An Introduction to the Legal Structures of the NHS

The abbreviations used in this chapter are:

CCG	Clinical Commissioning Group
GP	General Practitioner
NHS Act	National Health Service Act 2006
PbR	Payment by Results under the NHS National Tariff
STP	Sustainability and Transformation Partnership
TDA	Trust Development Authority
NHS England	The National Health Service Commissioning Board
2012 Act	Health and Social Care Act 2012
2012 Regulations	National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

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1. Introduction

1.1. The former Chancellor, Nigel Lawson, famously said that "The NHS is the closest thing the English have to a religion". That quotation accurately described the intense levels

of support for the NHS amongst the British public. The intensely "political" nature of the NHS is shown by the fact that funding and promises about improved delivery of NHS services are key issues in every General Election campaign. However the strength of commitment that staff, patients and the public have to the NHS is often matched by anger and frustration about the way that NHS decisions are made when, as regrettably happens, the services that the public receive are less than they feel they have a right to expect. Clinicians give advice and take decisions about options available to millions of individual patients in the NHS on a daily basis. Those decisions are mainly driven by clinical issues – what is the correct diagnosis, what are the right treatment options and what drugs should be prescribed to assist the patient. However all NHS clinical decisions are taken within a legal framework which explains what treatment decisions are open to HS clinicians and what options are not available to them.

1.2. The purpose of this website is to attempt to explain the legal structures of the NHS and how decisions are made in areas other than the interface between a clinician and a patient. The legal structures of the NHS govern how clinicians are employed, the options open to them, the ways in which patients can be referred for treatment and how funds flow from the Department of Health to meet the costs of providing NHS services. If everything goes right in the GP's consulting room or on the operating table, the structures behind the delivery of those services are rarely important. However if things go wrong or a clinician cannot offer a patient the most clinically effective treatment, the decision making structures that lie behind the treatment offered to individual patients comes under intense scrutiny.

1.3. Although the public see "the NHS" as a single entity, that is not the case. The NHS operates through networks of different organisations. Some of these are public bodies but many are commercial "for profit" organisations whose business is the delivery of NHS services in exchange for contract monies paid by NHS commissioners. However, collectively, more than 1.7 million people work in organisations that deliver NHS services. Of those, just under half are clinically qualified (including 39,780 general practitioners (GPs)), 370,327 nurses, 18,687 ambulance staff, and 105,711 hospital and community health service (HCHS) medical and dental staff. If the NHS were a single

employer (which it is not) only the Chinese People's Liberation Army, the Wal-Mart supermarket chain and Indian Railways directly employ more people. The NHS in England is the biggest part of the system by far, catering to a population of 53 million and employing more than 1.35 million people. The NHS in Scotland, Wales and Northern Ireland employs 153,427 – 84,817 and 78,000 people respectively. The NHS deals with over 1 million patients every 36 hours.

1.4. The creation of the NHS was a political decision which emerged from the Beveridge Report, on the Report of the Inter-Departmental Committee on Social Insurance and Allied Services. The original budget for the NHS was £437m (roughly £15bn at today's values) and the politicians and civil servants confidently predicted that the budget would be able to be reduced as the health of the nation improved. The health of the nation has undoubtedly improved since 1948 when average life expectancy was 66 years for men and 77 for women. In 2012–2014, a man in the UK aged 65 had an average further 18.4 years of life remaining and a woman had an average further 20.9 years of life remaining. In 1948 infant mortality was 34 deaths per thousand births whereas it is now just 5. Hence, the 1948 predictions of a healthier nation with the NHS were right (although the NHS has only been one factor in increased health outcomes and reductions in smoking rates probably have had far more impact). But the prediction that this would lead to a reduced requirement for NHS spending was perhaps "optimistic".

1.5. The overall budget for the NHS continues to be a matter of intense political debate, but the numbers are staggering. The NHS budget[1] in 2014/15 was £118.3 billion – that is £118,300 million. That is just short of £2,000 per person in the UK. The budget grew to £121.9Bn in 2015/16 and to £122.6bn in 2016/17. The kings fund helpfully summarises budget position as follows:

> "Planned spending for the Department of Health in England is approximately £123.7 billion in 2017/18 (at 2017/18 prices).

[1] These are figures from the Department of Health Annual Report, helpfully summarised in a report from the Kings Fund at https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget

> In the 2015 Spending Review the government announced that funding for the Department of Health would increase to £133.1 billion (or £126.5 billion at 2017/18 prices after adjusting for inflation) by 2020/21. The increase in health spending between 2015/16 and 2020/21 is less than the government has claimed, mainly because ministers have chosen to highlight the funding provided to NHS England only, rather than the Department of Health's total budget.
>
> Though NHS funding is continuing to grow, the rate of growth is slowing considerably compared to historical trends. The Department of Health budget will grow by 1.1 per cent in real terms between 2009/10 and 2020/21. This is far below the long-term average increases in health spending of approximately 4 per cent a year (in real terms) since the NHS was established.
>
> Looking ahead, between 2017/18 and 2019/20 the Department of Health budget will increase by just 0.6 per cent on average each year in real terms. This will place increasing pressure on the NHS, as demand for services is continuing to grow"

1.6. However the legal structures within which the NHS operates are largely unclear both to those who work in the NHS and those who work outside. There are huge public protests against any perceived "privatisation" of the NHS but those protesting appear to fail to realise that the NHS has always delivered a large part of its services through doctors in primary care who ran "for profit" businesses which contracted into the NHS rather than being NHS employees. It is perhaps inevitable that an organisation which is so complex as the NHS would have a hugely complex set of interlocking legal relationships which govern the rights and obligations of those working in the NHS. These legal basis of decision making by the various actors in the NHS is largely irrelevant for almost all of the working lives of most people in the NHS. They treat patients, order tests, make appointments and work with colleagues in a collegiate manner without worrying about who has the legal duty to do what. However when conflict arises or there is pressure on resources, questions about which NHS body is obliged to deliver what services come to the fore. There are also a huge variety of different types of legal obligation that emerge from any single set of facts.

