Independent review of the arrangements made by SHAs for the approval of registered medical practitioners and approved clinicians under the Mental Health Act 1983

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1 Introduction

Background

1.1 In October 2012, the Department of Health (DH) became aware of technical irregularities in the delegation of the arrangements for approving registered medical practitioners and approved clinicians (ACs) for the purposes of exercising functions under the Mental Health Act 1983 (as amended and hereafter referred to as "the 1983 Act").[1] The arrangements for approving registered medical practitioners under section 12 of the 1983 Act ("section 12 doctors"), for the purposes of assessing whether patients meet the criteria for detention under that Act, were of particular concern.

1.2 In 2002, when Strategic Health Authorities (SHAs) came into being, the then Secretary of State for Health delegated his function of approving section 12 doctors to them. From November 2008, the Secretary of State also delegated the approval of ACs to SHAs. However, in four out of the ten SHAs - North East, Yorkshire and the Humber, West Midlands and East Midlands - the authorisation of approvals was further delegated by those SHAs to National Health Service (NHS) Mental Health Trusts (MHTs) for various periods. Further delegation to MHTs is not permitted by the statutory regime. These further delegations constitute the technical irregularities referred to in this report. (The relevant legal obligations are set out in section 2 of this report. The future legislative position is outlined in appendix A).

1.3 The Department estimated that the approvals of approximately 2,000 registered medical practitioners and ACs were technically irregular, and that doctors whose approvals may have been technically irregular participated in authorising the detention of between 4,000 and 5,000 patients being cared for in the NHS and independent sectors as of October 2012.

1.4 There is no suggestion that the hospitalisation or detention under the 1983 Act of any patient has been clinically inappropriate. Though their approval under section 12 may have been technically irregular, the competence of doctors so approved had been properly assessed and all were properly qualified and experienced to make such recommendations. There is no evidence that these doctors might have made incorrect diagnoses or decisions about the treatment that patients needed. All patients were properly assessed by competent clinicians before their detention under the 1983 Act was authorised.

[1] Registered medical practitioners approved under section 12 of the 1983 Act also have functions in certain parts of criminal justice legislation.

1.5 Furthermore, the Department believes that no one has been detained in hospital who should not have been detained, and that no patients have suffered harm because of the technical irregularities that occurred. The doctors concerned were properly qualified and experienced and would have had no reason to think that they had not been properly approved as section 12 doctors. They acted in good faith and in the interest of their patients throughout this period.

1.6 The Department subsequently enacted emergency retrospective legislation to correct the situation and establish legal clarity. The legislation applied to the approval of all relevant section 12 doctors and ACs under the 1983 Act since its introduction in 1983. Its effect was to retrospectively validate the power of those organisations to which responsibility had been improperly delegated to exercise approval functions.

1.7 The accountable officers for the four SHAs in question have written to Sir David Nicholson, Chief Executive of the NHS, to confirm they have made the necessary changes to their governance arrangements to correct the irregularity. Furthermore, the accountable officers in the remaining six SHAs have written to Sir David, in the light of this issue, to confirm that they have reviewed their own arrangements and indicating that those arrangements were compliant with the statutory regime.

1.8 The Secretary of State for Health asked me to undertake an independent review of how this responsibility came to be improperly delegated by the four SHAs and, more broadly, what governance and assurance processes the SHAs followed in delegating any responsibilities. He also asked me to look at the issue in the context of the new NHS structure that comes into force from April 2013 and to see whether any lessons need to be learned. The Secretary of State asked me to deliver the review by the end of the year, including recommendations to ensure that every part of the system employs the highest standards of assurance and oversight in the delegation of any functions.

Terms of Reference

1.9 The Secretary of State set the following Terms of Reference for the review:

'The review will look at how the responsibilities were delegated by four out of the 10 SHAs (North East, Yorkshire and the Humber, West Midlands and East Midlands), including:

- How these SHAs came to delegate incorrectly the process of approving Mental Health Act clinicians, and for how long this persisted;
- What decision and governance processes the SHAs followed, and on the basis of what legal advice, and what advice from the DH; and

- Whether the irregularities could have been identified earlier, by the SHAs, the Department, or any appropriate regulator.

The review will also consider more broadly:

- The governance and assurance processes that SHAs have used for delegating statutory responsibilities; and
- The lessons to be learned in the context of the new NHS structures that come into force from April 2013, to ensure that every part of the system employs the highest standards of assurance and oversight in the delegation of any statutory functions and authority in the future.

