



Health & Social Care Act 2012

Making sense of the new NHS

1. Introduction

Despite UNISON's campaigning, the Health and Social Care Bill received royal assent to become an Act of Parliament on 27 March 2012. Along with accompanying reforms such as Any Qualified Provider and attacks on terms and conditions, the Act has major implications for UNISON members and for the NHS in England. The purpose of this short guide is to explain what the new NHS structure will look like and what it means for those working in it. More information from the union will follow and in the meantime some useful sources of further information are included below.

2. The new NHS

The Act removes two whole existing layers of the current English NHS. The 12 strategic health authorities (SHAs) at regional level and the 152 primary care trusts (PCTs) at local level are being abolished. These bodies are currently responsible for NHS commissioning – organising and buying in care for patients from hospitals and other healthcare providers.

In their place the government is devolving responsibility for the majority of commissioning to local **clinical commissioning groups** (CCGs), which will be made up largely of GPs, with some limited involvement for hospital consultants and nurses.

CCGs will be supported and held to account by a new national body called the **NHS Commissioning Board** (NHS CB), which was originally designed as a way of shunting responsibility for the NHS away from politicians and Parliament. The Board will be established as an independent body, at arm's length from the government by October 2012. Initially, it will work through 52 transitional clusters of PCTs to oversee the establishment and authorisation of CCGs, which will happen in waves between autumn 2012 and January 2013. The NHS CB confirmed in May 2012 that there will be 212 CCGs (subject to authorisation), with a full list available here:

www.commissioningboard.nhs.uk/2012/05/24/ccg-configuration.

The Board will also commission primary care services and some specialist services itself. It will take on its full range of responsibilities and the new commissioning system will begin to operate once it is fully established from April 2013. It will have 3,500 staff, nine national directorates, four area offices and 27 local branches (although these may have more than one office).

CCGs will be advised by – and may choose to outsource their commissioning work to – organisations providing **commissioning support services** (CSS). These will initially be hosted by the NHS CB, but will become commercial concerns by 2016 selling their services to CCGs. Some will operate across regional boundaries requiring UNISON branches and regions to work together to organise and represent affected members. The Health Service Journal included a map of planned CSSs as at March 2012: www.hsj.co.uk/Journals/2012/03/28/g/i/b/CSS-proposals-map.jpg.

In addition, there will be 15 **clinical senates**, the exact role and make-up of which is still uncertain. The Department of Health says that they are “expected to bring together clinical leaders across broad areas of the country to give clinical leadership and expert advice for commissioning.” The senates will operate in addition to **clinical networks** that currently bring together commissioners, providers and patients to test and spread best practice around particular types of care, such as stroke or cancer. The current set-up of the networks is also being reviewed.

CCGs will be encouraged to use competition and can even be directed to use competition in some circumstances. CCGs will be prohibited from regarding existing NHS services as the preferred provider. Instead, patients will increasingly be offered a choice of **any qualified provider** (AQP), that may include private or charity/voluntary sector organisations, to deliver particular types of care. This process is being rolled out between April and September 2012, initially for three locally chosen community services (although some areas have chosen fewer than this or as many as five services).

All hospitals (and other providers such as ambulance and mental health trusts) will have to become **foundation trusts** (FTs) by 2014, or join other foundation trusts through mergers or takeovers. Question marks remain over a number of hospitals, possibly as many as 20, that may never reach foundation status due to questions over their financial position – this is particularly problematic for those hospitals with large PFI debts. NHS trusts will therefore cease to exist in 2014. An **NHS Trust Development Authority** (NTDA) will be set up to see through the remaining hospital trusts becoming foundations. The management of Hinchingsbrooke Hospital in the east of England has been franchised off to private provider Circle and there are signs that a similar model may be used for other struggling hospitals. Once established, a “failing” foundation trust can no longer be brought back fully under government control, but there will be a “special health administration” regime to guarantee the

continuation of services. Foundation trusts will be able to make more money from private patients (that pay for their care), potentially as much as 49.99% of their income.

In addition to its existing role as the foundation trust regulator, **Monitor** will take on new powers to “prevent anti-competitive behaviour” although it may, in theory at least, insist that some services be provided “in an integrated way”. As a sector regulator, Monitor will license all providers of NHS services and, at a later date, adult social care providers. Working with the NHS CB, it will also take on responsibility for pricing – something which is currently done by the Health Secretary (via the Department of Health). The **Cooperation and Competition Panel (CCP)** that currently advises the Department on competition challenges will continue to act on complaints and advise Monitor – in time it will become part of Monitor. The **Care Quality Commission (CQC)** will continue to register all providers of care health and adult social care.

