These notes refer to the Health and Social Care Act 2012 (c.7) which received Royal Assent on 27 March 2012

HEALTH AND SOCIAL CARE ACT 2012

EXPLANATORY NOTES

COMMENTARY ON SECTIONS

Part 1 – The Health Service in England

Arrangements for provision of health services

Section 23 - The NHS Commissioning Board: further provision

194. This section inserts a new Chapter A1 into Part 2 of the NHS Act.

195. *Mandate to the Board.* New section 13A requires the Secretary of State to publish and lay before Parliament a document to be known as “the mandate” before the start of each financial year. Broadly, the mandate would set out what the Government expects from the NHS Commissioning Board on behalf of the public for that period. This would comprise a series of objectives that the Secretary of State thinks the NHS Commissioning Board should seek to achieve (section 13A(2)(a)), and any other requirements that the Secretary of State considers necessary to ensure those objectives are met (section 13A(2)(b)). The objectives must relate to the current financial year and such subsequent financial years as the Secretary of State considers appropriate. The requirements set out in the mandate will be given effect by regulations subject to the negative resolution procedure.

196. The intention is to require the Secretary of State to provide the NHS Commissioning Board with a single annual set of objectives and requirements in order to provide stability and clarity, allowing the NHS Commissioning Board to develop effective medium and long-term planning assumptions.

197. Subsection (3) of section 13A provides the Secretary of State to specify in the mandate the limits on the NHS Commissioning Board’s capital and revenue resource use for the financial year, provided for in new section 223D (as inserted by the following section). Subsection (4) allows the Secretary of State also to specify any proposals as to the limits that will apply for subsequent financial years. Such information may help the NHS Commissioning Board in planning how to achieve objectives which extend beyond the current financial year. Subsection (5) enables the Secretary of State to specify in the mandate any matters that are proposed for consideration in assessing the NHS Commissioning Board’s performance for that financial year. Such matters might include the achievement of the outcomes set out in the Outcomes Framework. The Secretary of State would not be able to specify in the mandate any objective or requirement which targets any individual CCG. This restriction, in subsection (6), mirrors that in relation to the standing rules (established under section 20).

198. Before specifying any objectives or requirements in the mandate, the Secretary of State must consult the NHS Commissioning Board, Healthwatch England and such other persons as the Secretary of State considers appropriate to ensure that the mandate would be effective, under subsection (8). Once the mandate is published, the NHS Commissioning Board will be under an obligation to seek to achieve the objectives and

comply with the requirements specified, under subsection (7) (provided, in the case of requirements, that they are given effect to by regulations – see subsection (9)).

199. *The mandate: supplementary provision*. New section 13B of the new Chapter A1 establishes the rules around in-year changes to the mandate. Subsection (1) places a duty on the Secretary of State to keep the NHS Commissioning Board's performance in achieving the objectives and requirements in the mandate under review, which underpins the Secretary of State's responsibility to hold the NHS Commissioning Board to account.

200. Should the Secretary of State have to make any change to the limits on the NHS Commissioning Board's total capital and revenue resource use (as provided for in new section 223D, as inserted by the following section), the mandate would have to be revised accordingly to reflect these changes. However, if the Secretary of State were to alter the objectives and requirements in the mandate, then they would not necessarily be required to revise these limits.

201. Subsection (3) provides that the Secretary of State may only make other changes to the mandate if the NHS Commissioning Board agrees to the revision or if the Secretary of State feels that there are exceptional circumstances that make the revision necessary. The Secretary of State may also revise the mandate following a parliamentary general election. After altering the mandate, the Secretary of State must publish the revised document, and lay the new version before Parliament with an explanation of the reasons for making the changes, as specified in subsection (5). Any changes to the requirements in the mandate would be given effect through regulations (see subsection (4) which makes provision comparable to section 13A(9)). This would ensure that the Secretary of State remained accountable to Parliament for any changes relating to the mandate.

202. *General duties of the Board.* New sections 13C to 13P confer some general duties on the NHS Commissioning Board.

203. *Duty to promote NHS Constitution*. New section 13C places a duty on the NHS Commissioning Board to promote and raise awareness of the NHS Constitution when exercising its functions. This is in addition to the duty on the NHS Commissioning Board under the Health Act 2009 (as amended by paragraph 175 of Schedule 5) to "have regard" to the NHS Constitution. The new duty means that when exercising all of its functions, the NHS Commissioning Board has to act with a view to securing that health services are provided in a way that promotes the NHS Constitution, and is required to promote awareness of the NHS Constitution among patients, staff and members of the public. This means that not only must the NHS Commissioning Board act in accordance with the NHS Constitution but it should also ensure that people are made aware of their rights under it and that they contribute as far as possible to the advancement of its principles, rights, responsibilities and values, through its own actions and through facilitating the actions of stakeholders, partners and providers.

