridation schemes and provision is made that payments by local authorities towards fluoridation costs are to be determined by agreement between the affected local authorities.

Sections 38-45 make a number of changes to the Mental Health Act 1983 in light of the abolition of SHAs and PCTs and other proposals in 'Equity and Excellence: Liberating the NHS'. The changes relate to: the approval of specialist clinicians who may exercise such approvals; the discharge and after-care of patients with mental health problems who are subject to compulsory measures; the provision of pocket money for in-patients; transfers to and from special hospitals; and other related matters.

Section 43* transfers from the SoS to local authorities the duty to arrange independent mental health advocate (IMHA) services.

Sections 46 and 47 amend the NHS Act to make provision in relation to emergencies affecting the health services, setting out the powers of the SoS and the role of the NHSCB and of CCGs and requiring all relevant service providers to appoint an ‘accountable emergency officer’.

Section 48 relates to the establishment of time-limited special health authorities for specific purposes.

Section 49 permits the SoS and the NHSCB to give directions as to the exercise of primary care services.

Section 50* permits the SoS to make regulations specifying the health improvement and health protection measures for which local authorities could charge.

The SoS is currently permitted to charge for health protection measures for populations, but not to charge for health protection services or facilities to individuals such as vaccination or screening.

Section 51 provides for remuneration for pharmaceutical services. Schedule 3, introduced in this section, gives further details.

Section 52 gives the SoS a duty to review health service functions and to intervene in the case of failure. This makes clear that the SoS is ultimately accountable for ensuring that the national level arm’s length bodies, such as the NHSCB, Monitor and the CQC, including the HWE Committee of CQC, are performing their functions effectively.

Section 53* requires the SoS to make an annual report to Parliament covering those aspects of the health service commissioned by the NHSCB and CCGs and the public health services for which the SoS and local authorities are responsible.

Section 54*: makes amendments to the Coroners and Justice Act 2009, placing responsibility for the appointment of medical examiners and related activities on local authorities (in England) instead of on PCTs.

Section 55*: introduces to Schedules 4, 5 and 6, which relate to amendments to previous legislation to bring it into line with the provisions outlined here. Issues specifically relating to local authorities include:

- permitting the NHSCB, CCGs and local authorities rather than the SoS to make monetary payments – ie ‘direct payments’ or ‘personal health budgets’ – to patients in lieu of providing them with health care services (Part 1 of Schedule 4)
- enabling the NHSCB and CCGs powers to supply goods and services to local authorities and to make certain services available to local authorities to enable them to discharge their functions relating to social services, education and public health (Part 3 of Schedule 4)
- enabling regulations to provide for the making and recovery of charges by the NHSCB, CCGs and local authorities in respect of certain services and supplies (Part 8 of Schedule 4)

- *conferring additional powers for the SoS to specify minimum sums that the NHSCB must pay to local authorities towards expenditure on local authority social care or other community services. This would not affect the powers of the NHSCB to make payments to local authorities under these powers in addition to those sums (Part 12 of Schedule 4)
- *amending the Local Government and Housing Act 1989 to add the director of public health to the list of statutory chief officers of local authorities (Part 1 of Schedule 5)
- *amending the Licensing Act 2003 to enable local authorities to make representations in relation to licence applications and early morning alcohol restriction orders affecting their area (Part 1 of Schedule 5)
- *amending the Mental Capacity Act 2005 to make local authorities, instead of the SoS, responsible for making arrangements to enable independent mental capacity advocates to represent and support specified persons (Part 1 of Schedule 5).

Part 2 – Further provision about public health

Section 56 abolishes the Health Protection Agency (HPA) and repeals the Health Protection Agency Act 2004. The section introduces Schedule 7, which makes a number of amendments to other Acts consequent on the HPA's abolition.

Section 57 confers on the SoS new UK-wide functions previously carried out by the HPA in relation to biological substances such as controlling vaccines or blood products.

Section 58 confers on the SoS functions previously carried out by the HPA in relation to protecting the public from radiation.

Section 59 repeals the AIDS (Control) Act 1987 which concerns the collection of information about numbers of HIV cases and deaths. The Department of Health regards the Act as redundant as laboratories and clinics now voluntarily report more accurate and relevant data than the Act calls for.

Section 60* amends the NHS Act 2006 to introduce a duty of co-operation between the SoS and all individuals and organisations who carry out health protection functions similar to those of the SoS.

Part 3 – Regulation of health and adult social care services

Sections 61-71 (Chapter 1 of Part 3) cover the duties of Monitor which will become the regulator for health care services. Monitor's overarching duty will be to protect and promote the interests of people who use those services, by promoting provision of health care services which is economic, efficient and effective and which maintains or improves the quality of services. It must enable integration where this would improve quality and reduce inequalities in access to health services or in health outcomes. Monitor has a duty to address anti-competitive or potentially anti-competitive behaviour in the provision of healthcare services, set or regulate prices and support commissioners in ensuring the continuity of services. To enable it to deliver these functions, Monitor will have the power to license providers of NHS-funded care.

Section 65* allows for Monitor's functions to be extended so that they are exercisable in relation to the provision of adult social care services.

Schedule 8 provides for the structure and governance of Monitor, which will remain as a non-departmental public body.

Sections 72-80 (Chapter 2 of Part 3) provide Monitor with powers to carry out its duty to prevent anti-competitive behaviour by providers 'that would harm patients' interests'. These sections also give Monitor concurrent powers with the Office of Fair Trading. The sections also make provision about mergers involving NHS foundation trusts and co-operation between Monitor and the Office of Fair Trading.

Sections 81-114* (Chapter 3 of Part 3) establish a licensing regime for providers of health care services for the purposes of the NHS and provide Monitor with the necessary powers to run the regime. The regime gives Monitor the means to perform its main duty and carry out its functions; for example, it will provide a means for Monitor to collect information needed to set prices.

Schedule 11 introduced by section 107 gives further details about Monitor's enforcement powers.

Sections 115-127 (Chapter 4 of Part 3), including Schedule 12 set out the framework for Monitor to set prices for NHS healthcare services, including the national tariff, which would apply to specific services. Details are given of how and whom Monitor should consult in setting prices and how providers and CCGs may refer to the Competition Commission the methodology used for specific prices.

Sections 128-133 (Chapter 5 of Part 3) provide for a health special administration regime, based on insolvency legislation, for the purposes of securing the continued provision of NHS services provided by a company licensed by Monitor that becomes insolvent (Part 4 makes separate provision for trust special administration for unsustainable foundation trusts).

Sections 134-146 (Chapter 6 of Part 3) require Monitor to set up effective mechanisms for providing financial assistance to providers in health special administration. The intention is that providers and commissioners of services will fund this financial assistance through financial contributions, or other financial mechanisms, determined by Monitor, for example, on the basis of risk.

Sections 147-150 (Chapter 7 of Part 3), including schedule 13 make a number of miscellaneous provisions relating largely to communication and amendment of previous legislation. These provisions include the requirement on the SoS not to seek to increase or decrease the proportion of NHS healthcare services that are delivered by a particular description of providers (eg the public, private or voluntary sector).

Part 4 – NHS foundation trusts and NHS trusts

Sections 151-158 deal with governance and accounting arrangements for NHS foundation trusts. They make changes to the powers of foundation trust governors giving them a right to training and development and an additional power to hold directors of the trust to account. They also require foundation trusts to ensure that their membership is representative of those eligible to be members. Foundation trusts are required to hold an annual meeting open to the public.

Sections 159-162 deal with the process of authorising foundation trust status, their constitutions and a new power for Monitor to set up a panel to advise governors.

Section 163 amends powers relating to the financial transactions of foundation trusts, external financing, transparency and powers relating to property and fees.

Sections 164*-167 deal with foundation trusts' ability to raise non-NHS income (for example, from private patients), providing that the majority of their income is derived from NHS services, including publicly-funded health services commissioned by local authorities. They also deal with financial information and decision-making requirements.

Sections 168-172 restrict the role of Monitor and increase the role of governors in relation to mergers of foundation trusts; make provision for foundation trusts to acquire each other and to acquire NHS trusts; make provision for foundation trusts to split into two or more separate trusts; and for trusts to dissolve.

Sections 173-178 develop a failure regime for foundation trusts. This includes a new role for Monitor in appointing and overseeing the work of a trust special administrator for failing trusts, to secure continuity of NHS services in line with the requirements determined by commissioners. The special administrator must also consider whether ceasing to provide a particular service would either have a significant adverse impact on health service users or on health inequalities, or would cause a failure to prevent or ameliorate a significant adverse impact on the health of such persons, or on health inequalities. There is also a role for the CQC in assessing the safety and quality of existing services.

Sections 179-180 repeal the legal framework establishing NHS trusts in England. This is because all NHS trusts are required to become foundation trusts "as soon as is clinically feasible".

Part 5 – Public involvement and local government

Public involvement

Section 181* establishes Healthwatch England (HWE) as a statutory committee of the CQC, representing the views of users of health and social care services, other members of the public and Local Healthwatch (LH) organisations. HWE is empowered to provide LH organisations with advice and assistance on patient and public involvement and to make recommendations to local authorities on this subject. HWE may also give written notice to a local authority where HWE is of the view that patient and public involvement activities (ie those activities mentioned in section 221(2) of the Local Government and Public Involvement in Health Act 2007) are not being properly carried on in its area. Meetings of HWE must be held in public.