The review will provide a report to the Secretary of State by 31 December 2012, and its findings will inform the final stages of the transition programme.'

Methodology

1.10 The review team was led by me and I was supported by three DH officials, with some secretarial and business management support from NHS South of England. I also received advice from the Department's legal advisors.

1.11 The team considered relevant documentation and interviewed representatives from the four SHAs involved and those MHTs to whom the SHAs had improperly delegated the approval functions. The review team also held detailed discussions with representatives from:

- NHS South (a cluster comprising three SHAs) and NHS London, as examples of SHAs that have indicated that their processes were compliant with the prevailing statutory regime, to understand what actions they had taken or measures they had in place to ensure that improper delegations had not occurred; and

- DH's Mental Health policy team to understand the Department's role in the past and future.

1.12 A complete list of those interviewed is attached at appendix B.

1.13 In addition, the review team held a workshop to confirm the team's understanding of events and to discuss and validate the initial findings. The workshop also considered how the system could work together, as well as in its constituent parts, to ensure that sound governance arrangements are in place in the new NHS architecture from 1st April 2013; that statutory functions will be correctly and comprehensively located in the new architecture; and that functions and services delivered by the new system are properly underpinned by any necessary delegated authorities.

1.14 A list of workshop attendees is attached at appendix C.

1.15 The outputs from all of the above have influenced the findings and proposals included in this report.

2 Legislation and Statutory Obligations

Provisions in Mental Health Act 1983

2.1 Under section 12(2) of the 1983 Act, the Secretary of State approves, for the purposes of that section, registered medical practitioners ("section 12 doctors") as having special experience in the diagnosis or medical treatment of mental disorder. The Secretary of State is also responsible for approving doctors and other professionals as approved clinician's (ACs) for the purposes of the Act[2]. The provisions relating to ACs were inserted into the 1983 Act as from 3rd November 2008 by section 14 of the Mental Health Act 2007. The functions of approving section 12 doctors and ACs are collectively referred to as "approval functions".

2.2 Certain decisions under the 1983 Act may only be taken by people who have been approved in this way. For example, section 12 of the 1983 Act itself provides that an application for detention or guardianship under Part 2 of the 1983 Act must be supported by two medical recommendations, one of which must be made by a doctor approved under section 12 of the 1983 Act. Similarly, courts may not order the detention of people in hospital under Part 3 of the 1983 Act unless they have received evidence from at least one section 12 approved doctor[3]. Section 12 doctors also have functions under certain other legislation. For example, a court may not impose a mental health treatment requirement as part of a suspended sentence order under the Criminal Justice Act 2003 without evidence from a section 12 doctor (see section 207(3)(a) of that Act).

2.3 An AC is defined in section 145(1) of the 1983 Act as "a person approved by Secretary of State (in relation to England) or by the Welsh Ministers (in relation to Wales) as an AC for the purposes of this Act." Unlike section 12, no explicit test for approval of an AC is given in the 1983 Act.

2.4 There are various functions under the 1983 Act which are reserved (partly or wholly) to ACs. For example:

(i) under section 5(2) the doctor or AC (but no-one else) in charge of a patient's treatment may, in effect, detain an in-patient for up to 72 hours pending an application for detention under the main provisions of Part 2;

[2] See s145(1) Mental Health Act 1983.
[3] See, for example, section 37(2) read with section 54(1).

(ii) under section 20(3), only a patient's responsible clinician may renew a patient's detention, and by definition the responsible clinician must be an AC (see section 34(1)); and

(iii) under section 63, in certain circumstances, a detained patient's consent is not required for the administration of treatment given by, or under the direction of, the AC in charge of that treatment.

2.5 Accordingly, the purpose of approving ACs is to ensure that they have the qualifications, experience and skills necessary to take decisions that may lead to the deprivation of individual's liberty.

2.6 Although the roles of section 12 doctors and ACs are distinct, any registered medical practitioner who is an AC is automatically treated as section 12 approved (see section 12(2A)). That is because it was thought that any doctor who was suitable to be an AC would, *a fortiori*, have the special experience in the diagnosis or treatment of mental disorder required for approval under section 12.