Responsibility for public health will transfer from PCTs to all English top tier local authorities (151) in April 2013. Currently PCTs and local authorities are drawing up transition plans to shape what the new structures will look like in each local authority. **Public Health England (PHE)** will be established to focus on national resilience against flu pandemics and other major health threats, as well as being a “knowledge bank” for evidence on changing behaviour and monitoring data.

As part of the changes to public health delivery, **health and wellbeing boards (HWBs)** are new bodies that will be established at all English top tier local authorities (those with social care responsibilities). They will be responsible for analysing the needs of the local population and producing a wellbeing strategy. They have no powers to veto commissioning plans, but will encourage commissioners to join up their work across the NHS and local government. They will be composed of at least one democratically elected councillor, representatives from the local CCG(s), directors of public health and others. There is no role for trades unions on HWBs, but the health secretary has indicated that they may involve schools. Local authority **health overview and scrutiny committees (HOSCs)** will continue to exist as council bodies that can scrutinise “substantial variations” in NHS services.

In terms of health scrutiny, local involvement networks (LINKs) are being replaced by local **HealthWatch (HW)**, who will have little power but can visit health and social care services. They can report concerns about services and will also be represented on the local health and wellbeing board. The national manifestation of HealthWatch is HealthWatch England that will be a part of the Care Quality Commission.

The system for education and training is also being overhauled. Nationally **Health Education England** (HEE) is designed to provide leadership and oversight of the planning and development of the health and public health workforce, and to allocate education and training resources. **Local education and training boards** (LETBs) will work with HEE at the local level “to improve the quality of education and training outcomes”. The Department of Health will set the education and training outcomes for the system as a whole and will hold HEE to account.

A new national property company, **NHS Property Services**, is being set up to manage the primary care trust estate. Once PCTs are abolished, it will take over property such as primary care centres, clinics, community hospitals and offices.

The Act has implications for a number of NHS arms-length bodies. For example, the Health Protection Agency and the National Treatment Agency for Substance Misuse will both be abolished and their functions transferred to Public Health England. The NHS Appointments Commission is being abolished, with its work transferring to the Department of Health. The National Patient Safety Agency is being abolished, with the NHS CB taking on its safety functions. There are also ramifications for NICE (the National Institute for Health and Care Excellence) who may see its world-leading evidence-based approach to determining the availability of medicines and treatments on the NHS undermined by rationing decisions increasingly moving to CCGs.