Section 182* imposes a duty on upper tier and unitary local authorities to make contractual arrangements with a LH organisation for the involvement of local people in the commissioning, provision and scrutiny of health and social services. These arrangements should include reporting arrangements to HWE.

Section 183* makes provision for contractual arrangements between local authorities and LH, which must be a social enterprise. It also enables local authorities to authorise LH organisations to contract with other organisations or individuals (LH contractors) to assist them to carry out their activities. Local authorities are given a number of duties in relation to monitoring and reporting on the work of LH.

Section 184* permits the SoS to make regulations about the contracts between local authorities and LH organisations and LH contractors.

Section 185* transfers from the SoS to local authorities the duty to make arrangements for the provision of independent advocacy services for complaints relating to health services. Local authorities may contract with LH for the provision of independent advocacy services, but need not do so. The SoS may make directions to local authorities about such services.

Section 186* enables the SoS to make regulations to require commissioners and providers of health or social care to respond to requests for information or reports or recommendations of LH organisations and to allow members of LH entry to premises.

Section 187* requires LH organisations to produce an annual report on their activities and finance and have regard to guidance from the SoS in preparing such reports. Copies of such annual reports must be sent to the NHSCB, relevant CCGs and HWE among others specified in previous legislation.

Section 188* permits the SoS to transfer property, rights, liabilities and staff from Local Involvement Networks (LINKs) to LH, to assist local authorities to transfer arrangements from LINKs to LH, a scheme may require a local authority to pay compensation to a transferring organisation or LINK.

Section 189 amends previous legislation consequent on the provisions relating to LH.

Local government

Health scrutiny

Sections 190-192*: amend previous legislation so that regulations may provide for local authorities, as a whole, rather than health overview and scrutiny committees, to carry out health scrutiny functions.

Further amendments permit regulations for requirements to consult the local authority, to attend before it and to provide information to it to apply to 'relevant NHS bodies' or 'relevant health service providers'. This will potentially include CCGs, the NHSCB and providers of health services including independent sector providers.

Regulations will continue to enable local authorities to make joint or other scrutiny arrangements.

Joint strategic needs assessments and joint health and wellbeing strategies

Section 192* amends previous legislation so that a local authority, and CCGs that have a boundary within or overlapping or coinciding with that local authority, have a duty to prepare a joint strategic needs assessment (JSNA). The amendments widen the scope of 'relevant need' so that it covers both the current and future needs of the local population.

CCGs and local authorities must involve the LH, relevant district councils and the people who live or work in the local authority's area when preparing their JSNA.

Section 193* imposes a duty on local authorities and CCGs to produce, and on local authorities to publish, a joint health and wellbeing strategy for meeting the needs identified in the JSNA. CCGs, the local authority and the NHSCB must have regard to the JSNA and joint health and wellbeing strategy when carrying out their functions.

A further duty requires the local authority and its partner CCGs to consider how the needs in the JSNA could more effectively be met through the use of flexibilities available under section 75 of the NHS Act 2006, such as pooled budgets, when preparing the joint health and wellbeing strategy.

The local authority and partner CCGs may also include in the strategy their views on how arrangements for the provision of health-related services could be more closely integrated with arrangements for the provision of health services and social care services in the area.

CCGs and local authorities must involve LH and the people who live or work in the local authority's area when preparing the joint health and wellbeing strategy. This is similar to the duty in relation to the JSNA (except that district councils are not mentioned in relation to the joint health and wellbeing strategy).

Local authorities and CCGs must also have regard to SoS guidance and to his or her mandate to the NHSCB when preparing the joint health and wellbeing strategy. Previous legislation imposes similar duties in relation to JSNAs.

Health and wellbeing boards

Section 194* requires each upper tier local authority to establish a health and wellbeing board (HWB) for the area, as a committee of the local authority under section 102 of the Local Government Act 1972. The section also permits regulations to be made to disapply or modify the provisions of the latter in relation to HWBs.

Membership of HWBs must include:

- the director of children's services
- the director of adult social services
- the director of public health
- at least one elected representative, which may be the elected mayor or leader of the local authority and/or a councillor or councillors nominated by them

- representatives of LH and each relevant CCG (a CCG may, with the consent of the HWB be represented by the representative of another CCG which has a boundary within or coinciding with the local authority area)
- additional members may also be appointed by the HWB and by the local authority following consultation with the HWB.

CCGs must co-operate with the HWB in the exercise of the board's functions.

Health and wellbeing boards: functions

Section 195* imposes a duty on HWBs to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population. A HWB must provide advice, assistance or other support in order to encourage partnership arrangements under section 75 of the NHS Act 2006.

The section also enables the HWB to encourage those who arrange for the provision of services related to wider determinants of health, such as housing, to work closely with the HWB; and to encourage such persons to work closely with commissioners of health and social care services.

Section 196* requires the functions of CCGs and local authorities of preparing JSNAs and joint health and wellbeing strategies to be discharged by a HWB. It enables the local authority to delegate any of its functions except its scrutiny function to the HWB. This could extend to functions relating to the wider determinants of health. A HWB may inform the local authority of its views on whether the authority is discharging its duty to have regard to the JSNA and joint health and wellbeing strategy in discharging functions.

Sections 197-199* cover the participation of the NHSCB in HWBs, joint activity between HWBs and information for HWBs.

The NHSCB will be required to appoint a representative to participate in the preparation of the JSNA and joint health and wellbeing strategy. It will also be required, upon request of the HWB, to appoint a representative for the purpose of considering a matter in relation to its local commissioning responsibilities, for example primary medical services commissioning. This could also involve taking part in discussions to improve joint working.

There is provision for HWBs to work across local authority boundaries by discharging their functions jointly, with advice, if they choose, from a joint sub-committee.

HWBs may request information from the local authority and any person who is represented on or is a member of the board.

Care Trusts

Section 200* enables NHS foundation trusts or CCGs to form Care Trusts with local authorities, integrating health and social care activity. The decision to form or remove the designation of a Care Trust would be for local bodies and they would make the designation themselves.

Section 201 enables the Health Service Commissioner for England (the Health Service Ombudsman) to share complaints investigation reports with appropriate persons.

Part 6 – Primary care services

Section 202-205 relate to provisions for who may provide General Medical Services and General Dental Services.

Section 206* transfers responsibility for developing, updating and publishing local pharmaceutical needs assessments from PCTs to HWBs in local authorities.

Sections 207-208 deal with the administration and operation of the list of those permitted to provide pharmaceutical services.

Part 7 – Regulation of health and social care workers

Sections 209-231* cover technical matters relating to the training and regulation of social care and mental health workers. Provisions and issues covered include:

- enabling primary legislation to be amended to regulate social workers and social care workers
- training and standards of professional conduct of approved mental health professionals.
- abolition of the General Social Care Council (GSCC) and transferring its role, from the date of Royal Assent of this Act, in regulating social workers to the newly-named Health and Care Professions Council (formerly the Health Professions Council) with which social workers must now be registered, rather than with the abolished GSCC.
- dealing with the manner in which appeals in cases involving social workers are to be heard.
- empowering the Health and Care Professions Council to approve training courses for approved mental health professionals and the process for such approvals.
- changes to the Council for Healthcare Regulatory Excellence which will become the Professional Standards Authority for Health and Social Care (PSAHSC).

Other technical amendments in these sections follow on from the changes described in previous sections and relate to the powers, funding, accountability and governance of the PSAHSC.

Section 231 abolishes the Office of the Health Professions Adjudicator.

Part 8 – The National Institute for Health and Care Excellence

Sections 232-233* establish the National Institute for Health and Care Excellence (NICE) as a body corporate (it was previously a Special Health Authority) and give effect to Schedule 16 which deals with the constitution of NICE, including its membership, accounting and general duties.

Sections 234-249* set out the role of NICE in developing quality standards for NHS, public health and social care; supplying such standards to the devolved administrations; training and advice and the force of such advice; the parameters within which the SoS and the NHSCB may give directions to NICE; and arrangements for appeals against NICE recommendations.

Section 237* states that the requirement on specified public bodies to make funding available within three months for treatments recommended by NICE's technology appraisal guidance applies to local authorities only in relation to their public health functions.

Section 241 provides for the NHSCB to direct NICE to prepare commissioning guidance to CCGs.

Part 9 – Health and adult social care services: information

Sections 250-277* enable the SoS and the NHSCB to set information standards for health services or adult social care. They also establish the Health and Social Care Information Centre and set out its powers, duties, details of its constitution (Schedule 18) and the conditions under which it is required to collect and disseminate information.

Part 10 – Abolition of certain public bodies etc

Section 278 abolishes the Alcohol Education and Research Council.

Section 279 abolishes the Appointments Commission.

Section 280* abolishes the National Information Governance Board for Health and Social Care and confers its functions on the CQC.