2.7 Both section 12 and AC approvals are carried out separately in England and Wales. However, regulations may be made jointly by Secretary of State and Welsh Ministers under section 142A about approvals that are to be recognised in either country. The Mental Health (Mutual Recognition) Regulations 2008 (No. 1204) provide that section 12 approval (including deemed section 12 approval of doctors who are ACs) in one country is to apply in the other country as well.

Delegation of approval functions

2.8 Since 2002, the Secretary of State's approval functions under section 12 have been delegated to SHAs by regulation 3(3) and Schedule 2 to the National Health Service (Functions of Strategic Health Authority and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (No. 2375) ("the 2002 Regulations")[4].

2.9 Before the creation of SHAs in 2002, the function of approving doctors under section 12 was exercised by Health Authorities (HAs) and, before them, by Regional Health Authorities. A series of regulations (now revoked) delegated the function:

(i) from 1st April 2001 to 2002, to Health Authorities by regulations 2 and 3 and Schedule 1 to the National Health Service (Functions of Health Authorities and Administration Arrangements) (England) Regulations 2001 (No. 747)[5];

(ii) from 1st April 1996 to 31 March 2001, to Health Authorities by regulations 2 and 3 and Schedule 1 to the National Health Service

[4] http://www.legislation.gov.uk/uksi/2002/2375/contents/made
[5] http://www.legislation.gov.uk/uksi/2001/747/contents/made

(Functions of Health Authorities and Administration Arrangements) (England) Regulations 1996 (No. 708)[6];

(iii) from 1st April 1991 to 31 March 1996, to Regional Authorities by regulations 2 and 3 and the Schedule to the National Health Service Functions (Directions to Authorities and Administration Arrangements) Regulations 1991 (No. 554)[7];

(iv) from 14 Feb 1989 to April 1991, to Regional Authorities by regulation 3 and Schedule 1 to the National Health Service Functions (Directions to Authorities and Administration Arrangements) Regulations 1989 (No. 51)[8];

(v) before 1989, to Regional Authorities by regulation 3 of the National Health Service Functions (Directions to Authorities and Administration Arrangements) Regulations 1989 (No. 287)[9].

2.10 The Secretary of State's approval functions in respect of ACs are currently delegated to SHAs by means of directions under section 7 of the NHS Act 2006: the Mental Health Act 1983 Approved Clinicians (General) Directions 2008 ("the AC Directions"). The directions set "professional requirements" which candidates must meet. These, in effect, define the professions from whom ACs may be drawn (currently doctors, nurses, occupational therapists, social workers and psychologists). They also set out in detail the "relevant competencies" that ACs must demonstrate and impose a number of procedural requirements (such as approvals being granted for 5 years, and attending an initial training course).

2.11 SHAs can further delegate this function in respect of ACs to a Primary Care Trust ("PCT") in its area (see direction 2 of the AC Directions). However, SHAs may not delegate the function of approving ACs to any other organisation, including an NHS provider Trust or a Foundation Trust, other than a PCT; and SHAs are not permitted to delegate the approval of registered medical practitioners under section 12 of the 1983 Act to any other organisation at all.

Restrictions on delegation of responsibilities

2.12 It is a well established principle[10] that a statutory power must be exercised only by the body or officer on whom it has been conferred unless sub-delegation of the power is authorised by express words or necessary implication.

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[6] http://www.legislation.gov.uk/uksi/1996/708/contents/made
[7] http://www.legislation.gov.uk/uksi/1991/554/contents/made
[8] http://www.legislation.gov.uk/uksi/1989/51/contents/made
[9] This dealt with the function under section 28(2) of the Mental Health Act 1959 which was the predecessor to section 12 of the 1983 Act.
[10] See e.g. Great Northern Rly Co v Eastern Counties Rly Co (1851) 9 Hare 306.

2.13 As explained above, both section 12 and AC approval functions are expressly delegated to SHAs. AC approval functions, but not those of secion 12 doctors may be sub-delegated to a PCT.

2.14 Regulation 5 of the 2002 Regulations specifically provides that section 12 approval functions cannot be exercised by a PCT and regulation 9(2) specifically provides that these functions cannot be exercised jointly by a SHA and a PCT.