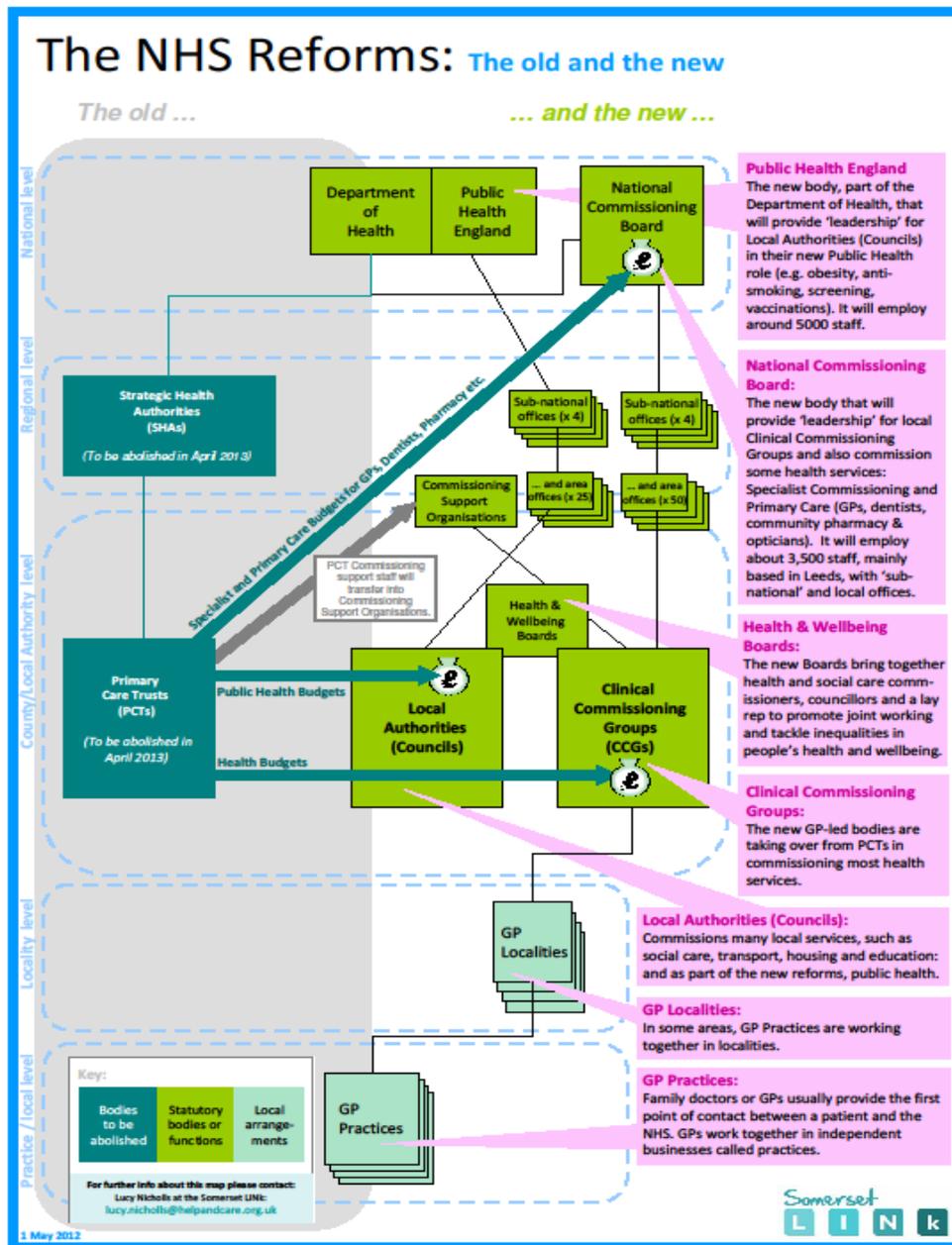
3. Jargon buster

The NHS will now contain many new organisations and is full of acronyms and abbreviations. Here is a list of some of those you can expect to hear mentioned:

AQP – Any Qualified Provider
CCG – Clinical Commissioning Group
CCP – Cooperation and Competition Panel
CQC – Care Quality Commission
CSS – Commissioning Support Services
FT – Foundation Trust
HEE – Health Education England
HOSC – Health Overview and Scrutiny Committee
HWB – Health and Wellbeing Board
HW – HealthWatch
LETB – Local Education and Training Board
NHS CB – NHS Commissioning Board
NTDA – NHS Trust Development Agency
PHE – Public Health England

4. A diagram of the new NHS

There have been various attempts to capture this complex new system in graphic format. One of the more useful ones from Somerset LINK is below:



5. Approximate timetable for implementation

The Bill became an Act of Parliament in March 2012 but much of the implementation depends on the subsequent secondary legislation (regulations) and consultations that follow. As a result of this, and the various changes to the legislation, the dates below should be considered as a guide only.

May 2012

- Consideration of Statutory Instruments subject to affirmative resolution begins (major changes coming from the Act where further regulations must be approved by both Houses of Parliament).

June 2012

- Health Education England and NHS Trust Development Authority established as special health authorities

July 2012

- Monitor established as sector regulator

Summer 2012

- Government lays regulations (secondary legislation) on the establishment of CCGs and on the membership of HealthWatch England
- Government consultations on the mandate to the NHS Commissioning Board, licensing under Part 3 of the Act, and health special administration

September 2012

- Patients get choice of Any Qualified Provider for a number of locally chosen community services

Autumn 2012

- Government lays regulations on the commissioning responsibilities of the NHS Commissioning Board, the public health functions of local authorities and local HealthWatch
- Government consultation on the NHS Constitution

October 2012

- HealthWatch England comes into existence
- Commissioning Board authorisation of Clinical Commissioning Groups begins

Early 2013

- Government produce secondary legislation on Part 3 of the Act (competition, licensing, pricing)
- Monitor expected to commence licensing functions

1 April 2013

- NHS Commissioning Board takes on its full statutory functions
- Clinical commissioning groups established with statutory powers and begin commissioning services in their own right
- Local authorities take on new public health responsibilities
- Local HealthWatch organisations come into being
- Strategic Health Authorities and Primary Care Trusts abolished
- Public Health England established following abolition of Health Protection Agency and National Treatment Agency for drugs and alcohol
- Health Education England and NHS Trust Development Authority operational

April 2014

- Health special administration regime for organisations providing NHS services comes into force

2014

- NHS Trust status abolished

6. What does it mean for me?

Over 31,000 PCT staff and nearly 4,000 SHA staff will be affected by the Act, with no clarity yet on how many posts there will be in the new receiving organisations.