1.7. The NHS took legal form under the National Health Service Act 1948[2]. That Act of Parliament was amended on numerous occasions. All of the changes to the legal structures of the NHS were brought together in the National Health Service Act 1977. Numerous further changes followed, particularly the creation of the "purchaser/provider" split for the NHS and the creation of semi-autonomous hospital trusts as a result of the National Health Service and Community Care Act 1990, which came into effect in 1993. By 2006 there had been so many changes to the National Health Service Act 1977 that a new consolidated Act of Parliament was needed. The new Act was – predictably – called the National Health Service Act 2006.

1.8. Today the legal structure of the NHS is substantially governed by the present version of the National Health Service Act 2006 ("**the NHS Act**"). However the NHS Act has been amended on many occasions since it was passed in 2006. The present version of the NHS Act includes many amendments which were made by the Health and Social Care Act 2012 which made very substantial changes to the structure of the NHS. In addition many of the sections of the NHS Act permit the Secretary of State to make Regulations which, once made, affect the legal obligations of NHS bodies.

1.9. There is also a wide range of other Acts of Parliament and other sources of law, including EU law, which impacts on the NHS. Hence, for example, procurement in the NHS is governed by the general rules on procurement within the Public Contracts Regulations 2006 as well as specialist Regulations for the procurement of NHS medical services known as the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.

2. The division between commissioners and providers in the NHS.

2.1. At the start of his judgment in *Keep Wythenshawe Special Ltd v NHS Central Manchester CCG and others* [2016] EWHC 17 (Admin) Dove J helpfully explained that:

[2] There are numerous academic works on the history of the NHS but the outline details are at http://www.nhs.uk/NHSEngland/thenhs/nhshistory/Pages/the-nhs%20history.aspx

> "As a consequence of successive legislative reforms, the provision of healthcare under the auspices of the National Health Service ("NHS") in England is a complex web of organisations with separate roles to play in the provision of services to patients …"

2.2. It has been the policy of successive governments, starting with Rt Hon Ken Clarke who was Secretary of State between 1998 and 1990 and steered the National Health Service and community Care Act 1990 through Parliament. The 1990 Act created the first NHS Trusts and thus started the divide between those bodies which have a duty to arrange services and those whose duty it was to treat patients.

2.3. Successive governments have maintained the separation between the NHS organisations that plan how resources should be allocated and what care should be commissioned for NHS patients and those organisations that deliver care to patients. This was originally known as the "purchaser-provider split" with some NHS organisations acting as "purchasers" and others as "providers". The terminology used by the present government and laid down in the Health and Social Care Act 2012 (and by previous governments) is that there should be a divide between "commissioners" and "providers". Whether this model remains appropriate for today's NHS is a subject of active debate, particularly given the creation of the "Sustainability and Transformation Partnerships ("**STPs**") which are the latest attempt to make the NHS operate in a more efficient manner. STPs are entirely non-statutory and hence their decisions have no direct legal effect.

2.4. The NHS England website defines describes "commissioning" as follows[3]:

> "At its simplest, commissioning is the process of planning, agreeing and monitoring services. However, securing services is much more complicated than securing goods and the diversity and intricacy of the services delivered by the NHS is unparalleled. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

[3] See https://www.england.nhs.uk/commissioning/

> There is no single geography across which all services should be commissioned: some local services can be designed and secured for a population of a few thousand, while for rare disorders, services need to be considered and secured nationally"

2.5. Once NHS commissioners have decided what services they wish to commission, they enter into "arrangements" with NHS bodies and a range of other organisations and individuals who agree to deliver those services to NHS patients who have a need of that service. These "arrangements" can be either:

2.5.1. A legal contract, normally in the form of an NHS Standard Contract, which defines the way in which the services are to be provided; or

2.5.2. An "NHS contract" which is a non-legally binding service level agreement which can only be enforced through the NHS's own dispute resolution processes.

2.6. A separate chapter is being written to describe the processes involved in NHS contracting and how the NHS's dispute resolution processes operates. However, for now, it is sufficient to note that these contracts are usually structured using the "Payment by Results" ("**PbR**") processes set out in the National Tariff. PbR arrangements operate "call-off" arrangements under which a provider of NHS services earns the right to a defined fee when the provider delivers a service to an NHS patient. Whilst an NHS provider can arrange for its clinicians to deliver any type of medical care to patients as its clinicians are willing to provide, an NHS provider will only be paid for delivering those services that are set out in the commissioning contract. Hence, in practice, NHS providers are only willing to provide care to NHS patients which is within the scope of the relevant commissioning contract.

3. Does the NHS have a duty to provide a comprehensive healthcare system?

3.1. One of the myths circulating in the NHS, and frequently perpetuated by politicians who are either supporting or attacking those currently running the NHS, is that the NHS has a duty to provide a comprehensive health service. The correct legal position is more nuanced. Section 1 of the NHS Act provides that the Secretary of State has a duty to

"*continue the promotion*" of a comprehensive health service. NHS England is also under this legal duty but it is not imposed on either the local commissioners of NHS services, namely Clinical Commissioning Groups ("**CCGs**") or on any providers of NHS services.