2.15 Similarly, from 1 April 2000 until 2002, regulation 4 and Schedule 4 to the Primary Care Trusts (Functions)(England) Regulations 2000 (No. 695)[11] expressly provided that functions under the MHA 1983, including section 12 approval functions, could not be exercised by a PCT and, as a consequence, regulation 5 of S.I. 2001/747 (see (i) at paragraph 2.9 above) provided that section 12 approval functions could not be exercised jointly by a SHA and a PCT. The regulations applicable prior to 1 April 1996, listed in (iii)-(v) above, expressly stated that the section 12 approval functions could not be sub-delegated by Regional Authorities to District Authorities; see regulation 5 of each of S.I..1991/554, S.I. 1989/51 and S.I. 1989/287 (see (iii)-(v) at paragraph 2.9 above).

2.16 However, returning to the current legal framework, regulation 9(1) of the 2002 Regulations provides that a SHA may arrange for the section 12 approval functions to be exercised (a) by another SHA or a Special Health Authority; (b) jointly with other SHAs; or (c) on behalf of the SHA by a committee, sub-committee or officer of the Strategic Health Authority.

2.17 Where a SHA sets up "an approvals panel", that panel cannot perform the approval functions – it can only act in an advisory capacity to the SHA unless it is formally set up as a SHA Board committee or comprises officers of the SHA.

2.18 As there is no express statutory power to do so, SHAs are not permitted to delegate their authority to approve section 12 doctors or ACs to an NHS Trust or Foundation Trust.

2.19 The position under the 1983 Act as from 1st April 2013 is covered in appendix A.

[11] http://www.legislation.gov.uk/uksi/2000/695/contents/made

3 Guidance

3.1 The following section summarises the guidance issued with regard to section 12 and AC approval functions which the review took into account.

Circular HC(90)21 1990

3.2 The review team was unable to locate a copy of this guidance.

Health Service Guidelines (96)3 – issued on 2 February 1996

3.3 These guidelines superseded HC(90)21 with effect from 31 March 1996 and explained that '*Hitherto approval of section 12 doctors has been undertaken by panels set up by each Regional Health Authority. The Health Authorities Act 1995 will abolish Regional Health Authorities with effect from 1 April 1996 and the Secretary of State's function of approving medical practitioners under section 12(2) will be delegated to Health Authorities*.'

3.4 The guidelines required Regional Offices *'…by 1 April 1996 to form consortia of health authorities with one or more of the member authorities chosen to commission or manage arrangements for appointing doctors under section 12*' and encouraged the lead Health Authority (HA) (or authorities) to *'…establish a suitably experienced panel of medical practitioners to approve doctors under section 12(2) of the Act'*, and to take other steps.

3.5 In light of this, the guidelines set out the qualifications and experience now required for approval and the training which had to be undertaken before approval was given.

Department of Health Guidance – Arrangements for approving doctors under section 12(2) of the Mental Health Act (1983) post 1 April 2002 – issued December 2002

3.6 The guidance clarified the arrangements for approving doctors under section 12 following the creation of SHAs. The guidance stated that the delegated duty, as previously delegated to all Health Authorities, had been passed to the 28 new SHAs with effect from 1 October 2002.

3.7 Paragraph 3 of the guidance states that '*The Registration and Approval Panel arrangements that existed before 1 April 2002 in England, in their totality (including their resourcing), should therefore continue to operate much in the same way as previously, while taking account of structural changes*… .'

Email from Office of the SHAs – 29 November 2006

3.8 Although the review team could not find an exact distribution list for the email, it was initially sent to the Chief Executives of all of the SHAs. I believe the email was circulated to SHAs in order to confirm the requirement for them to continue to exercise this function, there having been some uncertainty about this. It recommended that the SHAs assure themselves that they are not inappropriately delegating the function. It stated, '*An arrangement which contracts this function out (as distinct from a hosted and formally delegated arrangement provided by another SHA) in my view needs checking for legality. It is probably ok, but obviously does not discharge the SHA from its responsibilities under the regulations, and is merely a means for securing the administrative processes involved.'*

National Institute for Mental Health in England: 'Mental Health Act 2007 New Roles' - Guidance for approving authorities and employers on Approved Mental Health Professionals and Approved Clinicians – issued in October 2008

3.9 The National Institute for Mental Health in England (NIHME) issued guidance in 2008 following the Mental Health Act 2007. The principal focus of the guidance was on the new roles created by the 2007 Act ("Approved Mental Health Professional", "Approved Clinician" and "Responsible Clinician"), as inserted into the 1983 Act. The guidance was drafted to *'…assist all those who approve, employ or have responsibility for staff who commission or deliver mental health services to understand their responsibilities and duties under the Act'*. It was specifically aimed at the Chief Executives and Directors of SHAs, PCTs and MHTs.