Section 281 abolishes the National Patient Safety Agency (NPSA). Provision is made in Part 1 of the Act for the NHSCB to have responsibility for the functions currently carried out by the NPSA in respect of reporting and learning from patient safety incidents.

Section 282 abolishes the NHS Institute for Innovation and Improvement, part of whose functions are transferred in Part 1 of this Act to the NHSCB.

Section 283 repeals legislation permitting the establishment of standing advisory bodies.

Part 11 – Miscellaneous

Section 284* provides for a new regulation-making power, which allows the SoS to specify in regulations that local authorities must notify births and deaths to the NHSCB, CCGs and other local authorities.

Section 285* extends the list of persons who can receive information from the Registrar General of births and deaths. The list will now include local authorities, among others.

Section 286 makes similar arrangements for Wales.

Section 287* extends the list of persons to whom the Statistics Board may give information on births and deaths, to include local authorities, among others.

Sections 288-291 contain provisions to require Monitor and the CQC to co-operate with each other and with other relevant bodies.

Sections 292-294 deal with relations between the SoS and the CQC in respect of: remunerations to CQC staff; requiring the CQC to seek approval of the SoS before carrying out special reviews or investigations, except where there is a risk to health, safety or welfare of service users; and permitting the SoS to intervene where he or she believes the CQC is failing significantly (although the SoS is not permitted to intervene in individual cases).

Sections 295-298 (including Schedule 21) deal with arrangements between the NHS, the NHSCB and Northern Ireland, Scotland, Wales, the Isle of Man and the Channel Islands.

Section 299* amends the Mental Health Act 1983 in relation to treatment of patients on supervised community treatment. It changes the circumstances in which their treatment has to be approved by a second opinion appointed doctor (SOAD), appointed by the CQC. The effect of the changes is that approval by a SOAD will not generally be necessary if the patient is consenting to the treatment in question.

Sections 300-302* deal with transfers of staff, property, rights and liabilities between certain bodies such as PCTs and others such as CCGs and local authorities. Bodies from and to which staff can be transferred are listed and arrangements are set out for the establishment of holding companies, for example to hold PCT property before it is transferred to local authorities.

Part 12 – Final provisions

Sections 303-308 deal with mechanisms for changing legislation consequent on the changes in this Act; provision for regulations, orders and directions and for commencement of the different provisions of the Act.

Resources

Final version of the Health and Social Care Act 2012, as enacted:

<http://tinyurl.com/c9dpdp5>

‘Equity and excellence: Liberating the NHS’, July 2010, white paper setting out the Government’s vision for the health reforms:

<http://tinyurl.com/2a8ljeo>

3. Implications for local government

Summary

This section draws together aspects of the legislation that relate to the major changes for local government; and gives further details, where they are known, of how the legislation will be developed through regulation, guidance and policy. For ease of understanding, the cumulative effect of the different provisions in the Act, the headings below do not follow the structure of the Act, although they do refer to the relevant sections of the Act.

Public health and health improvement

The transfer of responsibility for public health from the NHS to local government is accompanied by new powers for local authorities both to commission and to provide public health services (Section 1). Public health and health improvement will, therefore, be one of local government's major functions.

It will require: a new body of expert staff and a workforce strategy to supplement, in the future, the public health specialists currently being transferred from PCTs; integration with existing environmental health activities; a holistic approach to health across the full range of local government functions; new national and local partnerships; a different relationship with the Department of Health (DH), a new relationship with NHSCB and the new national public health service, Public Health England (PHE); and a leadership role for elected Members in public health and reducing health inequalities.

Upper tier and unitary local authorities are given a duty to improve the health of the people who live in their areas (Section 12). The steps that local authorities may take are, broadly, the current responsibilities of Directors of Public Health (DsPH) and their teams. Government policy documents, the public health profession and local government have all emphasised, however, that the transfer is an opportunity to transform public health, addressing the wider social determinants of health through the full range of local government functions and partnerships. An important aspect of improving health will be to pursue closer working and integration of health and social care, so that people's needs are recognised and responded to in a holistic way. All of this means that the system as a whole needs to change along with this powerful new role and that it should not just be 'business as usual' in local government.

Health improvement and public health functions transferred under the Act

PCTs' public health duties to improve the health of their local population will transfer to local authorities on their abolition (Section 34).

In exercising their public health functions, local authorities must have regard to SoS policy documents such as the public health outcomes framework. The SoS may also issue guidance about the employment of local authority public health staff (Section 31).

Mandatory functions

The Act directly (ie on commencement, rather than through regulation) transfers certain specific public health activities to local authorities (Section 17) relating to the schools medical programme (eg duties to weigh and measure schoolchildren). It also transfers the whole of the school nursing service, ie those nurses working in a public health role with school-aged children and their families. Note that, at present, these duties do not include children from 0-5 years. The NHSCB will be responsible for public health in relation to 0-5 year olds until 2015 when the SoS has indicated that responsibility for this group will transfer to local authorities.

Section 29 creates a duty on local authorities to support public health in prisons. It creates the possibility for local authorities and the prison service to delegate public health functions to each other – this inter-delegation would still require regulation to come into effect, as would the transfer to local authorities of PCTs' existing functions around dental public health.

Sections 35-37 give powers to upper tier local authorities or groups of local authorities to make proposals to the SoS for the fluoridation of local water supplies. These powers resided with SHAs, which are to be abolished under the Act.

Section 18 gives the SoS powers to make regulations requiring local authorities to carry out public health functions and Section 22 enables him/her to delegate further public health functions. In DH policy documents, it has been made clear that the SoS intends to make the provision of certain additional public health services mandatory for local government from April 2013. These include:

- providing appropriate access to sexual health services
- ensuring there are plans in place to protect the health of the population, including immunisation and screening plans
- ensuring NHS commissioners receive public health advice on matters such as health needs assessments for particular conditions or disease groups, evaluating evidence to support the process of clinical prioritisation for populations and individuals and new drugs and technologies in development – this advice has become known as the 'core offer' from public health to CCGs.
- the NHS Health Check programme for people between 40 and 74.

Under Sections 43 and 55 respectively, local authorities have an additional duty to arrange independent mental health advocate (IMHA) and independent mental capacity advocate (IMCA) services. IMHAs provide help and support for people subject to the 1983 Mental Health Act and IMCAs provide a similar service under the Mental Capacity Act 2005 (see resources).

A late addition during the passage of the Act (Section 54) places a duty on local authorities to take on the duties of PCTs, created by the Coroners and Justice Act 2009 (see resources) but not yet commenced, for appointing medical examiners and related activities, including funding and monitoring the work of medical examiners. Medical examiners scrutinise the Medical Certificates of Cause of Death (MCCD) issued by the doctors who attend patients in their final illness. Note that the creation of the Medical Examiner role was instigated by the Shipman Inquiry and the consequent Fundamental Review of Death Certification 2003. This important role has associated duties to collect and analyse statistical data relating to death certification, with the aim of ensuring that there can not be a repeat of the Shipman case, where multiple deaths of older patients went unnoticed and unchallenged.

Section 60 introduces a duty of co-operation between the SoS and all those who carry out health protection functions – this includes local authorities.

Other services will be at the discretion of local authorities, depending on national and local priorities. But note that the SoS through regulations and guidance permitted by the Act is likely to transfer additional public health duties, such as responsibility for dental public health and for prison health, which would no longer be discretionary, if regulations to this effect were made.

Charges and payments by and to local authorities

Some existing services for which local authorities charge under current legislation, such as decontamination of premises and/or land, would now fall within the new duty to improve health. Therefore, Section 50 would enable the SoS to allow local authorities to continue to charge, in appropriate cases, while maintaining the general position that services to individuals under the NHS Act are free of charge, unless specific provision is made for a charge in legislation. Specification of which services could be charged for would require regulations (Section 55).

Section 55 of the Act permits local authorities to make direct payments to patients through ‘personal health budgets’ instead of providing services – similar to the direct payments made to those eligible for adult social care. The DH is currently carrying out pilots in this area and has indicated that it would expect to see direct payments for healthcare extended.

Section 55 also enables the SoS to specify minimum allocations from the NHSCB to local authorities for social care and other community services.

Whilst the Act enables the NHSCB and CCGs to supply goods and services to local authorities, local government and health partners will need to work together to determine the spatial level at which collaboration will be most effective.

Complaints

Section 32 gives the SoS powers to establish complaints procedures about local authorities' exercise of public health functions. The explanatory notes to the Act indicate that regulations will provide that the complaint be made to the local authority that is the subject of the complaint and also that complaints may be made to the local government ombudsman in compliance with the Local Government Act 1974.