3.2. CCGs clinical commissioning groups and NHS England do not have a legal duty to provide services which, added together, amount to a comprehensive health service. The primary legal duties on CCGs and NHS England is imposed by section 3(1) of the NHS Act, namely to "arrange for the provision" of a wide range of health services "to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility". NHS England has like duties and also has duties to put in place primary care, dental and pharmacy services. However none of the obligations to set up specific services require the cumulative effect of the services to add up to a comprehensive health service for patients.

3.3. There is an important distinction in law between the duty on the Secretary of State to promote (or continue the promotion of) a comprehensive health service and a duty to provide a comprehensive health service. The statutory duty to promote a comprehensive health service has limited overall legal effect because the combination of budgetary, staffing and other resource pressures on the NHS mean that a truly comprehensive health service will never, in fact, be provided. The supply of publicly funded health services, largely free at the point of use, means that NHS doctors can do more for patients and that, in turn means that there is more demand for health services. The NHS cannot ever provide a truly comprehensive health service (in the same way as no publicly funded health services anywhere in the world can be comprehensive). However the statutory duty exists to remind the Secretary of State that his duty is to ensure the NHS should be as comprehensive as budgets and other resources permit. The Court of Appeal considered the conundrum of a legal duty which can never be fulfilled in *Coughlan v North and East Devon Health Authority* [2001] QB 213 where the court said:

> "24. The first qualification placed on the duty contained in section 3 makes it clear that there is scope for the Secretary of State to exercise a degree of judgment as to the circumstances in which he will provide the services, including nursing services

> referred to in the section. He does not automatically have to meet all nursing requirements. In certain circumstances he can exercise his judgment and legitimately decline to provide nursing services. He need not provide nursing services if he does not consider they are reasonably required or necessary to meet a reasonable requirement.
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> 25. When exercising his judgment he has to bear in mind the comprehensive service which he is under a duty to promote as set out in section 1. However, as long as he pays due regard to that duty, the fact that the service will not be comprehensive does not mean that he is necessarily contravening either section 1 or section 3. The truth is that, while he has the duty to continue to promote a comprehensive free health service and he must never, in making a decision under section 3, disregard that duty, a comprehensive health service may never, for human, financial and other resource reasons, be achievable. Recent history has demonstrated that the pace of developments as to what is possible by way of medical treatment, coupled with the ever increasing expectations of the public, mean that the resources of the NHS are and are likely to continue, at least in the foreseeable future, to be insufficient to meet demand"

3.4. The duties on commissioners under section 3(1) of the NHS Act impose legal obligations on commissioners to make arrangements for services that can be accessed by patients that wish to do so. However these duties do not create private law legal duties owed to individual patients. The Secretary of State has no general private law[4] duty of care to members of the public as potential patients and neither do NHS commissioning bodies. The legal duties under the NHS are fulfilled if health and social care services are made available to potential patients to meet what the NHS commissioners consider to be their "reasonable requirements". Thus the NHS Act does not impose legal duties on NHS bodies to provide healthcare to individual patients (save possibly in the case of patients who are sectioned under the Mental Health Act 1983). The role of NHS commissioners and providers is put services in place so they are accessible, if the public wish to avail themselves of those services.

4. The NHS Triple Lock: Patients, Treating Clinician and NHS commissioner

[4] I.e. A legal duty which can be the subject of a private law action for damages if it is alleged to have been breached.

4.1. There is a triple lock operating in the NHS. A patient will only secure NHS funded treatment if the patient, the relevant treating clinician and the relevant NHS commissioner all concur that medical treatment is clinically appropriate for a particular patient. The NHS commissioner often defines the broad categories of medical treatment that it is prepared to support and then leaves the selection of appropriate patients to clinicians to decide, using parameters defined by the commissioners. However, no NHS funded treatment will be provided unless all 3 of the patient, the treating clinician and the NHS commissioner have agreed that NHS funded treatment will be given.

4.2. One reason why the NHS Act imposes no direct legal duty on doctors to treat patients is that everyone who has the legal capacity to make their own decisions to give or refuse treatment is under any legal obligation to consult a doctor or attend a hospital. Save in unusual situations such as compulsory mental health treatment, patients have the right to take their own decisions about receiving medical treatment. However ill a patient is, the patient has the absolute right to refuse to accept medical treatment. Whether an individual patient with capacity wishes to access such services or not is a matter for that individual, not for doctors or their relatives. Save in the case of a detained mental health patient, we all have the right to refuse medical treatment. In *Re T (Adult: refusal of treatment)* [1992] 1 WLR 782 Lord Donaldson MR said:

> "An adult patient who, like Miss T., suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered. ….. This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent: see *Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] A.C. 871* , 904-905"

4.3. Thus the UK state, acting through the NHS, cannot have a duty to provide medical care unless a patient requests it. Whilst this absolute right of a patient to make their own decisions is confined to patients with capacity, a person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise. It is

important in this regard to recall the words of Peter Jackson J in *Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP)* at [7]:

> "The temptation to base a judgment of a persons capacity upon whether they seem to have made a good or bad decision, and in particular on whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity. Any tendency in this direction risks infringing the rights of that group of persons who, though vulnerable, are capable of making their own decisions. Many who suffer from mental illness are well able to make decisions about their medical treatment, and it is important not to make unjustified assumptions to the contrary."