3.10 The guidance, at page 19, specifically states that *'[SHAs] may not delegate the approval of section 12 doctors (though they can delegate processes, for example administration*.'

Code of Practice Mental Health Act 1983 – as revised in 2008

3.11 In 2008, the DH revised the statutory Code of Practice Mental Health Act 1983, comprising guidance to which those exercising functions under the 1983 Act must have regard. Paragraph 4.102 states that *'The Secretary of State has delegated to SHAs the task of approving medical practitioners under section 12(2) of the Act. Medical practitioners who are approved clinicians under the Act are automatically treated as being approved under section 12 as well*.'

3.12 Paragraph 4.103 of the Code of Practice sets out responsibilities of SHAs in relation to approval functions, including that SHAs should take active steps to encourage sufficient doctors to apply for approval and

SHAs should ensure that regularly updated lists of approved doctors are maintained. .

Reference Guide to the Mental Health Act 1983 – published in 2008

3.13 In 2008, the Department also published a Reference Guide to the Mental Health Act 1983, which became a popular reference source for practitioners. Chapter 32 states, in relation to section 12 approved doctors, at paragraphs 32.33 - 32.34, *'Section 12 allows the Secretary of State to approve doctors for the purposes of the Act as having special experience in the diagnosis or treatment of mental disorder.*

The Secretary of State has delegated this function in England to SHAs, which make their own arrangements for the approval process. SHAs may not delegate this function to PCTs.'

In relation to ACs, at paragraph 32.39 *'The Secretary of State has delegated the function of approving approved clinicians in England to SHAs, which in turn make their own arrangements for the approval process. SHAs may in turn delegate the function to PCTs*.'

4 What arrangements were put in place by SHAs from 2002?[12]

4.1 In order to gain an understanding of how and why six out of ten SHAs carried out the approval functions in accordance with the prevailing statutory regime, the review team spoke with NHS London and NHS South of England cluster.

4.2 The four SHAs (NHS London and the three SHAs in the NHS South of England cluster) approached the discharge of this function in slightly different ways. However, both current organisations had a strong emphasis on governance and an unambiguous view that the final act of approval must rest at SHA level.

4.3 The three SHAs in NHS South of England have not contracted out the administration of the section 12 approval function (or the AC approval function from 2008). The individuals carrying out the work are employed by the SHA. The Chair of each of the Approvals Panels (which act as committees of their respective SHA Boards) is remunerated for the appointment. The panel members themselves are drawn from the SHA's mental health providers. The panels meet within a building of the SHA and the letters approving section 12 doctors and ACs are sent on SHA headed paper and signed by SHA staff.

4.4 A very similar process exists in NHS London with the exception that the SHA has recently chosen to contract out the administration of the function while maintaining very clear and necessary links back to the SHA.

4.5 Over the past few years, NHS London has worked hard to build a stringent governance process around the approval of section 12 doctors and ACs. The Chair of the approvals panel holds a contract with the SHA and is remunerated for one day per week. Panel members are drawn from a variety of disciplines from across London, representing the necessary specialisms, BAME communities and all MHTs. All panel members have job descriptions and an agreement from their employer to be released from their regular appointment for the necessary amount of time to undertake this work and to embed a system of governance in the use of the 1983 Act in their respective employer MHTs. Again, the panel acts as a committee of the SHA Board, as permitted by the statutory regime, with a dedicated multi agency oversight and scrutiny committee of all the partner agencies essential to ensure the equalities based implementation of the mental health legislation.

[12] This review has not explored the arrangements from 2002 to 2011 in relation to those SHAs which were carrying out the functions (without delegation) as at October 2012.

Arrangements in West Midlands SHA

4.6 From 2002 until 2012, the section 12 approval function has been carried out on behalf of the SHA by Birmingham and Solihull Mental Health Trust (Birmingham and Solihull Mental Health NHS Foundation Trust since 2008). However, I believe that similar arrangements were made with predecessor MHTs as far back as the mid-1990s. From 2008, the arrangement also covered the approval of ACs.

4.7 The approvals panel acted as a committee of the MHT Board. As explained in section 2 of this Report, an approvals panel may only act in an advisory capacity to the SHA unless it is formally constituted as a committee of the SHA Board. The contract with Birmingham and Solihull specified that all of the administration for the approval functions was to be carried out by the Trust. For example, approval letters were sent from and signed by the MHT. In return the MHT was remunerated for this work by the SHA.