The government itself expects around 13,000 redundancies as a result of the overhaul brought about by the Act. Up until March 2012 the government operated a Mutually Agreed Resignation Scheme to make it easier for individual employees – in agreement with their employer – to choose to leave their jobs voluntarily, in return for a payment. This has largely affected managerial staff. UNISON, in common with other trades unions, has also been working to ensure that as many staff as possible can transfer to the new system – to protect jobs and to save on redundancy pay-outs.

As well as the distress and uncertainty caused by job losses (or the fear of job losses), there are concerns that those left in the NHS will be required to take on extra duties to cover for those losing their jobs – at least in the transitional period. Similarly many staff may find themselves working in unfamiliar new environments or job roles. All of these changes are being made at a time when the NHS is expected to make £20bn of cuts in the name of “efficiency savings”.

The government has confirmed that CCGs will be bound by the Agenda for Change pay structure, but this only applies for transferring staff, so pay and grading arrangements will need to be agreed with each CCG for new staff and staff that move jobs post-transfer. However, the whole of the new NHS system is based on loosening central control – or “liberating” the NHS to use the government terminology – and threats to break away from national pay bargaining are appearing at a number of foundation trusts, encouraged by the government’s exploration of regional or local pay bargaining.

The government has already abolished the two-tier workforce agreement, which opens up the prospect of staff having different terms and conditions within the same organisation, depending on whether they transferred in or are new starters. There are also concerns to make sure that TUPE (the Transfer of Undertakings Protection of Employment regulations) will apply in transfers to new bodies. The Department of Health has already made clear that TUPE will not apply for staff that end up working for new providers as a result of changes brought about by the Any Qualified Provider approach.

7. What is UNISON doing?

UNISON is continuing to campaign hard at national, regional and local level to block privatisation and to defend the NHS from the full force of the market. The union continues to campaign in the strongest terms against the introduction of regional and local pay.

In addition, the union is working as part of the HR Transition Partnership Forum, which has been established to provide a single national forum for the discussion and development of HR policies and processes to support workforce transition across the new NHS. The forum is a partnership of Department of Health, trades unions, employer and SHA representatives. It reports to the National Social Partnership Forum. For further information go to:

www.socialpartnershipforum.org/CurrentWorkProgrammes/SupportingStaffThroughChangeAndTransfer/Pages/HRTransitionPartnershipForum.aspx

UNISON is producing a detailed guide on how members can get involved in the new system to try to block privatisation and defend services. Members can take this online survey to share current experiences and to sign up for greater involvement: <https://www.surveymonkey.com/s/newNHS>.

A new “Protecting the NHS” factsheet is also available here: www.unison.org.uk/acrobat/20868.pdf.

8. The Act and the Devolved Nations

The Health and Social Care Act refers specifically to England, and much of the NHS in the devolved nations should manage to avoid being dragged into the market free-for-all planned for England.

There are, however, a number of caveats. Some existing services operate across borders, such as the NHS Blood and Transplant service, where blood collection also covers North Wales and organ transplantation run by NHS BT is across all four of the UK nations – so a more fragmented English NHS will have implications elsewhere. In the past there have also been attempts to import English market models to the devolved nations, such as experiments with Independent Sector Treatment Centres in Scotland and Payment by Results in Northern Ireland. It would therefore be dangerous to assume that the latest plans will automatically be confined to England in the longer term.

The current NHS set-up in the devolved nations is summarised below.

Scotland

Although they are separate bodies, the organisational separation between NHS Scotland and the rest of the UK NHS tends to be hidden from its users due to the coordination and cooperation where "cross-border" or emergency care is involved. Current provision of healthcare is the responsibility of 14 geographically-based local NHS Boards and a number of National Special Health Boards. In April 2004 the NHS became an integrated service under the management of NHS Boards. Local authority nominees were added to Board membership to improve coordination of health and social care. Trusts were abolished and hospitals are now managed by the acute division of the NHS Board. Contracted services such as GPs and pharmacies are contracted through the NHS Board, but work in Community Health Partnerships based largely on local authority boundaries and serving up to 100,000 people and including local authority membership of their Boards. Some now also provide social care and are called Community Health & Care Partnerships. There are proposals to legislate in 2013 to further the integration of health and social care for services to adults and children. Highland Region has already introduced a 'lead agency' model from 1 April 2012 which saw 1,000 staff move from employment by the Council to the Health Board and 200 moving the other way.