204. *Duty as to effectiveness, efficiency etc.* New section 13D is a duty on the NHS Commissioning Board to exercise its functions in a way that is effective, efficient and economical.

205. *Duty as to improvement in quality of services.* New section 13E puts the NHS Commissioning Board under a duty to exercise its functions with a view to improving the quality of services provided as part of the health service. This also reflects the accepted definition of quality outcomes[1] as comprising effectiveness, safety and patient experience. The NHS Commissioning Board must pursue this quality improvement objective with reference to two sets of guidance: a) "any document published by the Secretary of State for the purposes of this section", such as the NHS Outcomes Framework; and b) the Quality Standards that the National Institute for Health and Care

1 For example see the NHS Outcomes Framework published by the Department of Health on 20 December 2010 - http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

Excellence (NICE) produces (see notes on Part 8 of the Act, below). This duty mirrors the Secretary of State's duty in new section 1A to improve quality of services as inserted earlier in this Part.

206. *Duty as to promoting autonomy*. New section 13F requires the NHS Commissioning Board, in exercising its functions, to have regard to the desirability of securing, so far as is consistent with the interests of the health service, that any person exercising functions in relation to the health service, or providing services for its purposes is free to exercise those functions, or provide those services, in the manner that they consider most appropriate, and that they are not subject to unnecessary burdens. This mirrors the duty placed on the Secretary of State earlier in this Part.

207. This duty would therefore require the NHS Commissioning Board, when considering how to exercise its functions in relation to CCGs such as publishing commissioning guidelines, or when determining matters to be included in contracts with healthcare providers for example, to make a judgement as to whether these were in the interests of the health service. If challenged, the NHS Commissioning Board would have to be able to justify why these requirements were desirable.

208. The duty will cover those arm's-length bodies in relation to which the NHS Commissioning Board has functions (such as NICE and the Information Centre) as well as providers of NHS services. Although the NHS Commissioning Board will not have the same direct relationship with providers of NHS services as SHAs and PCTs have under existing legislation with NHS trusts, it will still have certain functions which impact on providers. For example, it will be able to require certain terms to be included in contracts entered into either by the NHS Commissioning Board itself or by CCGs for the provision of NHS services by virtue of regulations made under new section 6E.

209. This duty is intended to address the policy outlined in *Liberating the NHS: Legislative Framework and Next Steps*, which stated among its aims to:

"enshrine the principle of autonomy at the heart of the NHS" by "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[2]

210. *Subsection (2)* of new section 13F makes clear that in the event of a conflict between those aspects of autonomy, on the one hand, and the discharge by the NHS Commissioning Board of its duties to promote the comprehensive health service and to exercise its functions in relation to CCGs so as to secure the provision of services on the other, it is the latter which takes precedence.

211. *Duty as to reducing inequalities.* New section 13G(1)(a) requires the NHS Commissioning Board when exercising its functions to have regard to the need to reduce inequalities between patients with respect to their ability to access health services; the NHS Commissioning Board must seek to narrow inequalities in access to health services for individuals and groups of people from which they could derive significant benefit. For example, the NHS Commissioning Board may seek to narrow inequalities in ability to access through providing guidance to CCGs on how information about NHS services are to be communicated to specific groups, on opening hours, on reducing late presentation, or about where particular services should be located in order to be more accessible to specific populations. It may also make use of reports from Healthwatch or other groups. However, it will be up to the NHS Commissioning Board to decide how it complies with this duty.

212. New section 13G(1)(b) requires the NHS Commissioning Board to have regard to the need to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services; the NHS Commissioning Board must seek to

2 Copies are available in the House library, and from the DH website at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

narrow clinically unjustifiable inequalities in the outcomes of health care. For example, the NHS Commissioning Board may seek to improve the outcomes of care for specific groups through guidance to CCGs on access issues, on appropriate referral practices for certain groups, on coordination of care, or through advising on contract specifications. As the NHS outcomes framework develops, and information on outcomes becomes more available by the protected characteristics of the Equality Act 2010 or by area deprivation or socio-economic group, it is expected that this will be increasingly helpful in guiding the NHS Commissioning Board's actions.