4.8 In 2007/08, the Special Commissioning Team within the SHA drew up a formal contract between the SHA and the MHT. This was done as part of a programme of work to regularise a number of functions being delivered on behalf of the SHA. The contract was based on the *de facto* position at the time and from this point the contract continued to be rolled forward.

4.9 The contract between the SHA and MHT states that it is for '*The provision of management of the West Midlands statutory responsibilities for the approval of Section 12 Medical Practitioners and Approved Clinicians under the Mental Health Act 2007'* and it provides that *'This specification outlines the agreement to delegate this function to Birmingham and Solihull Mental Health NHS Foundation Trust on behalf of West Midlands Strategic Health Authority*.'

4.10 It is worth noting that the officers of the MHT to whom we spoke were unaware of the existence of this contract.

4.11 Although the SHA did not believe it had technically delegated the approval functions to the MHT, the Chair of the approvals panel and the MHT itself were very clear, in their own minds, that the functions had been completely delegated to them. However, the MHT was unaware that the SHA did not have the power to delegate the functions: on the contrary, the MHT assumed that, because the SHA was delegating the functions to them, the SHA must have the authority to do so.

Arrangements in East Midlands SHA

4.12 Since the creation of the East Midlands SHA in June 2006, the SHA has held a contract first with Doncaster and South Humber Healthcare NHS Trust until August 2007 and then its successor, Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust (RDASH) to

administer and manage the process of approvals. It is likely that very similar arrangements had been in place since the mid-1990s.

4.13 The approvals panel was made up of practitioners from across the region with a member of the SHA invited to attend on a standing basis. Minutes from the panel and its annual report were also sent to the SHA. However, approval was granted by the panel, on behalf of the SHA, but on RDASH headed paper. The panel acted as a committee of the MHT not the SHA.

4.14 The contract between East Midlands SHA and RDASH sets out that RDASH will, '*Provide an Approvals Service and maintain the Register on behalf of the Strategic Health Authority'*.

4.15 All those concerned believed that the agreement between the SHA and RDASH was purely for the management and administration of the process and that the SHA was still ultimately, legally, accountable for the approval functions. They did not believe the functions had been delegated.

Arrangements in Yorkshire and the Humber SHA

4.16 Yorkshire and the Humber SHA also has a contract with RDASH to administer this process. The arrangements for Yorkshire and the Humber, including the provisions of the contract with RDASH and the fact that similar arrangements are likely to have been in place since the mid-1990s, mirrored those arrangements outlined above for the East Midlands.

4.17 Once again, all those concerned believed that the agreement between the SHA and RDASH was for the management and administration of the process and that the SHA was still ultimately, legally, accountable for the approval functions. They did not believe the functions had been delegated.

Arrangements in North East SHA

4.18 I found that, unlike the other SHAs discussed above, the arrangements for section 12 approvals in North East SHA were probably compliant with the statutory framework until 2007.

4.19 In 2007, the SHA took the decision to transfer an individual member of staff who had been responsible for undertaking this work to the Tees, Esk and Wear Valleys NHS Trust (Tees, Esk and Wear Valley NHS Foundation Trust since July 2008). The decision to transfer this individual was made for good management reasons, but as no arrangements were put in place to maintain the link between the SHA and MHT regarding the final approval process, the function was inadvertently delegated in a technically irregular manner.

4.20 By 2008, the arrangement also covered the approval of ACs. The contract between the North East SHA and Tees, Esk and Wear Valleys stated that it was for '*The provision of management of the North East statutory responsibilities for approval of Section 12 Medical Practitioners and Approved Clinicians under the Mental Health Amendments Act 2007*.'

4.21 The contract goes on to say that '*This specification outlines the agreement to delegate the management of their delegated panel, the North East of England Registration and Approvals Panel (NEERAP), to ensure it is supported appropriately in the administration of, and process associated with, the approval and re-approval of Section 12(2) approved doctors, Approved Clinicians (ACs) and Mental Health Assessors, to Tees, Esk and Wear Valleys NHS Foundation Trust on behalf of North East Strategic Health Authority*.'

4.22 Section 3.5, Legal Issues, states that where an approval is not given and the applicant appeals this decision or where an issue arises with a doctor who has already been approved '…*panel will seek clarification and assistance from the SHAs legal department as it is the SHA (who have delegated that duty to the panel) as opposed to TEWV who are accountable for approval and none (sic) approval*.'