4.4. However, where a patient decides that his or her medical condition should be treated by a clinician, patients do not have a legal right to demand a specific form of medical treatment. Medical treatment within the NHS is not based on a consumer relationship – a patient cannot "purchase" any item off the shelf and demand that it is provided to them. The doctor or nurse has a duty to consider what medical treatment is clinically appropriate for a patient and is fully entitled not to offer to provide medical treatment which the doctor or nurse considers is not clinically indicated by the patient's presenting condition. Thus, in *Re (A Minor) (Wardship: Medical Treatment)* [1992] Fam 11 Lord Donaldson said:

> "However consent by itself creates no obligation to treat. It is merely a key which unlocks a door"

4.5. Thus consent gives the doctor the legal right to treat a patient but imposes no legal duty on the doctor to do so. However a doctor has a duty of care to the patient and that will usually lead the doctor to having a duty to provide advice to a patient to define the appropriate treatment options for the patient and, once the patient has made the choice amongst those options, a duty to provide the treatment selected by the patient. However where a doctor is working within the NHS, the treatment options that a doctor is able to offer to a patient may be circumscribed by decisions made by an NHS commissioner.

4.6. Each NHS commissioning organisation is required to work within a defined, limited annual budget. This means that NHS cannot offer unlimited care to any patient or

guarantee that patients will have access to NHS funds to support any medical care which might be clinically effective for that patient. NHS bodies have a duty to break even financially and so are not only entitled to ration care but have a legal duty to do so in a rational way. This can lead NHS commissioning organisations to take the decision not to make a clinically appropriate treatment available to a patient, even though both the patient and the treating doctor have reached the view that the patient should have the treatment: see for example *R (Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910[5].

4.7. Hence, in practice, NHS funded treatment is only provided where all 3 of the patient, the treating doctor and the relevant NHS commissioner approves the treatment.

5. The role of the different public bodies within the NHS.

5.1. The NHS is composed of a large number of public bodies, all of which have different functions and on occasions overlapping responsibilities. Making sense of the legal systems operating in the NHS requires an understanding of the roles and responsibilities of the different public bodies operating within the NHS and how they interact with private sector providers who contract to deliver services to NHS patients.

5.2. NHS bodies can broadly be divided into 4 types, namely:

5.2.1. Overarching national NHS bodies;

5.2.2. Commissioners of NHS services;

5.2.3. Providers of NHS services; and

[5] http://www.bailii.org/ew/cases/EWCA/Civ/2011/910.html

5.2.4. Regulators of NHS services, namely public bodies which supervise the performance of those individuals and public bodies who commission or provide NHS services and body that oversee the performance of NHS bodies.

5.3. Some NHS bodies perform more than one function. Hence, for example, NHS England is both a commissioner and a regulator. The Secretary of State sits at the apex of the NHS. The Secretary of State is a cabinet minister and a member of parliament, usually an elected MP. The present occupant of the office is Rt. Hon Jeremy Hunt MP. The Secretary of State has overall political responsibility for the NHS and plays a key strategic role, particularly by setting the Annual Mandate for NHS England. However his operational legal role has been substantially diminished by the Health and Social Care Act 2012 ("the 2012 Act"). Section 1 of the NHS Act provides:

> "The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—
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> a) in the physical and mental health of the people of England, and
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> b) in the prevention, diagnosis and treatment of physical and mental illness.
>
> (2) For that purpose, the Secretary of State must exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act.
>
> (3) The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England"

5.4. The Secretary of State has a duty to "promote" a comprehensive health service under this section. In order to achieve this vision of a comprehensive health service, clinical commissioning groups and the NHS England have a duty to provide a range of services to meet the reasonable requirements of patients for services as well as making arrangements to provide primary care, dental and pharmaceutical services.

5.5. There were fierce debates about the role of the Secretary of State during the passage of the Health and Social Care Bill which led to the 2012 Act. The then Secretary of State, Andrew Lansley, saw the role of the Secretary of State to set the strategic framework

but to be detached from any duty to implement those decisions. However that meant that no one was accountable in parliament for decisions taken within the NHS. A compromise is reflected in section 1(3) of the 2012 Act which provides that

> "The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England"

5.6. Thus, as has always been the case, the minister is required to take responsibility for decisions to close hospitals, for breaches of waiting list targets and anything else which goes wrong right across the NHS.

5.7. The Secretary of State has a range of procedural duties which govern the way in which he is required to discharge his functions, set out in sections 1Aff of the NHS Act including the duty to exercise his functions with regard to the need to reduce inequalities.

6. Commissioners of NHS services

6.1. The term "commissioning" is not defined in the NHS Act but (before it was closed down in the latest reorganisation of government websites) the "NHS Improvement" website explained the meaning of "commissioning" as follows:

> "Commissioning is a cycle of activities that includes assessing the needs of a population; analysing 'gaps'; setting priorities and developing commissioning strategies; influencing the market to best secure services and monitoring and evaluating outcomes. In other words, it involves buying in services from a range of health service providers (including GPs, dentists, community pharmacists, NHS and private hospitals, and voluntary sector organisations) to meet the health needs of local people, and monitoring how well they are being delivered. Commissioning is an on-going process that applies to all services, whether they are provided by the local authority, NHS, other public agencies, or by the independent sector"

6.2. This definition suggests that "commissioning" NHS services is a continuing activity for NHS commissioners. Within the overall commissioning process, specific decisions may have to be made such as closing down or reconfiguring a particular NHS service. When

that happens, an NHS commissioner will enter into a particularly intense period of decision making regarding the defined service. However, as the above definition explains, the overall commissioning duties of NHS commissioners are continuous and work on commissioning matters continue at all times and exist outside of any specific processes set up for service areas.