Resources

DH/LGA, 'From Transition to Transformation: a resource to assist the transfer of public health to local authorities' (February 2012): <http://tinyurl.com/7rnexzh>

DH, 'Public Health in Local Government' (December 2011), a series of factsheets detailing the new public health roles and responsibilities of local government: <http://tinyurl.com/d69mkdj>

DH, 'Healthcare Public Health Advice to CCGs' (February 2012), draft guidance on the mandatory 'core offer' of public health to CCGs <http://tinyurl.com/dxdcnjm>

LGA, 'Local Government Transition Guidance on Public Health' (January 2012): <http://tinyurl.com/d723g6n>

DH website on personal health budgets and direct payments: <http://tinyurl.com/ces5zm3>

National Institute for Mental Health in England guidance for commissioners on independent mental health advocacy (2008): <http://tinyurl.com/bueeee>

Office of the Public Guardian information on the Independent Mental Capacity Advocate service: <http://tinyurl.com/bnmo6am>

The Coroners and Justice Act 2009: <http://tinyurl.com/cjmp7f2>

The Shipman inquiry website: <http://tinyurl.com/ca6hsaj>

Death Certification and Investigations in England, Wales and Northern Ireland: Report of a Fundamental Review (2003): <http://tinyurl.com/d84plcj>

Directors of Public Health

Section 30 requires local authorities and the SoS, 'acting jointly', to appoint directors of public health who must be chief officers of the local authority (Section 55, Schedule 5, Part 1), on a par with directors of children's services and adult social care. They will then be local authority employees, but may only be dismissed following consultation with the SoS. A letter of guidance from the DH and the LGA (issued in January 2012 – see resources) on appointments of DsPH during and after the transition period makes clear that PHE will, in practice, take on the role of the SoS.

Section 30 also defines the responsibilities of DsPH, which are, broadly, to implement all the health improvement and public health duties of local authorities conferred by the Act, including producing an annual report (Section 53). The DH has published a factsheet outlining the expected role and accountability of the DPH and is producing statutory guidance on the responsibilities of DsPH, in the same way that guidance is currently issued for Directors of Children's Services and Directors of Adult Services (see resources).

Resources

DH factsheet on the role of the Director of Public Health in local government (December 2011): <http://tinyurl.com/buco799>

Letter from DH and LGA on DPH appointments (January 2012): <http://tinyurl.com/cnr6pre>

Faculty of Health template job description for the new role of DsPH (November 2011): <http://tinyurl.com/br9nqy5>

HWBs

HWBs are established by Section 194 as committees of upper tier and unitary local authorities under section 102 of the Local Government Act 1972. Regulations may disapply or modify provisions of the latter in relation to HWBs. Such regulations will be required, for example, to permit DsPH and directors of adult social care and children's services to sit on HWBs as full members, thereby introducing a new type of relationship between officers and elected Members. Membership of HWBs must include these three officers as well as at least one councillor and representatives of LH, CCGs and others as desired. HWBs are given a number of specific functions and powers. They are summarised below.

- A duty to encourage integrated working between commissioners of NHS, public health and social care services, including arrangements under Section 75 of the NHS Act 2006 (Section 195). These consist of pooled budgets, lead commissioning, where one partner leads on commissioning for a particular service or group of service users on behalf of both, and integrated

provision, where staff from the NHS and local government work in a combined team. HWBs also have powers to bring together commissioners of any services that impact on the wider determinants of health, to work with the HWB and other commissioners of health and social care (Section 195).

- There is also a power for the local authority to delegate any of its powers to the HWB, except health scrutiny. Housing is the example given, but many other local government functions, such as education, environmental and leisure services also impact on health (Section 196).
- A duty to discharge the functions of CCGs and local authorities (conferred in Sections 192 and 193) to prepare JSNAs and joint health and wellbeing strategies. In effect this means that these strategies will be prepared by the HWB but will require endorsement by the CCGs represented on the board (Section 196). CCGs must consult with HWBs on whether their commissioning plans have adequately taken account of the latest joint health and wellbeing strategy (Section 26). The same section enables HWBs to report to the NHSCB their views on this issue. This means that HWBs will need to have arrangements in place to review CCG commissioning plans each year against the priorities in the joint health and wellbeing strategy. In practice, HWBs should, through their CCG members, be in dialogue with CCGs at an early stage in the development of commissioning plans so that final reviews will be a formality.
- A duty to prepare and publish local pharmaceutical needs assessments: an overview of local pharmaceutical needs, services and gaps in provision similar to JSNAs (Section 206).

- Powers to request information from the local authority and any person or organisation represented on the HWB.

Sections 197-199 provide for the NHSCB to appoint representatives to HWBs and for HWBs to work jointly across local authority boundaries.

HWBs are operating in shadow form during 2012-13 before commencing their full statutory role from April 2013. JSNAs and joint health and wellbeing strategies will need to be in place by October 2012 to inform the first CCG commissioning plans for 2013-14.

A number of programmes are supporting the setting up and development of HWBs. These include the DH National Learning Network which brings together a range of resources, including the LGA's collaborative leadership development support programme.

Resources

Local Government Association, 'New partnerships, new opportunities: a resource to assist setting up and running HWBs' (November 2011): <http://tinyurl.com/c4nf27y>

DH et al, 'Operating Principles for HWBs' (August 2011), an informal publication based on an event with stakeholders in July 2011: <http://tinyurl.com/cv9ukt3>

National Learning Network for HWBs: <http://tinyurl.com/dx2esfu>

Health scrutiny

Local authorities will no longer be required to have overview and scrutiny committees to discharge health scrutiny functions, but will continue to have such functions, which they will be able to discharge in various ways. For example, although it is the local authority itself which now holds the health scrutiny powers, local authorities may still choose to continue to operate their existing health overview and scrutiny committees. They may also choose to put in place other arrangements, such as appointing committees involving members of the public (Section 190-192).

The current powers relating to consultation, providing information and attending before health scrutiny committees will be conferred by regulations on local authorities as a whole and the complementary duties will be extended to all NHS Commissioners and providers of NHS services. At the time of writing, it is not clear if they will extend to any commissioning support organisations, which are not part of the NHS.

The changes brought about by the legislation will mean that those undertaking the health scrutiny function in a local authority will need to develop a close relationship with their LH and an understanding of their respective roles. It will also be important to develop a relationship with the HWB and, as with other executive functions of the council, to plan the health scrutiny programme so as to align appropriately with the HWB's planning cycle.

Health scrutiny committees will no doubt already have developed a working relationship with their director of public health, but they may now wish to extend this to other senior public health specialists who will be transferring to the local authority.

The Centre for Public Scrutiny has received funding from the DH to help support scrutiny and accountability as the health system changes in response to the Act.

Resources

Centre for Public Scrutiny, 'Health overview and scrutiny: Exploiting opportunities at a time of change' (2011), reports on work by CfPS with seven scrutiny development areas looking at scrutiny within the context of the health reforms: <http://tinyurl.com/cohssm3>

Healthwatch

Healthwatch England

Section 161 establishes HWE as a statutory committee of the CQC. It will be set up in October 2012. It is intended that the Chair of HWE will be a member of the CQC Board. The CQC has consulted on the membership of HWE and at the time of writing is developing proposals on membership.

Local Healthwatch

Upper tier and unitary local authorities are required to contract with a LH organisation, which must be a social enterprise, to involve patients, service users and the public in the commissioning, provision and scrutiny of health and social services (Section 182). Despite their name, LH cover social care as well as health services. Amendments to the legislation at a late stage and policy guidance from the DH (see resources below)

have made it clear that LH will be corporate, ie non-statutory, bodies carrying out statutory functions. LH will have similar rights and duties in relation to information provision and to visit health and social care premises as the rights currently held by Local Involvement Networks (LINKs) (Sections 186 and 187).

In relation to the transition from LINKs to LH, the legislation (Section 188) enables the SoS to transfer property and staff from LINKs to LH, including requiring a local authority to pay compensation to a LINK.

Local authorities have a number of powers and duties in relation to LH:

- They can authorise LH to arrange contracts with other organisations to provide support – these will be known as LH contractors.
- They must ensure that LH are acting effectively and providing value for money and must publish an annual report on these two objectives.
- They must have regard to, and must require LH to have regard to, guidance from the SoS on managing potential conflicts of interests between being funded by local authorities and being able to challenge them effectively when required (Sections 183 and 187).
- The SoS may make regulations about contracts between local authorities, LH and Local Healthwatch contractors (Section 182). This could include requiring LH to obtain a licence from the CQC or requiring a Local Healthwatch contractor to be representative of local residents and service users or potential service users.

- Local authorities must provide for independent advocacy services for complaints about health services (Section 185). They may arrange with LH organisations to provide these advocacy services, but they are not required to do so. For example, a local Citizen's Advice Bureau could be asked to provide the service. Local authorities will continue to have responsibility for managing complaints relating to adult social care and to commission advocacy services to support service users including those who may wish to complain.
- Following representations from local authorities and LINKs, the start date for LH was put back from April 2012 to April 2013.
- The DH has produced a document, 'LH: A strong voice for people – the policy explained' (see resources), which clarifies and restates the Government's vision for LH. This also gives more detail on the relationship between LH and local authorities.

The DH Healthwatch Programme Advisory Group has produced a checklist of how LH will work on a day-to-day basis.