213. *Duty to promote involvement of each patient.* New section 13H requires the NHS Commissioning Board, in exercising its functions, to promote the involvement of individual patients and their carers and other representatives in decisions about their own care (shared decision-making). This duty is intended to address the commitment outlined in the White Paper *Equity and Excellence: Liberating the NHS* to the policy of "no decision about me without me".

214. The duty would apply to any decisions at all stages of that individual's health care, from preventative measures, diagnosis of an illness, and any subsequent care and treatment they receive. Effective involvement of patients in these decisions might include such things as opportunities for patients to participate in treatment decisions in partnership with health professionals, to be supported to make informed decisions about the management of their care and treatment and to discuss opportunities for patients to manage their own condition.

215. In addition to the commissioning of those services for which the NHS Commissioning Board will be directly responsible, it could exercise this duty through promoting the importance of involving patients in its dialogues with CCGs. The NHS Commissioning Board will also be required to publish guidance on how CCGs could discharge their equivalent duty to which CCGs must have regard.

216. *Duty as to patient choice.* New section 13I requires the NHS Commissioning Board to act with a view to enabling patients to make choices with respect to aspects of health services provided to them. The NHS Commissioning Board will be responsible for championing effective involvement and engagement in decisions about healthcare by working with CCGs, local authorities, voluntary sector groups, patient-led support groups and Healthwatch, for example. The intention is that the NHS Commissioning Board will also develop and agree with the Secretary of State the guarantees for patients about the choices they can make. In addition, the NHS Commissioning Board will be responsible for commissioning, promoting and extending information to support meaningful choice over the care and treatment that people receive, where it is provided and who provides it (including personal health budgets). This information should include patient-reported experience and outcome measures.

217. *Duty to obtain appropriate advice*. New section 13J provides that the NHS Commissioning Board must obtain appropriate advice from other professionals, so it can effectively discharge its functions. This would include, for example, obtaining advice when making commissioning decisions and when designing NHS pricing structures. In the Government response to the NHS Future Forum report, published on 20 June 2011, the Government proposed that potential sources of such advice could include clinical networks, which bring together groups of healthcare professionals to form networks that are specific to a particular health condition or profession, and clinical senates, groups of experts covering different areas of the country.

218. *Duty to promote innovation.* New section 13K places a duty on the NHS Commissioning Board, when exercising its functions, to promote innovation in the provision of health services by, for instance, encouraging both innovative commissioning and the commissioning of innovative health services. This could be achieved, for example, through the NHS Commissioning Board developing commissioning guidelines for CCGs as well as hosting some clinical networks where appropriate. New section 13K

also provides for the NHS Commissioning Board to make payments as prizes in order to promote innovation in the provision of health services.

219. Innovation will originate primarily from the actions of commissioners and providers but it is intended that the NHS Commissioning Board will take a lead role in promoting it. The duty will support delivery of the NHS Commissioning Board's duty to secure continuous improvements in the quality of health care under new section 13E. This duty is similar to the duty that previously applied to SHAs.

220. *Duty in respect of research.* New section 13L confers a duty on the NHS Commissioning Board in the exercise of its functions, to promote research on matters relevant to the health service and to promote the use in the health service of evidence obtained from research. The NHS Constitution confirms that the NHS is committed to the promotion and conduct of research to improve the current and future health and care of the population. To support this, the NHS Commissioning Board will be expected to promote the conduct of research and the use of evidence obtained from research when it exercises its commissioning and other functions. For example, through commissioning guidance, contracts and pricing structures, the NHS Commissioning Board could encourage providers to participate in research and to use research evidence to deliver and improve services. This is consistent with the general duty of the NHS Commissioning Board to exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, or the protection or improvement of public health.

221. *Duty as to promoting education and training*. New section 13M places a duty on the NHS Commissioning Board, when exercising their functions, to have regard to the need to promote education and training so as to assist the Secretary of State in the discharge of his related duty in new section 1F. This will also apply to any Special Health Authority supporting the Secretary of State in the discharge of his duty.