6.3. The commissioning cycle for every clinical commissioning group works on an annual cycle which is, at least in part, is defined by the NHS commissioners' annual plan which ought to set out its commissioning intentions. The main commissioners in the NHS are:

6.3.1. **NHS England**: NHS England was created by the 2012 Act. It licences and, to limited extent, performance manages, clinical commissioning groups. However NHS England is also a commissioner of a wide range of specialist NHS services, including prison health services, medical services for the armed forces and a wide range of specialised and tertiary acute services. NHS England commissions services for patients with rare conditions and also commissions primary care medical and dental services. This means that all GP practice contracts are between NHS England and the local GP provider. Detailed arrangements for NHS England are set out in Schedule 1 to the 2012 Act;

6.3.2. Clinical Commissioning Groups ("CCGs"): These are local corporate public bodies created by the 2012 Act. The members of a CCG are the local general practices in the CCG area who hold NHS commissioning contracts with NHS England. CCGs substantially replaced primary care trusts by taking on the commissioning of a range of acute and community NHS services (other than primary care, dental care and specialist services) for the patients for which the CCG has responsibility. The CCG has a constitution and a Board, which is partly elected by the local GPs, and partly consists of other stakeholders in the local NHS. Detailed arrangements for CCGs are set out in Schedule 2 to the 2012 Act; and

6.3.3. Local Social Services Authorities: The 2012 Act transferred responsibility for public health commissioning from primary care trusts to the local authorities. In

practice this means that commissioning public health services is the responsibility of unitary local authorities or, in a case where there are 2 tiers of local authority, the county council.

6.4. The division of commissioning responsibility between NHS England, CCGs and local authorities are largely set out in the NHS Act and the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("**the 2012 Regulations**"). The division between the services defined in section 3(1) of the NHS Act that are commissioned by NHS England and those that are commissioned by CCGs is described in a later chapter. NHS England also has a duty to commission the following services:

6.4.1. Primary care medical services (see Part 4 of NHS Act);

6.4.2. Primary care dental services (see Part 5 of the NHS Act);

6.4.3. Ophthalmic services (see Part 6 of the NHS Act); and

6.4.4. Community pharmaceutical services (see Part 7 of the NHS Act).

6.5. Included within the overall responsibilities of NHS England is the duty to commission "specialist services": see Schedule 4 to the 2012 Regulations. The budget for specialised services has grown substantially in recent years and is now is in the region of £15.6Bn and so constitutes about 13% of the overall NHS budget. It has grown from 10% of the overall budget in the last 4 years. The list of 144 specialist areas (as at June 2017) has been amended on various occasions since the list was published in 2012, and looks set for further amendment. Some descriptions of services which are commissioned by NHS England are fairly generic such as "Specialist surgery for children and young people". However further details are set out in the Manual for Specialised Commissioning published by NHS England.

6.6. Local authorities only had a limited role in the NHS until the Health and Social Care Act 2012. However that Act transferred public health functions from primary care trusts to

the local authority which had social services functions. This is a county council in areas where there are 2 tiers of local authorities or unitary authorities in those areas just having a single local authority. Local authorities are required to work jointly with the Secretary of State to appoint a "Director of Public Health" (see section 73A of the NHS Act).

6.7. The primary duties of local authorities are expressed widely in section 2B of the NHS Act as follows:

> "Each local authority must take such steps as it considers appropriate for improving the health of the people in its area"

6.8. These are, of course, open ended obligations which are severely restricted by the budgets available to local authorities. They include health prevention services, sexual health services and a host of other areas where timely intervention can reduce the need for later acute services. A useful guide to discharging public health functions has been prepared by the Kings Fund.

6.9. The main commissioning duties of CCGs are set out in section 3 of the NHS Act which provides as follows:

> "A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility—
>
> a) hospital accommodation,
>
> b) other accommodation for the purpose of any service provided under this Act,
>
> c) medical, dental, ophthalmic, nursing and ambulance services,
>
> d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the group considers are appropriate as part of the health service,
>
> e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have

suffered from illness as the group considers are appropriate as part of the health service,

f) such other services or facilities as are required for the diagnosis and treatment of illness"

6.10. Section 3(1E) provides that the duty in subsection (1) does not apply in relation to a service or facility if the Board has a duty to arrange for its provision. There can therefore be no "overlap" between the services NHS England is obliged to commission and those which are the responsibility of local CCGs. Thus CCGs only have commissioning responsibility for the above services to the extent that these are not the commissioning responsibility of NHS England.