4.23 All those concerned believed that the agreement between the SHA and the MHT was for the management and administration of the process and that the SHA was still ultimately, legally, accountable for the approval functions. They did not believe the functions had been delegated.

5 Could the irregularities have been identified earlier?

5.1 The arrangements in three of the four SHAs that were found, in summer 2012, to have delegated their section 12 approval responsibilities in ways that were technically irregular, have endured since at least 2001, prior to the creation of SHAs in 2002. It is possible that the arrangements under the auspices of HAs in the 1990s, which I have not examined in this review, were also, in some cases, technically irregular. We know that the administration of the approvals processes at this time was undertaken by a mixture of staff in HAs, in directly managed mental health provider units, and in NHS trusts.

5.2 When the SHAs were established in 2002, there was an opportunity to review the extant arrangements for delivering these functions, in part to establish their compliance with the statutory regime for the discharge of those functions. There was a similar opportunity when the approval of ACs was added to the arrangements from 2008, again involving delegation in a technically irregular way.

5.3 We found no evidence that a review of this type happened in any of the SHAs concerned (or their predecessor organisations) in 2002. One interviewee pointed out that these SHAs started life as very small organisations, with a principal focus on health strategy, and with no process of due diligence around the discharge of statutory functions.

5.4 When the 28 SHAs were consolidated into 10 successor bodies in 2006, there was a further opportunity to review the regularity of the arrangements for discharge of statutory functions, which could have identified any procedural or technical irregularities in contractual arrangements. However, as in 2002, I found no evidence that any such reviews were conducted. This was in spite of the email to SHA Chief Executives from the Office of the SHAs (OSHA) on 29 November 2006, which emphasised that registration of doctors approved to act under section 12 of the 1983 Act was a statutory duty of an SHA which could not be delegated, and that any contracting-out of this function should be checked for legality. This advice does not appear to have resulted in any review of the legality of contracts in the three SHAs which had contracted with Trusts to deliver the section 12 approval functions.

5.5 Similarly, the arrangements could and should have been reviewed when they were being renewed, rather than simply rolling each contract forward. This would have presented a good opportunity to identify the irregularity.

5.6 The NIMHE Guidance issued in October 2008 was explicit that SHAs '*may not delegate the approval of section 12 doctors*' *(though they can*

delegate processes, for example administration)'. By this time a fourth SHA had also established arrangements that were, on balance, technically irregular. In response to this guidance we have established that there was some review activity in two of these SHAs, but in neither case did this identify issues about compliance with the law:

- Officers in the Yorkshire and the Humber SHA commissioned a review of their arrangements by representatives of NIMHE, which had issued the guidance. This review did not identify that the SHA had (unwittingly) delegated its section 12 approval function to the RDASH Foundation Trust;

- The management board of North East SHA discussed the section 12 arrangements in October 2009, following a review that had been undertaken of its Service Level Agreement with the Tees, Esk and Wear Valleys NHS Trust. The paper to the board stated that '*the function cannot be delegated to another body*', but did not identify any irregularities. The submission from North of England SHA to this review attributes this to '*the common understanding within the SHA was the SHA retained statutory responsibility for the function'*. As a result, the recommendations to the board were aimed at strengthening the arrangements and ensuring that they were compliant with best practice, starting from an assumption that they were lawful.

5.7 A further significant opportunity arose to identify the technical irregularities in 2009, when the Department planned and conducted a comprehensive assurance exercise with SHAs. The full extent of the statutory duties and powers of SHAs was a key focus of the SHA Assurance Exercise, as were the arrangements in place for their discharge. As part of the documentation for the review, all SHAs completed a template schedule, setting out how their 74 statutory duties and 32 powers were being discharged and exercised.

5.8 In one case (Yorkshire and the Humber) the fact that the function was contracted out was picked up in the self-assessment by the SHA and referred to as '*qualified compliance*'. Although legal advice was sought by the SHA on its self-assessment before submission to the Department, the legal firm did not indicate as part of the that process that the arrangement for delivering the section 12 approval duty was not permitted by the statutory regime.