Resources

Letter from David Behan, DH Director General for Social Care, Local Government and Care Partnerships, about start date and funding for LH (January 2012): <http://tinyurl.com/722lmeo>

DH, 'LH: A strong voice for people – the policy explained' (March 2012): <http://tinyurl.com/dyclcdu>

Healthwatch Programme Advisory Group checklist about day-to-day functions of LH (March 2012): <http://tinyurl.com/c2r57d4>

The regulatory regime

Regulation of providers and commissioners

The Act (Section 81-114) extends the powers of Monitor, which becomes the regulator for the health care sector. The Act provides for Monitor to regulate adult social care. Children's services will continue to be regulated by Ofsted. As yet, there has been no indication of whether or how the role of Monitor in relation to adult social care will develop.

The CQC currently registers providers of health and adult social care services to provide assurance that they meet essential levels of quality and safety. It will continue to exercise this role. Monitor and the CQC are required to co-operate and share information and they are required to establish a joint licensing/registration process (Sections 292-294). The CQC will take over the role of the National Information Governance Board for Health and Social Care (which is abolished) in regulating the collection and provision of information (Section 280).

The National Institute for Health and Care Excellence (NICE) will retain its role in developing quality standards for NHS, public health and social care (Sections 234-249). With the transfer of public health to local government, the requirement on specified public bodies to fund treatment recommended by NICE will extend to local authorities in relation to their public health functions only (Section 237). At this stage, it is difficult to estimate what the cost implications of this duty may be.

Regulation of social care staff

In relation to the regulation of social care staff and their education and training, Sections 211-213 abolish the General Social Care Council (GSCC) and transfer its functions to the Health and Professions Council, which will become the Health and Care Professions Council (HCPC), under which social care will be the largest profession. The GSCC will close on 31 July 2012 and the HCPC will be the new regulator for social workers from 1 August 2012.

Social work will still be a regulated profession and social workers will still need to renew their registration and abide by a set of standards. However, there will be some key changes. Currently the GSCC investigates allegations of misconduct against social workers. The HCPC will instead investigate allegations of impairment to practice. HCPC will renew registrations every two years, instead of three. Employers of social care workers, including local authorities still need to tell the GSCC about potential misconduct of a social worker. Following the transfer, they will need to contact the HCPC with any concerns about a social worker.

The Council for Healthcare Regulatory Excellence also has its functions extended to social and work and social care. It will become the Professional Standards Authority for Health and Social Care. The name change reflects the Authority's new functions in overseeing the HCPC, and its new power, conferred in Sections 222-230, to accredit voluntary registers of unregulated health professionals and unregulated health care workers in the UK, and unregulated social care workers in England.

Resources

DH, 'Sector Regulation – a short guide to the Health and Social Care Bill' (February 2012), outlines the respective roles of the NHSCB, Monitor and the CQC in regulating healthcare providers (it does not cover regulation of social care):
<http://tinyurl.com/bqb6w5b>

General Social Care Council, 'Transfer of GSCC's functions to the HPC: frequently asked questions' (March 2012):
<http://tinyurl.com/cwz77k6>

4. What's not in the Act: aspects of the current health reforms that do not appear in legislation

Summary

This section considers important aspects of the ongoing health reforms which do not appear on the face of the legislation but which are relevant to it and to the work of local government.

Transfer of public health staff

Some public health staff currently employed by PCTs will transfer to PHE. The majority will transfer with their DPH to local government on 1 April 2013. The Public Health HR Concordat provides the principles and standards for managing the processes to support the transfer. The DH and LGA have also produced detailed transition planning support guidance, which indicates that local authorities and PCTs should have developed a public health transition plan for the transition year, 2012/13. The LGA has produced separate guidance specifically on public health workforce issues. This indicates that:

- public health staff transferring to local government under the Act will do so on a TUPE or 'TUPE-like' basis
- local authorities and PCTs are strongly encouraged to work together jointly with relevant trade unions to prepare for the transfer
- arrangements should be agreed locally to help transferring staff to engage more closely with their eventual new employers in the transition year 2012-13

- however, no staff should transfer employment in advance of the due date of 1st April 2013 which is the date the statutory responsibilities transfer
- PCT clusters should provide a formal governance handover document to the local authority in January 2013
- councils are strongly encouraged to implement best employment practice, taking account of the need for future recruitment and retention of specialist public health staff.

In April 2012, the DH launched a consultation, endorsed by the LGA, on a public health workforce strategy following the transition to local government and PHE.

In May 2012, the Chief Medical Officer and the Chief Executive of the LGA provided in a letter to PCTs an update on the treatment of pensions in relation to the transfer of public health staff; and published a set of answers to frequently asked questions on this topic. The letter confirms the DH and LGA agreement that staff who have access to the NHS Pension Scheme on 31 March 2013 should retain access to the NHS scheme on transfer

Resources

LGA local government transition guidance, 'Public health workforce issues' (January 2012): <http://tinyurl.com/6w6l8yq>

DH and LGA, 'Public health transition planning support for primary care trusts and local authorities' (January 2012): <http://tinyurl.com/7unsrej>

DH Public Health Human Resources (HR) Concordat ((November 2011): <http://tinyurl.com/d33dcxq>

DH consultation on public health workforce – 'Healthy Lives, Healthy People: Towards a workforce strategy for the public health system' (April 2012): <http://tinyurl.com/74xqu52>

LGA/DH resource to support the public health transition to local government (January 2012), 'From transition to transformation': <http://tinyurl.com/7rnexzh>

Letter on treatment of pensions in relation to transfer of public health staff: <http://tinyurl.com/c2kv696>

Answers to frequently asked questions on treatment of pensions in relation to transfer: <http://tinyurl.com/d3jul6q>

Public health funding

The DH has provided baseline projections for local authorities derived from PCT expenditure. At the time of writing, the allocations for 2013-14 are not yet confirmed, but the DH advises that the figures for individual local authorities in its estimates can be used for planning. Actual allocations for 2013-14 will be published by the end of 2012.

At the time of writing, the total resource for all parts of the new health architecture for 2013 is likely to be £92 billion. Of this £5.2 billion, or around 5.5 per cent of total health spend, will be allocated to public health.

Of the £5.2 billion expected to be allocated to public health £2.2 billion will be allocated to local authorities as a ring-fenced grant, £2.2 billion to the NHSCB, £220 million to PHE and £600 million to the DH.

The DH's Advisory Committee on Resource Allocation (ACRA) is developing a distribution formula for the local authority public health grant.

The public health outcomes framework indicates that local authorities will be awarded extra funding, under a 'health premium' incentive scheme on which further information will be available later in 2012. The Health Premium incentive payments are unlikely to be introduced before 2015-16.

Resources

DH baseline spending estimates for the new NHS and Public Health commissioning architecture (February 2012): <http://tinyurl.com/85542f5>

LGA briefing on baseline spending estimates for the new NHS and public health commissioning architecture (March 2012): <http://tinyurl.com/bo3nexr>

The public health outcomes framework

The public health outcomes framework, published by the DH in January 2012, sets out the DH's desired outcomes for public health and how these will be measured. The framework has two overarching outcomes. They are:

- increased healthy life expectancy taking account of the quality of health as well as the length of life
- reduced differences in life expectancy and healthy life expectancy between communities through greater improvements in more disadvantaged communities.

Outcomes will be expected to be delivered through improvements across a broad range of public health indicators grouped into four domains:

- health protection
- health improvement
- healthcare/public health and preventing premature mortality
- improving the wider determinants of health.

There will be 66 public health indicators which will be published by PHE and will form the basis of the outcomes framework. A 'health premium' will be introduced to 'incentivise' local authorities to improve public health. It is not yet clear how the incentive system will work, or whether it will be additional to the funding already announced.

The LGA has welcomed proposals that recognise and reward councils for making positive progress to improve health and reduce health inequalities, but is very concerned that a narrow incentive system based on central measures of performance will fail to take into account that there are multiple influences on the health choices individuals make.

Resources

DH public health outcomes framework (January 2012), 'Healthy lives, healthy people: improving outcomes and supporting transparency': <http://tinyurl.com/84u23sy>

LGA response to public health outcomes framework (January 2012): <http://tinyurl.com/d35hbe7>

The role of Public Health England and its relations with local government

PHE's overall stated mission will be to protect and improve the health and wellbeing of the population, and to reduce inequalities in health and wellbeing outcomes.

The operating model for PHE states that it will not duplicate the work of DsPH. Instead, it will be the expert body with the specialist skills to support the system as a whole. The intention is that it will carry out functions and activities that would not be practicable at local authority level. PHE will support local authorities in their new role by providing services, expertise, information and advice in a way that is responsive to local needs. It will support local authorities to ensure action taken is on the basis of best available evidence.

Examples of the role and functions of PHE include:

- providing specialist public health services to national and local government, the NHS and the public, eg on infectious diseases and emergency preparedness
- an information and intelligence service to support local action on promoting and protecting health and wellbeing, tackling inequalities and improving public health outcomes
- supporting the commissioning and delivery of health and care services and public health programmes by the NHS and local authorities through public health advice, analysis, service specifications, evidence and best practice dissemination
- designing and delivering nationwide communications and interventions to support the public and protect and improve their health
- supporting health ministers, the DH and the Chief Medical Officer in working across government on public health issues
- supporting the development of the specialist and wider public health workforce.