7. Providers of NHS services.

7.1. The main providers of NHS services are:

7.1.1. **GP practices**: Almost all GP practices are private sector businesses which are owned by GPs which contract with NHS England to provide primary care services to NHS patients across one or more practice areas. A GP practice can be owned by a single GP, a partnership of GPs, a partnership consisting of GPs and other approved persons or by a medical company. More details of the types of organisations that can hold GP contracts can be found here;

7.1.2. **Dental practices**: Almost all NHS Dental practices are private sector businesses which are owned by dentists which contract with NHS England to provide primary care services to NHS patients across one or more practice areas. Largely same restrictions on ownership apply to dentists as apply to GP practices;

7.1.3. **NHS Trusts**: These are NHS bodies created under Chapter 3 of Part 2 of the NHS Act 2006. NHS Trusts enter into acute services contracts with CCGs to provide a wide range of community, mental health and hospital services to

patients. The present plan of the government is that all NHS Trusts should become NHS Foundation Trusts or be taken over by an NHS Foundation Trust by 2016. The Secretary of State has the power to issue Directions to an NHS Trust under section 8 of the NHS Act which, if lawfully made, imposes specific legal obligations on NHS Trusts to do things or provide services, or to cease to do something or cease to provide a service as specified in the Direction;

7.1.4. **NHS Foundation Trusts**: These are public benefit corporations under Chapter 5 of Part 2 of the NHS Act 2006. NHS Foundation Trusts have Members and Governors, as well as a Board of Directors. NHS Foundation Trusts are accountable to a regulator, known as Monitor and are accountable to their members. The Secretary of State has no power to issue Directions to an NHS Foundation Trust;

7.1.5. **Special Health Authorities:** These are NHS bodies that perform particular specialist functions within the NHS such as NHS Blood and Transplant which co-ordinates the supply of blood and organ transplantation services for the NHS.

8. Regulators of NHS services

8.1. The main bodies that regulate the performance of services by NHS bodies and have an interest in the way that NHS bodies are managed are as follows:

8.1.1. **The Care Quality Commission:** The CQC is the statutory body with responsibility for **ensuring that** hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and to encourage them to make improvements. The CQC inspects and reports on all providers of social and health care in England, covering both the state and private sectors;

8.1.2. **Monitor:** Monitor was previously known as the Independent Regulator for NHS Foundation Trusts. However its role was changed by **Part 3** of the 2012 Act. Its new role to "*protect and promote the interests of patients*" by attempting to ensure that the whole health sector works for their benefit. It was set up as, in effect, the competition regulator for the health market and so now has interests which extend far beyond NHS Foundation Trusts. It exercises a range of powers granted by Parliament which include setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences issued to NHS-funded providers.

8.1.3. **The Trust Development Authority:** The "Trust Development Authority", known as the "**TDA**", provides support to NHS Trusts in a similar way to Monitor oversees and works with NHS Foundation Trusts. In operational terms (but not in legal terms), the TDA and Monitor have now been amalgamated in a single organisation known as "**NHS Improvement**". However these 2 organisations continue to be separate legal entities;

8.1.4. **NHS England:** NHS England has a limited regulatory function in respect of CCGs. It licences CCGs and can step in if a CCG is not performing properly;

8.1.5. **Healthwatch**: Healthwatch is the latest in a long line of public bodies which are designed to feed the voice of the patient into the NHS. Previous bodies include Community Health Councils and PALS. Healthwatch England is a new public body set up by the 2012 Act to act as a national champion of patients' interests. There are now 152 local healthwatch groups who are supposed to champion the interests of patients in their local NHS. It is too early to tell whether local healthwatch groups are likely to have any real impact on local service delivery;

8.1.6. **Health Overview and Scrutiny Committees**: These are committees made up of members of the local social services authority. Their role is to "review and scrutinise any matter relating to the planning, provision and operation of the

health service(5) in its area: see Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The committee must be consulted about any "substantial development of the health service in the area of a local authority" and, if they consider that the development is not "in the interests of the health service in its area", it can refer the decision to the Secretary of State who then becomes the final decision maker;

8.1.7. **Health and Wellbeing Boards**: The Health and Social Care Act 2012 established health and wellbeing boards as committee of the local authority. The Boards are intended to operate as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities, in particular by facilitating better working between health and social care services. Health and wellbeing board members ought to collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

8.2. It is difficult if not impossible to argue that the NHS is set up in a coherent or entirely logical way. The arrangements have as much to do with politics as with good governance. However the above system is designed to ensure a system of checks and balances with the patient supposedly at the centre of all decision making. Whether that happens in practice is, of course, a matter of considerable debate. Within the complex legal system operating in the NHS, clinicians undertake a variety of different functions and, depending on which function they are undertaking, will have different legal obligations. For example a GP wears a large number of legal "hats" depending on which function the GP is undertaking. An individual GP can be:

8.3. A doctor who owes duties in tort (i.e. in negligence) to the patients of that individual doctor;

8.3.1. A partner in a GP practice with legal duties to her partners under the deed of partnership

8.3.2. An employer of other clinical and not clinical staff with a variety of contractual and statutory duties to her[6] employees.

8.3.3. Part of a clinical commissioning group ("a CCG") and thus someone who takes commissioning decisions. These are administrative decisions which are taken within the scope of the public law duties of the CCG.

8.3.4. A professional who has regulatory obligations to the General Medical Council.

8.3.5. A person whose duties can attract the attentions of the police and the criminal justice system.

8.4. A clinician who works in hospitals have some but not all of the above legal duties. He or she (and the NHS Trust or NHS Foundation Trust that employs the clinician) has private law duties to patients and is a regulated professional. However, unlike his or her colleagues in primary care, the clinician will be a direct employee of an NHS body rather than a self-employed professional or an employee of a primary care organisation.