222. *Duty as to promoting integration.* New section 13N requires the NHS Commissioning Board to exercise its functions with a view to securing that health services, health and social care services, and other health-related services (for instance services such as housing that may have an effect on the health of individuals, but are not health services or social care services) are provided in an integrated way where it considers that this would either improve the quality of health services and the outcomes they achieve, or reduce inequalities in access to or outcomes from health services. This requirement would cover both integration between service types (such as between health and social care) and integration between different types of health services (such as hospital and community care). This will apply to all the NHS Commissioning Board's functions, not just its commissioning functions, including, for example, when it exercises public health functions under arrangements with Public Health England. The practical effect should be that services are integrated around the needs of the individual.

223. Subsection (3) requires the NHS Commissioning Board to encourage CCGs to enter into joint arrangements with local authorities under section 75 of the NHS Act where this would improve the quality of health services or reduce inequalities in outcomes from or access to health services. The intention is that the NHS Commissioning Board should encourage CCGs to work closely together with local authorities in arranging for the provision of integrated services.

224. *Duty to have regard to impact on services in certain areas.* New section 13O requires the NHS Commissioning Board to have regard to the likely impact of its commissioning decisions on the provision of health services to persons living in areas of Scotland or Wales that are close to the border with England. It is intended that CCGs, in practice, will also have regard to the impact of their commissioning decisions on border areas.

225. *Duty as respects variation in provision of health services.* New section 13P prohibits the NHS Commissioning Board from exercising its functions for the purpose of increasing

or decreasing the market share of any particular type of provider – whether public or private sector or according to some other aspect of its status – in the provision of NHS services. This means the NHS Commissioning Board may not pursue a policy designed to encourage the growth of a particular sector of provider. It would not prevent the NHS Commissioning Board from commissioning services from whoever it considered the most suitable provider, including new service providers, or from seeking to develop integrated services.

Public involvement

226. *Public involvement and consultation by the Board.* New section 13Q requires the NHS Commissioning Board to make arrangements to secure public involvement and consultation in: (a) the planning of commissioning arrangements; (b) the development and consideration of proposals for service change where they would have an impact on the range of services provided and / or the manner in which they are provided; and (c) decisions affecting the operation of commissioning decisions. The duty applies to the NHS Commissioning Board only as respects health services which it commissions and its plans, proposals or decisions about such services. This reflects the duty that previously applied to PCTs under section 242 of the NHS Act.

Functions in relation to information

227. *Information on safety of services provided by the health service.* Following abolition of the National Patient Safety Agency under Part 10, new section 13R will give the NHS Commissioning Board responsibility for the functions currently carried out by the Agency in respect of reporting and learning from patient safety incidents. The intention is to ensure that patient safety is embedded into the health service through CCGs and the contracts they agree with providers.

228. *Guidance in relation to processing of information.* New section 13S places a duty on the NHS Commissioning Board to publish guidance on information processing requirements, sometimes termed information governance requirements, in respect of patient information or other information obtained or generated in the course of the provision of health services. These requirements may include confidentiality and information security and risk management practice, records management, data protection, disclosure of information and information quality. Subsection (2) requires registered persons who carry out activities connected to healthcare provision to have regard to the published guidance. Information processing is as defined in the Data Protection Act 1998 and covers any possible activity involving information obtaining, holding, recording, using or sharing. Provisions within Part 10 of this Act insert new section 20A into the Health and Social Care Act 2008, which incorporates the definition of "processing" in the Data Protection Act.

Business plan and report

229. *Business plan.* New section 13T requires the NHS Commissioning Board to publish a business plan before the start of the financial year setting out how it is to exercise its functions over the coming three years with a view to achieving its statutory duties and the objectives and requirements set for it by the Secretary of State in the mandate. The NHS Commissioning Board's business plan must, in particular, set out how it intends to discharge its duties as to improvement of quality under section 13E, as to reducing inequalities under 13G and as to the involvement of the public under 13Q as well its various financial duties under new sections 223C to 223E of the NHS Act. CCGs are required to cover similar matters in their commissioning plans.

230. *Annual report.* New section 13U requires the NHS Commissioning Board to publish an annual report, as soon as practicable after the end of each financial year, on how it has exercised its statutory functions during that year. In particular, the annual report must set out how, in its view, the NHS Commissioning Board has progressed against the

proposals it made in its business plan for that year and the objectives and requirements set for it by Secretary of State in the mandate. It must also include an assessment of how effectively it has discharged its duties as to improvement of quality under section 13E, as to reducing inequalities under 13G and as to the involvement of the public under 13Q. The Secretary of State will be under an obligation to review the annual report and publish a letter in response setting out how, in the Secretary of State's view, the NHS Commissioning Board has performed for the previous year against its statutory duties and the objectives and requirements set for it in the mandate. This letter must also be laid before Parliament.