It is expected that PHE's structure will include:

- a national office, including national centres of expertise and four geographical hubs, covering London, the South of England, Midlands and East of England and North of England that oversee its locally facing services, including emergency preparedness
- units that deliver its locally facing services and act in support of local authorities, other organisations and the public in their area
- a distributed network for some functions, including information and intelligence, to allow them to be located alongside the NHS and academic partners.

A Chief Executive Designate of PHE has been appointed and PHE will be operating in shadow form in the latter part of the transition year of 2012-13, before being formally established in April 2013.

The DH has sought and indicated that it will continue to seek the views of local authority chief executives on how PHE can best prove its responsiveness and expert contribution to localities. The Department is planning further work in the summer with local authorities, early implementer HWBs and local partners on how PHE might contribute to the annual reports of the DsPH; what its contribution to HWBs will be; its relations with CCGs, clinical senates and healthcare providers; and how its annual work programme can be informed by local and cross-local authority priorities.

The DH has indicated that it is looking forward to an ongoing dialogue with local government on the design and future delivery of PHE services.

Resources

Operating Model for Public Health England:
<http://tinyurl.com/bq5okms>

The development of the NHSCB and its geographical structures

The NHSCB was established in shadow form as a Special Health Authority on 31 October 2011, with Sir David Nicholson as its Chief Executive. It will take on its full responsibilities on 1 April 2013, becoming an executive non-departmental body. Its role will include:

- delivering outcomes for patients by delivering the NHS outcomes framework
- supporting, developing and holding to account the system of CCGs
- carrying out certain direct commissioning functions, such as commissioning primary care services and health services for armed forces veterans and people in prison, as well as some specialist services
- hosting clinical networks, which will advise on distinct areas of care, such as cancer or maternity services
- hosting clinical senates to provide multi-disciplinary input to strategic clinical decision making to support commissioners.

The Board will have a central headquarters with a structure based around four geographical sectors, reflecting the current division of SHAs. There will also be local offices. Each local office will undertake direct commissioning, and oversight and development of CCGs.

Resources

Developing the NHSCB and update (July and October 2011):
<http://tinyurl.com/c8ahocj>

Link to Sir David Nicholson video on structure of NHSCB (January 2012):
<http://tinyurl.com/d6e2jnp>

Integration of health, social care and other local government services

Closer integration of health and social care and other relevant local government services has been a policy goal for many years. Integration of services receives considerable emphasis in the Act. In particular, CCGs and HWBs have specific duties to promote integration and to consider the use of integrative tools available under Section 75 of the NHS Act 2006. Integrated care was one of four areas the NHS Future Forum was asked to focus on in advising on the health reforms. There is general agreement that further integration is crucial to sustainability of services and to improving health and wellbeing outcomes.

A number of recent and forthcoming reports lay out options for reforms of adult social care and further integration with health and with other local government services such as housing. These include:

- The Law Commission's review of the legal framework for adult social care: its report recommends that to prevent a service-led or 'silo' approach, new legislation should focus on an individual's care and support needs and the outcomes they wish to achieve. The Government has announced that it will introduce legislation in 2012 to implement the recommendations it accepts in this report.
- The report of the Dilnot Commission on Funding of Care and Support: it recommends putting a limit on the maximum lifetime costs people may face towards the cost of their care; greater integration of welfare benefits with other forms of funding; and improved integration of adult social care with other services in the wider care and support system. The Government is committed to publishing a white paper on social care in 2012, which will respond to the proposals of the Dilnot Commission and the recommendations of the Law Commission.

The LGA has long campaigned for reform of the care and support system and has set out in a guide, 'Ripe for reform', a number of tests which it believes the forthcoming white paper needs to meet if the proposed reforms are to build a better care and support system which focuses on overall quality of life, and integrating services around individuals not organisations.

Resources

LGA, 'Ripe for reform: the sector agrees, now the public expects – a guide to the care and support white paper' (March 2012): <http://tinyurl.com/c9gsvx6>

Law Commission Report on Adult Social Care and related documents (May 2011): <http://tinyurl.com/d3oe8go>

Commission on Funding of Care and Support (Dilnot Commission), 'Fairer Funding for All' (July 2011) and associated documents: <http://tinyurl.com/cvh7j2o>

Association of Directors of Adult Social Services, 'The Case for Tomorrow: Facing the Beyond' (March 2012): <http://tinyurl.com/cvync3k>

The Children and Young People's Health Outcomes Strategy

The Marmot Review of health inequalities, Fair Society, Healthy Lives, recognised the importance of the early years in its priority policy objective – "give every child the best start in life" – which is crucial to reducing health inequalities across the life course, and other social and economic inequalities throughout life. Starting in the womb, what happens during the early years has lifelong effects on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational achievement and economic status.

Reducing inequalities across the social gradient requires a sustained commitment to children and young people through continued family support, education, training and employment.

In developing their public health function, which includes specific duties in relation to school children, including taking on responsibility for the school nursing service, and in taking forward their safeguarding roles, and their leadership role on HWBs, local authorities will want to ensure that the health of children and young people is given appropriate priority. Similarly, they will want to promote the health of children and young people through their JSNAs and joint health and wellbeing strategies, developed with CCGs through their HWBs. They will also want to give attention to the integration of children's health, social care and other services, using similar mechanisms to those available for the integration of adult social care. As 'corporate parents' of children and young people looked after by the local authority, they will want to pay special attention to the health and wellbeing of this group.

The DH is developing a children and young people's health outcomes strategy to help improve outcomes for children and young people. Supported by an independent Children and Young People's Health Outcomes Forum, the strategy will lay out how the different parts of the health system will work together. The Forum sought views on four particular areas:

- acutely ill children
- mental health
- children with disabilities and long-term conditions

- public health.

The Forum will report to the Government with independent advice to inform the forthcoming strategy, which is scheduled for publication in 2012.

Resources

Children and Young People's Health Outcomes Forum area of the DH website:
<http://tinyurl.com/d9v9hj4>

Marmot Review of Health inequalities, 'Fair Society, Healthy Lives':
<http://tinyurl.com/d8kksdx>

The role of commissioning support services

Clinical commissioning groups will have the freedom to decide which commissioning activities they do themselves, share with other groups or buy in from external organisations. The assistance that they buy in was described as 'commissioning support'. The NHSCB's frequently asked questions on commissioning support says that CCGs are likely to need support in carrying out both the transformational commissioning functions, like leading change and service redesign, and the more transactional commissioning functions, such as payroll and IT services, procurement, contract negotiation and monitoring, information analysis and risk stratification.

A variety of local and national commissioning support services (CSS) are being set up. Many PCT clusters are developing CSS for their local CCGs.

These services are being hosted by the NHSCB at 'arm's length' before a transition by the April 2016 deadline to become 'standalone enterprises'. They will have to become financially sustainable and commercially viable. CSSs will be expected to compete in a new commissioning support market to sell support to CCGs. Once they become legal entities, CCGs may either provide their own commissioning support through directly employing staff, use the PCT cluster offering, or may tender for their commissioning support services from a range of providers, including social enterprises, third sector bodies and private enterprises.

With their extensive experience of commissioning from a wide range of providers, local authorities will also be in a good position to provide commissioning support to CCGs. Discussions are already taking place in some areas about the possibility of integrated commissioning support services across health and social care. It will be vital that CCGs are supported in preserving existing arrangements between health and social care which are working well and in focusing on further integration of health, social care and wider determinants of health in their commissioning priorities. The LGA and ADASS emphasise these points in their 'Vision for commissioning support'.

In December 2011, a paper was circulated by the DH to SHA and PCT clusters, and CCG and local authority leads clarifying the role of local authorities, both as a key partner in and potential provider of commissioning support, and reiterating the importance of continued collaboration.

Resources

NHSCB frequently asked questions about commissioning support for NHS and local authority audiences:

<http://tinyurl.com/c8xajky>

LGA and ADASS 'Vision for commissioning support for CCGs': <http://tinyurl.com/bsdhezey>

DH paper on role of local authorities in commissioning and commissioning support: <http://tinyurl.com/dxd45sn>

5. The role of the LGA and local government in influencing the legislation

Summary

On behalf of local government, the LGA played an active role in influencing the legislation during its passage through Parliament. On a number of issues, the LGA was able to persuade the Government to make changes or accept amendments which would be beneficial to local authorities and the communities they serve. Some of these issues, the concerns raised by the LGA and the outcomes are outlined below.

Responsibility for ‘whole population’ commissioning

LGA concerns

The LGA was concerned that vulnerable groups, such as homeless people, refugees and asylum seekers, people with mental health problems and people with alcohol and drug misuse problem are not always registered with a GP. Without a duty to commission for whole populations rather than just their registered patients, some of the most vulnerable groups would be in danger of falling through the gaps in commissioning duties.

Government response

The Government introduced amendments to ensure that CCGs have responsibility for commissioning not only for people registered with a GP practice but also for those who are not registered, but are usually resident in the area covered by the CCG (Section 13).

A place-based approach to integration and ‘Cinderella services’

LGA concerns

The LGA argued that early drafts of the Bill did not adequately address commissioning of so-called ‘Cinderella services’ such as health and wellbeing services for homeless people, people with mental health problems, learning disabilities, AIDS/HIV, dementia and children’s health services.