8.5. In order to provide a description of the legal rights and obligations of a clinician in any individual situation, it is necessary to identify the legal function or functions the clinician is undertaking because, depending on what "hat" the clinician is wearing, the legal responsibilities will vary. However different types of legal obligation are engaged in any situation faced by a practising doctor, nurse or other NHS employee. It is not enough to ask if a proposed act is "lawful" or not. The word "lawful" is used and misused in common parlance, and can have a wide variety of meanings depending on the type of legal obligation involved. It is thus necessary to identify the type of legal obligation

[6] I will refer to the GP as "she" but the legal structures apply equally whether the GP is a man or a woman.

engaged in any particular set of facts and in particular to identify the consequences for that individual of any breach of that legal duty.

9. The different meanings of "law" and legal obligations in the NHS

9.1. The different types of legal obligations which arise for a clinician or anyone working in the NHS can, in general terms, be summarised as follows:

9.1.1. **Criminal Law obligations:** Criminal law statutes and the common law define criminal offences which apply to everyone in defined circumstances. If a clinician acts in breach of those duties then he or she may be prosecuted for breach of the criminal law in the same way as any other citizen. Hence, for example, a GP who assists a person to commit suicide may face prosecution in the Crown Court under section 2 of the Suicide Act 1961. The outcome of a prosecution for the breach of the criminal law is a punishment imposed by the criminal courts, which can vary from a sentence of imprisonment to a fine depending on the circumstances;

9.1.2. **Contractual Law obligations**: Clinicians that are employed by an NHS body have a contract of employment. That contract sets out contractual rights and duties on both sides. GPs tend either to be employees of a GP practice, principals in that practice or self-employed locums. In each situation the GP will be party to one or more contracts which define contractual rights and duties on both sides. If a GP is a party to a partnership deed, the GP can acquire legal duties. This can give rise a wide range of legally binding obligations[7]. GP practices will hold a contract with NHS England[8] which defines their obligations and set out the duties of NHS England to make payments to the practice. Patients who are

[7] A "contract" for these purposes is an agreement of sufficient certainty of terms concluded between 2 or more parties who intend to create legal relations supported by adequate consideration and where there is no other legal objection to the creation of enforceable legal obligations between the parties.

[8] NHS England is the operating name for the National Health Service Commissioning Board. For details see

treated by a GP privately will have a contractual relationship with the GP. Employees of a GP practice are owed duties under their contracts of employment and, on a smaller scale, a GP may be a party to a contract to lease a photocopier. Each of these contracts gives rise to private law legal obligations. Contractual rights can be enforced by the GP or by another party against the GP in the civil courts (namely the County Court or the High Court). If a breach of contract is proved, the remedies available include damages and/or injunctions;

9.1.3. **Non-contractual private law legal obligations**: There is no contract between an NHS clinician and his or her NHS patients. However where a clinician is treating patients, the clinician owes a legal "duty of care" to his or her patients for treatment which is given or omitted to be given. Other legal duties include the duty to maintain the confidentiality of patient related information held by the clinician. These are private law duties which are owed because the relationship between a clinician and his or her patients. It is the nature of the relationship which gives rise to the duty of care owed by the clinician to the patient for medical treatment and to maintain confidentiality. Any allegations of breach of this duty would be an allegation that the clinician has committed a civil wrong, which can give rise to a claim for damages. Such claims are tried in the civil courts if not otherwise resolved. GPs who are not direct NHS employees are professionally required to be insured against such claims, usually with the Medical Protection Society or the Medical Defence Union;

9.1.4. **Information Governance Duties**: NHS bodies, including GP practices, hold vast quantities of personal data relating to their patients and others. Both NHS bodies and GP practices have to be registered "data controllers" under the Data Protection Act 1998. Medical information relating to patients is defined as being sensitive personal data under the Data Protection Act 1998. As a result NHS bodies have a series of complex legal duties concerned with the handling of personal data. Any complaint that they have breached such duties can result in a compliant to the Information Commissioner's Office. In addition NHS bodies are "public bodies" within the Freedom of Information Act 2000. They thus have

disclosure duties under that Act, although these duties do not apply to personal data which is covered exclusively by the Data Protection Act 1998. Any complaint that an NHS body (including a GP practice) has breached its duties under the Freedom of Information Act 2000 can also result in a compliant to the Information Commissioner's Office;

9.1.5. **Professional Regulatory Obligations**: In order to be lawfully entitled to deliver primary care medical services to patients, virtually all clinicians working in the NHS are required to be included on the list of the statutory regulator which is relevant to their professional group. Doctors must be on the list maintained by the General Medical Council ("GMC") and nurses are regulated by the Nursing and Midwifery Council ("NMC"). The purpose of the GMC is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Breaches of the GMC Code of Conduct will not necessarily amount to a breach of any other legal obligation owed by the doctor to his or her patient or indeed to anyone else, but may do so. A breach of the Code of Conduct may result in the GMC taking regulatory action against the doctor to seek removal from the Medical List or the imposition of conditions on the doctor's continuing inclusion on the list;

9.1.6. **Performers List Obligations:** In addition to the regulatory role of the GMC, Regulations require that every primary care professional (including GPs) delivering services to NHS patients (as opposed to treating patients privately) is included on a Performers List maintained by NHS England. NHS England are entitled to seek the removal of a primary care professional from the Performers List in a variety of circumstances including where NHS England conclude that it would be "prejudicial to the efficiency of the services which those included in that performers list perform" to maintain the primary care professional on the Performers List or that the Practitioner is "unsuitable to be included in that performers list";