Additional powers

231. *Establishment of pooled funds.* New section 13V allows the NHS Commissioning Board and one or more CCGs to set up a pooled fund (which is made up of contributions by the bodies establishing the fund), which can be used to make payments with the agreement of the bodies contributing to the fund, towards expenditure incurred in the discharge of any of their commissioning functions. This power is intended to assist the NHS Commissioning Board and CCGs working together to discharge their functions, allowing them to share financial resources to meet expenditure requirements.

232. *Board's power to generate income***.** New section 13W confers on the NHS Commissioning Board a power to generate income for improving the health service. This enables the NHS Commissioning Board to do anything specified in section 7(2) of the Health and Medicines Act 1988. The NHS Commissioning Board will have a duty to remain within the resource limits set by the Secretary of State under new section 223D of the NHS Act and any income it generates could therefore reduce the funding required from public finances.

233. *Power to make grants etc.* New section 13X enables the NHS Commissioning Board to make payments by way of loans as well as grants to voluntary organisations that provide, or arrange for the provision of, services similar to those which the NHS Commissioning Board will be responsible for commissioning. This reflects the power that the Secretary of State has under section 64 of the Health Services and Public Health Act 1968, (exercised by SHAs and PCTs prior to their abolition). Equivalent provision is provided in the Act for CCGs under new section 14Z6.

234. *Board's incidental powers: further provision.* New section 13Y gives the NHS Commissioning Board powers to enter into agreements, acquire and dispose of property and accept gifts (including property to be held on trust for the purposes of the NHS Commissioning Board).

Exercise of functions of Board

235. *Exercise of functions.* New section 13Z confers a power on the NHS Commissioning Board to exercise any of its functions by or jointly with a Special Health Authority, a CCG or any other body specified in regulations. Regulations may specify which functions of the NHS Commissioning Board may not be exercised by or jointly with such bodies. Where functions are exercised jointly, this may be through a joint committee of the NHS Commissioning Board and the other body under arrangements agreed between them.

Power to confer additional functions

236. *Power to confer additional functions on the Board.* New section 13Z1 gives the Secretary of State the power to confer additional functions relating to the health service on the NHS Commissioning Board through regulations. These regulations would be subject to the affirmative procedure, and would enable the Secretary of State to provide for additional functions to be carried out by the NHS Commissioning Board if this were beneficial for the effective operation of the health service. A function may only

be conferred on the NHS Commissioning Board if it is connected to another function of the NHS Commissioning Board.

Intervention powers

237. *Failure by the Board to discharge any of its functions.* New section 13Z2 confers a power on the Secretary of State to intervene in cases of significant failure of the NHS Commissioning Board to carry out any of its functions properly or at all. Failure to discharge a function properly would include failure to discharge that function consistently with what the Secretary of State considers to be in the interests of the health service (subsection (5)). It is in line with similar powers in the case of significant failure of the other arm's-length bodies.

238. Similar intervention powers exist in respect of Monitor and the Care Quality Commission, but with the difference that as regards those bodies the Secretary of State would not be able to intervene in a particular case - he would have to demonstrate that the failure was more widespread. This limitation is intended to maintain the independence of the regulators, but is not appropriate with respect to the NHS Commissioning Board. The NHS Commissioning Board has a wide range of functions in relation to the health service. As a result, in the event of significant failure, it might be appropriate for the Secretary of State to intervene in a particular case, for example if the NHS Commissioning Board failed to allocate funds to a particular CCG or if it failed to commission a service as required by the NHS Act.

239. The powers conferred by this new section are not intended to be powers that the Secretary of State would use regularly or routinely to intervene in the affairs of the NHS Commissioning Board.

Disclosure of information

240. *Permitted disclosures of information.* New section 13Z3 sets out categories of information obtained by the NHS Commissioning Board that it is permitted to disclose. It also deals with the relationship between the powers under the section and the rules of common law on disclosure.

241. *Interpretation.* New section 13Z4 sets out interpretation of various terms used throughout Chapter A1, including the definition of health services. Subsections (2) and (3) list those references to functions of the NHS Commissioning Board in Chapter A1, elsewhere in the Act and in other legislation that are to include public health functions that are delegated to the NHS Commissioning Board by the Secretary of State using the powers in new section 7A. Those powers and duties would therefore apply when the NHS Commissioning Board exercises any delegated public health functions.