The LGA was also concerned that the Bill did not initially emphasise the importance of a place-based approach to services which recognised the complex packages of support needed to sustain and improve the health and wellbeing of these groups. Early drafts of the Bill did little to require or encourage integration of services.

Government response

The Government introduced an amendment following the ‘listening exercise’ which takes steps towards setting out clearer grounds of responsibility (Sections 13 and 26 deal with the commissioning duties of CCGs).

Following representations by the LGA, CCGs now have a duty to promote health and care integration (Section 26) and Monitor is required to enable integration (Section 62). HWBs have a stronger role in promoting joint commissioning and integrated care, including greater use of pooled budgets and other flexibilities under Section 75 of the NHS Act 2006 (Section 195-196).

Transparency and democratic accountability

LGA concerns

The LGA was concerned that early drafts provided for no clear local accountability over GP commissioning plans or processes, or a requirement for commissioning plans to address local priorities for health improvement and reducing health inequalities.

Government response

Amendments which introduced a governing body for CCGs were a move in the right direction towards greater transparency. Section 25 lays down conditions for CCG approval, including the requirement for a published constitution and a governing body. CCGs will also be required to have regard to the joint health and wellbeing strategy in developing their plans. Furthermore, if HWBs consider that CCG commissioning plans do not adequately address local priorities, they have the power to refer plans back to the CCG or upwards to the NHSCB. However, this falls short of the LGA proposal that HWBs would be responsible for 'signing off' CCG commissioning plans.

Public health funding

LGA concerns

The LGA welcomes the transfer of responsibility for health improvement to local government as a significant opportunity to integrate public health with mainstream local government plans and services, for example for adult social care, housing, economic development and environmental services in order to address the wider determinants of health. However, we remain concerned about the level of overall level of resources for local government.

Government response

The LGA is continuing to engage with Government on ensuring that the 'global' figure to local government is sufficient to meet their public health responsibilities and that the distribution formula will reflect the intensity of health need.

Children and young people's health

LGA concerns

The LGA pressed for local government to be responsible for children and young people's public health from birth to adulthood. We were concerned that the split responsibility between the NHSCB (0 – 5 years) and local government (5 – 18 years) would lead to fragmentation of planning and provision.

Government response

The Government maintains that the split responsibility provides the best way of achieving the Government's commitment to providing an additional 4,200 health visitors by 2015.

6. Abbreviations and glossary of useful terms relating to health and social care reforms and legislation

Abbreviations

CCG – Clinical Commissioning Group

CQC – Care Quality Commission

DH – Department of Health

DPH – Director of Public Health

GSCC – General Social Care Council

HCPC – Health and Care Professions Council

HPA – Health Protection Authority

HPC – Health Professions Council

HWB – Health and Wellbeing Board

HWE – Healthwatch England

JHWS – Joint health and wellbeing strategy

JSNA – Joint strategic needs assessment

LH – Local Healthwatch

LINK – Local Involvement Network

NHSCB – National Health Service Commissioning Board

NICE – National Institute of Health and Care Excellence

OHPA – Office of the Health Professions Regulator

PCT – Primary Care Trust

PHE – Public Health England

SHA – Strategic Health Authority

SoS – Secretary of State

Care pathway – an important concept in the integration of services, a care pathway is the sequence of care events that a patient or service user undergoes in receiving treatment or other forms of support for an acute or long-term condition. Integrated care pathways involve taking an overview of the patient's or service user's experience as a whole, so as to co-ordinate the services and/or treatment they receive.

Care Quality Commission (CQC) – the regulator of health and social care for England. It registers, and therefore licenses, care services if they meet essential standards of quality and safety and monitors them to ensure they continue to meet these standards. **Healthwatch England** will be part of the CQC.

Clinical Commissioning Group (CCG) – the bodies which will carry out local commissioning of NHS services. They will be public bodies holding their meetings in public. Their members will be primary and secondary care doctors, nurse specialists, lay people and others.

Clinical networks and clinical senates – the **NHSCB** will host clinical networks, which will advise on distinct areas of care such as cancer or maternity services. The Board will also host new clinical senates which will provide expert multi-disciplinary input to strategic clinical decision making to inform and support local and national commissioning.

Commissioner – a manager in the NHS or a council who oversees the day-to-day process of **commissioning** services.

Commissioning – the process of ensuring that health and care services are provided so that they meet the needs of the population; it includes a number of stages including assessing population needs, prioritising outcomes, procuring products and services, and overseeing service providers. The concept of commissioning is expanding to include the way decisions are made about directing investment as well as direct service commissioning.

Community mental health team (CMHT) – teams of mental health workers from the NHS and social care who work in the community to support people with mental health problems, usually referred to the team by their GP.

CQUIN – Commissioning for Quality Indicators – a payment framework used in the NHS by commissioners to reward high quality services, by linking healthcare providers' income to the achievement of quality improvement goals.

Direct payments – budgets paid directly to social care users to meet their needs. They are a form of **personal budgets**, giving service users direct control of the money allocated to them for care.

Director of Public Health (DPH) – appointed through local authorities and PHE (on the SoS's behalf), acting jointly, directors of public health will bring leadership and direction to local collaborative discussions about the best use of the local ring-fenced public health budget. There will be a director of public health for each upper tier local authority, although one DPH may cover more than one local authority.

Foundation Trusts – NHS providers which are granted foundation trust status (by **Monitor**) have greater freedoms and are subject to less central control than NHS trusts without foundation status. The Government has indicated that all NHS trusts should become Foundation Trusts.

Health Act Flexibilities – see **Section 75 arrangements**.

HWB – a statutory committee of a local authority which will lead and advise on work to improve health and reduce health inequalities among the local population. It will have a performance monitoring role in relation to NHS clinical commissioning groups, public health and social care. Members will include councillors, GPs, health and social care officers and representatives of patients and the public, including local LH. Shadow Boards should have been established by Spring 2012, with full statutory Boards coming into existence by April 2013.

Health inequalities – differences in health (and increasingly, in definitions, the wellbeing) experienced by different groups in a community which are avoidable and therefore held to be unacceptable (See also **Marmot review of health inequalities**).

Health Needs Assessment (HNA) – a method for reviewing the health issues facing a population, leading to a set of agreed priorities and the allocation of resources to improve health and tackle inequalities. HNAs also provide an opportunity for specific populations to contribute to service planning and resource allocation. HNAs are also a tool used in the commissioning process. In future **JSNAs** should also encompass the kind of issues currently included in HNAs.

Health Premium – an incentive payment proposed by the Government to be received by local authorities. Payment will be dependent on the progress made against improving the health of the local population and reducing health inequalities and will be linked to performance against a number of indicators.

Health Overview and Scrutiny Committee (HOSC) – often known as health scrutiny committees, HOSCs were committees of local authorities with statutory powers to monitor and scrutinise local healthcare and health improvement and make recommendations. Under the Act, these powers are transferred to the local authority itself which may delegate them to a HOSC or other committee.

Healthwatch England – a committee of the CQC, which will be the national body representing the voice and perspectives of patients, service users and the public. It will provide support and guidance to **LH**.

Integration – in the context of health, social care and local government, the term is used in relation to bringing services closer together, for example by developing joint teams of staff (eg housing, social care and/or health staff), co-locating staff or using **pooled budgets** (for example to provide health and care services to a group of people such as people with learning disabilities). The objective is for services to take a holistic view of services users and to be ‘seamless’ from their perspective. Planning integrated services ought also to enable prevention and early intervention and greater efficiency and effectiveness across **care pathways**.

JSNA – the process and document(s) through which local authorities, the NHS, service users and the community and voluntary sector research and agree a comprehensive local picture of health and wellbeing needs. The development of JSNAs will be the responsibility of CCGs and local authorities through **HWBs**. **CCGs** and the **NHSCB** are required to ‘have regard to’ JSNAs when developing their commissioning plans.

Joint health and wellbeing strategy (JHWS) – **HWBs** are required to produce a JHWS for the local area, based on the needs identified by the **JSNA**.

Lifecourse – a lifecourse approach to health emphasises the accumulated effects of an individual's experience across their life span in understanding the maintenance of health and the prevention of disease; poor economic and social conditions in the very early years of life have been shown to affect adversely individuals' growth and development, their risk of disease and ill health in later life and their life expectancy.

Professor Marmot's 2010 review of health inequalities, 'Fair Society, Healthy Lives', strongly advocates a lifecourse approach to population health, health improvement and tackling health inequalities, with the first five years of life being the highest priority.

Local Healthwatch (LH) – effective from April 2013, LH will be patient and public engagement bodies taking over from **Local Involvement Networks (LINKs)**. They will be supported by a national organisation, **Healthwatch England (HWE)**, which will be part of the CQC.

Local Involvement Network (LINK) – a local organisation of individual and organisational members which collects and represents the views of health and social care service users and the public. Under the Health and Social Care Act 2012, LINKs will be superseded by **LH**.