9.1.7. **Statutory duties:** A huge variety of Acts of Parliament or Regulations made under Acts of Parliament impose legal obligations on doctors working in the NHS including GPs. These are known as "statutory duties". There are, for example, statutory duties arising out the Health and Safety at Work Act 1974 which require GP practices to make their premises reasonably safe for visitors and those who work there. The Employment Rights Act 1996 imposes duties on employers to protect staff and prohibits NHS bodies from unfairly dismissing staff. The Equality Act 2010 imposes a range of duties on everyone providing public services not to discriminate when undertaking public functions. The obligation to pay a wide variety of taxes is all set out in statutes and enforced by HMRC. All these statutes create legal obligations and then provide a variety of mechanisms for determining whether there has been a breach of the statutory duty. Breach of statutory duty can result in a criminal case (as with health and safety breaches), a case before a tribunal (such as with employment rights that are heard before an Employment Tribunal) or may result in a civil claim for damages. Hence, by way of a further example, section 5B of the Female Genital Multination Act 2003 imposes a duty on healthcare professionals to make a report of any act of FGM that comes to their knowledge. Breach of that duty is an "unlawful" act but the statute does not provide for any penalty. Nonetheless a clinician who breached that legal duty could expect to face professional discipline charges;

9.1.8. **Public law obligations:** Lastly there are specific legal obligations that are owed by public bodies. CCGs, NHS Trusts and NHS Foundation Trusts are clearly public bodies as a result of the statutory duties imposed on them by the NHS Act. A GP practice can also be treated as a public body for some purposes. Clinical commissioning groups are public bodies with a wide variety of public law duties, breach of which can result in action in the administrative court. Public bodies have a range of specific legal obligations both at common law and under a huge variety of statutory schemes. Different public law obligations are enforced in different ways. For example, breaches of the duties under FOIA are enforced by the Information Commissioner and on appeal to the First Tier Tribunal

(Information Rights). If there is no other enforcement mechanism laid down in legislation, breaches of public law duties are enforced by way of applications for Judicial Review in the High Court.

10. How do these multiple legal duties work out in practice for a NHS clinicians and managerial staff?

10.1. A single act or sequence of events involving an NHS clinician or a staff member may engage more than one of the above legal duties. Hence, to take an extreme example, it may be alleged that a GP has delivered seriously sub-standard care to a patient who has subsequently died as a result of the failure of the care provided by the GP. Such a GP may find himself or herself having to meet the following legal problems:

10.1.1. The GP may be prosecuted for breach of the criminal law, probably for the offence of manslaughter. If such a criminal case were to be brought, it will be tried in the Crown Court;

10.1.2. The actions of the GP may be alleged to be a breach of the contract the GP holds with NHS England (such as a General Medical Services Contract). That may entitle NHS England to impose contract sanctions or even terminate the GMS contract;

10.1.3. The actions of the GP may leave him or her in breach of his duties to his partners and may lead to expulsion from the medical partnership;

10.1.4. The GP will have breached his duties to the patient and thus the patient's executors or administrators may sue the GP for damages. That claim would be brought in the civil courts. The GP may be able to rely on his professional indemnity insurance (provided for example by the MDU or MPS) to meet any damages;

10.1.5. The GMC may take action to remove the GP from the Medical List by bringing the GP before a Fitness to Practice Panel; and

10.1.6. The GP may also face action from NHS England to remove him or her from the Performers List.

10.2. Each of the above legal consequences will involve different legal considerations even though they arise from the same set of primary facts.

10.3. A hospital doctor who was in a similar situation would face a slightly different set of legal issues, namely:

10.3.1. The hospital doctor may be prosecuted for breach of the criminal law, probably for the offence of manslaughter. If such a criminal case were to be brought, it will be tried in the Crown Court;

10.3.2. The actions of the hospital doctor may be alleged to be a breach of his employment contract with his employing trust. That may entitle the trust to suspend and eventually dismiss the doctor;

10.3.3. The hospital doctor will have breached his duties to the patient and thus the patient's executors or administrators may sue the employing trust and possibly also the doctor for damages. That claim would be brought in the civil courts. The NHS Litigation Authority will become involved as the in-house "insurer" for NHS Trusts;

10.3.4. The GMC may take action to remove the hospital doctor from the Medical List by bringing the doctor before a Fitness to Practice Panel.

10.4. In each case the doctor will have to work closely with the lawyers he or she has appointed (and possibly more than one set of lawyers) to protect his or her position. Some aspects of this legal work will be covered by professional indemnity insurance in the case of a GP or the NHSLA for a hospital doctor. Others aspects may have to be

funded by the doctor or by his professional organisation. However, in assessing and understanding the legal options and risks for the doctor, it will be essential to understand the particular legal framework within which the doctor is working, and the legal principles that apply to that particular legal action.

10.5. The chapters of this website seek to look in detail at the legal obligations that arise within the NHS and the legal rights and duties of various players within the NHS system in a variety of different situations. However it is important that anyone working in the NHS who advises NHS employees recognise that legal problems rarely exist in individual silos. The same set of primary facts can give rise to multiple legal issues with NHS clinicians wearing different "hats". Individual sections of this website are able to point out some occasions where there are likely to be multiple legal effects but it would be impossible to predict every situation where one set of facts or allegations will give rise to multiple legal issues.

10.6. There are limitations to the extent to which a general guide can assist in a particular set of circumstances. If the text of this website is insufficient to assist in starting to address relevant questions, readers would be well advised to seek expert legal advice in relation to the particular facts of a case, building on the initial guidance obtained from this site.