Local Health Boards are supported by a number of non-geographical Special Health Boards providing national services. These including: NHS Health Scotland (public health and health education); NHS Healthcare Improvement Scotland; the Scottish Ambulance Service (the single public

emergency ambulance service in Scotland); Scottish National Blood Transfusion Service; NHS24, telephone helpline serving Scotland; NHS Education for Scotland; NHS National Services Scotland providing services for NHS Scotland boards; and the State Hospitals Board for Scotland is responsible for the State Hospital for Scotland and Northern Ireland at Carstairs, providing high security services. In addition, the Golden Jubilee National Hospital is a special NHS Board in Scotland with the purpose of reducing waiting times using a single modern hospital located at Clydebank. It was previously a private sector hospital, but was bought in-house in 2002 by the Scottish Executive for £37.5 million, after it failed to produce a profit despite being established with the help of a subsidy provided by a previous government.

NHS Scotland has a unique system of employee relations described by Nottingham academics as a "leading example" of how public sector industrial relations can help improve service delivery.

Cymru/Wales

The NHS in Wales comprises seven Local Health Boards who plan, secure and deliver healthcare services in their areas: Aneurin Bevan (Gwent area), Abertawe Bro Morgannwg (Swansea and Bridgend), Cardiff and Vale (Cardiff and Vale of Glamorgan), Cwm Taf (Rhondda Cynon Taff and Merthyr), Hwyl Dda (Carmarthenshire, Pembrokeshire and Ceredigion), Betsi Cadwaladr (North Wales), and Powys.

In addition there are three NHS Trusts with an all-Wales focus: the Welsh Ambulance Services Trust; Velindre NHS Trust, offering specialist services in cancer care and a range of national support services; and the new Public Health Wales.

A National Advisory Board is responsible for providing independent advice to the Minister for Health and Social Services. The Board assists in discharging ministerial functions and meeting ministerial accountabilities for the performance of the NHS in Wales. A National Delivery Group is responsible for overseeing the development and delivery of NHS Services across Wales. There are seven Community Health Councils coterminous with the LHBs. The National Leadership and Innovation Agency for Healthcare (NLIAH) provides a national strategic resource to support NHS Wales in building leadership capacity and capability to secure continuous service improvement underpinned by technology, innovation and best practice.

The Welsh Health Minister launched the NHS Wales Five Year Vision at the end of 2011. It calls for a review of the current service provision across all LHBs and Trusts. The proposal is that in five years' time, NHS Wales will look different to today with greater emphasis on community provision of health services, together with a

realignment and redesign of current hospital provision. LHBs are charged with the consultation process towards service change which is currently being undertaken. The main challenge these potential changes present to UNISON members is the need for re-skilling and flexibility.

Northern Ireland

The system in Northern Ireland differs from the rest of the UK in that it covers both health and social care.

The Northern Ireland Executive's Health Department is organised under a Permanent Secretary into several groups and one agency. The groups are the Planning and Resources Group, the Strategic Planning and Modernisation Group, and the Primary, Secondary and Community Care Group. The Department's Executive Agency is the Health and Social Services Estates Agency. There are then five professional groups: Medical and Allied Services; Social Services Inspectorate; Nursing and Midwifery Advisory Group; Dental Services; and Pharmaceutical Advice and Services.

Over recent years the health and social care system has faced radical change as part of the wider Review of Public Administration. The first phase was completed in April 2007 with the establishment of five new integrated Health and Social Care Trusts to provide health and social care. They replaced 18 Trusts. There is also a NI Ambulance Service Trust.

The second phase was completed in April 2008 with a single Health and Social Care Board for Northern Ireland, a new Public Health Agency, a new Business Services Organisation, and a single Patient and Client Council to provide a voice for patients, clients and carers.

The block grant to Northern Ireland has been cut by £4.3bn. This has had a major impact on services. The Minister has commissioned a major review and the main recommendations have been adopted, which contain a strong impetus to privatisation. The devolved government will be a focus for much of UNISON's campaigning on this.

9. Where can I find more information?

- UNISON – Our NHS Our Future: www.unison.org.uk/ournhs
- UNISON – Any Qualified Provider info: www.unison.org.uk/healthcare/agh.asp
- Department of Health: <http://healthandcare.dh.gov.uk>
- NHS Employers: www.nhsemployers.org/managingthetransition
- NHS Commissioning Board: www.commissioningboard.nhs.uk
- Monitor: www.monitor-nhsft.gov.uk
- Cooperation and Competition Panel: www.ccpanel.org.uk
- Care Quality Commission: www.cqc.org.uk
- National Association of LINks Members: www.nalm2010.org.uk/healthwatch
- Scotland: www.scotland.gov.uk/Topics/Health/NHS-Scotland
- Cymru/Wales: www.wales.nhs.uk
- Northern Ireland: www.n-i.nhs.uk