Marmot review of health inequalities – a review of the causes and the 'causes of the causes' (ie the social and economic determinants) of **health inequalities** in England, carried out by Professor Sir Michael Marmot in 2010. It was commissioned by the previous Government and its findings were endorsed by the present Coalition Government. It identifies a number of key areas for action to reduce health inequalities, the most important of which is "giving every child the best start in life". The review, 'Fair Society, Healthy Lives', is an invaluable resource to assist with developing priorities for **JHWS**.

Monitor – the regulatory body for NHS Foundation Trusts. Under the Health and Social Care Act 2012, Monitor's key role will be to promote and protect patients' interests. It has statutory powers in relation to co-operation and competition and will be required to support the delivery of integrated care where this would improve quality or efficiency.

National Institute for Health and Clinical Excellence (NICE) – the body responsible for providing research, evidence and guidance on what medication, treatments and interventions should be available through the NHS and, in the case of public health, through local authorities.

Needs assessment – a systematic method for reviewing the characteristics of a population (for example, their health status, the number with long-term conditions, numbers in different age groups) and their needs, leading to agreed priorities and resource allocation that will improve health and wellbeing and reduce inequalities. A **JSNA** is a statutory requirement for each area.

NHS Constitution – lays down the objectives of the NHS, the rights and responsibilities of the various parties involved in healthcare (patients, staff, trust boards) and the guiding principles which govern the health service.

NHS Commissioning Board (NHSCB) – a national body to be created under the Health and Social Care Act, whose role will include supporting, developing and holding to account the system of clinical commissioning groups, as well as being directly responsible for some specialist commissioning.

NHS Operating Framework – an annual document which outlines the business and planning arrangements for the NHS in the forthcoming year.

Outcomes Framework – a national framework which sets out the outcomes and corresponding indicators against which achievements in health and social care will be measured. There are currently three outcomes frameworks – for the NHS, for adult social care and for public health.

Overview and scrutiny – currently a function of local government with specific powers to scrutinise council executive decisions. **Health overview and scrutiny committees** had additional powers to enable them to monitor and scrutinise NHS commissioners and providers. These powers have been transferred to local authorities.

Outcomes based accountability – an approach to planning services and assessing their performance that focuses attention on the results, or outcomes – as distinct from inputs and outputs – that the services are intended to achieve.

Outcomes-focused approach – an approach based on focusing on the results rather than on the outputs of investing in a service or providing it in a certain way. Commissioners can be clearer about the real benefits they are seeking by defining the outcomes being sought in terms of improved health and wellbeing. (See also ‘Health inequalities’).

Patient Reported Outcome Measures (PROMS) – provide information on how patients feel about their own health, and the impact of the treatment or care they receive

Payment by Results (PbR) – the term was originally introduced in the NHS to describe a system of paying providers of NHS services a standard national price or ‘**tariff**’ for each individual episode of treatment supplied. It has caused some confusion among non-specialists as it is not about payment based on health results, as its name might suggest, but is based on activity. More recently, the same term has been used in other areas of public policy, such as the criminal justice system and the employment service, where it is more closely linked to outcomes.

Personal health budget – see **personal budget**

Personal budget – the amount of money allocated for an individual’s social care, either paid directly to the individual in **direct payments** or held by social services or a third party. Now often used interchangeably with ‘individual budget’. Personal budgets are being piloted in health services as **personal health budgets**.

Personalisation – the principle behind the current transformation of adult social care services, and also related to health services; refers to the process of providing individualised, flexible care that is intended to promote the independence of those who need care.

Pharmaceutical Needs Assessment – an assessment of the current need and provision of pharmaceutical services for a community, provided mainly through local community pharmacies. Its aim is to identify any gaps in the services, and see what new services may be offered to improve the health of the local population. The Act makes the preparation of pharmaceutical needs assessments a responsibility of the **HWB**.

Pooled budgets – one of a range of options available to support the integration of health and social care (under **Section 75** of the NHS Act 2006). While partners such as local government and the NHS can delegate some functions to each other, they may also commit some of their financial resources to create a single or ‘pooled’ budget which is discrete and separate and for a specific purpose, thus helping to avoid funding disputes and create greater flexibility in the use of budgets. The Act requires HWBs to encourage the use of pooled budget (See also **Section 75 arrangements**).

Population Health – an approach that aims to improve the health of the entire population and tackle health inequalities between different groups in society. Rather than focusing on individuals, population health addresses a broad range of factors that affect the health of entire populations, such as environment, social structure, and the distribution of resources.

Primary Care Trust (PCT) – PCTs are the commissioning bodies for the NHS. Under the Act, their work will be taken over by CCGs.

Programme budgeting – the analysis of expenditure in healthcare programmes, such as cancer, mental health and cardiovascular diseases. Programme budgeting usually makes comparisons between expenditure and outputs or outcomes between one geographical area and another and is therefore a useful benchmarking tool.

Provider – organisations which provide services direct to patients and service users, including hospitals, mental health services and ambulance services; providers are commissioned to provide NHS, public health and social services by NHS and local government commissioners.

Public health – “The science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society.” (UK Faculty of Public Health, 2010). Public health is generally thought of as being concerned with the health of the entire population, rather than the health of individuals – and therefore requiring a collective effort – and as being about prevention as well as treatment. The three domains of public health are: health improvement; health protection; and health services. Under the Health and Social Care Act, responsibility for public health is to be taken over from the NHS by local government. A national public health service, **PHE** will also be created.

Public Health England – the new national public health service which will integrate the work of a large number of disparate public health organisations into a single, expert body providing advice and services across the range of public health. It will allocate ring-fenced funding to local authorities and will also act on behalf of the SoS in the process of appointing DsPH at the local authority level.

Quality premiums – a Government proposal to offer GPs financial rewards for performing well.

Quality, innovation, productivity and prevention (QIPP) – a framework for the NHS intended to deliver efficiency savings while maintaining quality.

Quality Outcome Framework (QOF) – a voluntary reward and incentive programme for all GP surgeries in England, detailing practice achievement results.

Resource Allocation System (RAS) – system each council has for allocating social care budgets to individuals, based on need determined by assessment/self-directed assessment. If personal budgets are introduced into health services, similar RASs will be needed.

Risk stratification – means of classifying the risk of individuals within a group or population of experiencing a particular health condition or event (such as hospitalisation) and thereby determining what preventive action can be taken.

Ring-fenced budgets (for public health) – public health budgets that will be allocated to local authorities from April 2013 for their new role in public health. The DH will set out the purpose of the funding but not exactly how the money should be spent, although a limited number of services will be mandatory. Local authorities will be able to use the ring-fenced budget widely to improve public health in their local area in line with local priorities. This may include using it jointly with other local authority budgets such as those for children's service, schools, housing, transport and environmental health.

Scrutiny – see **Overview and scrutiny**.

Section 75 arrangements – section 75 of the NHS Act 2006 consolidates previous powers to allow local authorities and NHS bodies to make financial arrangements (often described as the Health Act 'flexibilities'). These include **pooled budgets**, lead commissioning in which partners agree to delegate commissioning of a service to one lead organisation and integrated provision in which partners can join staff, resources and management structures to integrate a service. In future, Section 75 arrangements are likely to be made between **CCGs** and local authorities and are to be encouraged by HWBs. CCGs and **Monitor** also have duties to promote integrated services, which may entail the use of Section 75 arrangements.

Single assessment process – a process for assessing an individual's health and social care needs without assessment procedures being needlessly duplicated by different agencies. Single assessments are an important first step towards **integration** of services.

Social determinants of health – the social and economic conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The **social determinants of health** are mostly responsible for **health inequalities**.

Strategic Health Authority (SHA) – part of the structure of the NHS, currently responsible for implementing policy and overseeing the work of NHS trusts and PCTs. In October 2011, the 10 strategic health authorities in England merged to form four clusters which will manage the NHS until April 2013.

Tariffs – in relation to payment by results, the tariff is the calculated price for a unit of healthcare activity eg treatment for a coronary artery bypass. Prices in the national tariff have been set on the basis of the average cost of providing a particular procedure, using data gathered from all NHS hospitals. They include non-clinical costs such as food, cleaning and estate costs.

Transition planning – in the context of NHS reforms, the process of supporting the development and implementation of key elements of reform including the transfer of public health to local authorities, establishing **CCGs**, setting up **HWBs**, supporting **JSNA** and **JHWS** and establishing **Healthwatch**; programmes are carried out at regional and local levels.

Upstream and downstream investment – based on an analogy by McKinley (1979) of the health and wellbeing system as being like a fast flowing river in which people were drowning. The system was so preoccupied with rescuing them (ie treating them when they fall ill) that there was no time to go upstream to prevent them falling in (ie public health and early intervention) – which would have been a more fruitful, (upstream) activity.

Value-based pricing – a controversial mechanism for linking the prices the NHS pays drug providers to the value of the treatment – this would be defined in terms of such factors as effectiveness and/ or innovativeness of treatments. The DH consulted on the issue in 2011 and said that negotiations with the pharmaceutical industry would begin in 2012.

Wellbeing – used by the World Health Organisation (1946) in its definition of health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. More recently the concept was described as “feeling good and functioning well” (New Economics Foundation, 2008). Creating wellbeing (of which good physical health is a component) requires the mobilisation of the widest assets to ensure community cohesion, safety and so on.



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