5.9 It is clear from the documents that I have seen, and from my interviews, that legal compliance with statutory duties was not a principal focus of the SHA assurance exercise, which was more concerned with questions of strategy for healthcare, its quality, clinical safety and resourcing. The completed templates were submitted to DH, but there is no evidence that any issues about legality, which might have arisen from them, were picked up and followed through. For all 10 SHAs, the reports of the assurance panels, from the Department to the SHA, confirmed that the

SHAs were discharging their statutory obligations. The report for Yorkshire and the Humber SHA did conclude that some further work was required '*to develop a deeper understanding of SHA statutory obligations'*, but there was no indication of any concerns about legality, in terms of compliance with the statutory regime for the discharge of functions.

5.10 The paragraphs above have focused particularly on the opportunities that the SHAs and DH had to identify the technical irregularities in the discharge of approval functions. It is also the case that the three MHTs that were awarded contracts by SHAs for these functions, might have identified irregularities at various points of contract award and re-setting. They might have taken legal advice as to whether the MHT had the authority and powers to enter into such a contract, and whether the SHA had the power and authority to award the contract. In this review we found no evidence that the MHT had sought legal advice on these aspects, at any stage between 2002 and 2012, before the arrangements were found to be irregular in summer 2012.

5.11 My terms of reference required the review to look at whether the irregularities could have been identified earlier by 'any appropriate regulator.' In this review we found no evidence of opportunities having been missed by regulatory bodies to pick up the technical irregularities. The mechanisms by which responsibilities were delegated by SHAs to MHTs were not subject to examination by regulatory bodies including the Health Care Commission, the Care Quality Commission and the Mental Health Act Commission. Such bodies focused principally in their work on the quality of services, the efficiency of resource use and the safeguarding of the rights of patients, and not on compliance with statutory requirements.

6 Why did irregular delegation happen?

6.1 There are two, high-level, principal reasons why SHAs put in place, and operated for periods of years, arrangements for the discharge of their section 12 and AC approval functions that were technically irregular.

- The SHAs concerned do not appear to have operated on the basis of the fundamental principle of public law that, where a function has been conferred by statute on a public authority, the public authority may not further delegate the performance of the function to another body unless expressly permitted to do so. If they had taken on board more fully the significance of this fundamental principle, this could have led those SHAs that inherited contractual arrangements from predecessor bodies to audit them more rigorously. Similarly, SHAs that established new contractual arrangements could have been more aware of the legal risks entailed in so doing.

- The SHAs did not overtly or wittingly delegate the functions. In all instances, notwithstanding the ways in which the contracts were written, and how the approval panels were constituted and operated, the act of delegation to MHTs was not overt or conscious. The SHAs considered that, because they remained accountable for the functions, the delegation of the operation of the approval arrangements to MHTs through contracts was not legally suspect. This focus on accountability, which remained irreducibly with the SHAs, diverted attention from matters of statutory responsibility.

6.2 There were a number of factors that led to this situation, which are reviewed below.

6.3 **First**, there were strong imperatives on the NHS to roll forward arrangements for discharging these functions which were resourced, durable and seemingly effective. This particularly applied when SHAs were created in 2002, when the DH guidance to clarify the arrangements (December 2002) emphasised that the existing Registration and Approval Panel arrangements '*in their totality (including their resourcing) should therefore continue to operate much in the same way as previously, while taking account of structural changes*.'

6.4 Because arrangements were known to be working, and were not giving any cause for concern, they were able to endure through multiple reorganisations. In some cases, the key people that worked as Chairs and members of the Approval Panels, and those administering them, were the only constants in an environment of organisational change. It was their corporate memory that was relied on through these changes,

rather than that of those charged with governance in the organisations. As one SHA Chief Executive told us, as contracts were continued and novated, there was almost an inevitability that if something had been in place for a long period of time it was less likely to be questioned, especially if it seemed to be working smoothly.

6.5 **Second**, it was not a prominent feature of the culture of NHS management in the 2000s to take as a starting point the statutory duties and powers of any NHS organisation and understand in detail the limitations on their discharge. The schedule of Legal Duties & Powers of Strategic Health Authorities, compiled by DH Legal Services for the SHA Assurance Exercise in 2009, was ground-breaking in setting out the 74 duties and 32 powers of an SHA in one document. The 28 SHAs established in 2002 had no such schedule to refer to in setting themselves up as organisations, and taking on functions like the section 12 approval functions transferred from predecessor HAs. The guiding imperatives were generally about health strategy and NHS performance in the context of the commitments in the NHS Plan 2000, on the assumption that the statutory basis for discharge of SHA functions was secure and that any existing delegation arrangements were legally compliant.

6.6 In 2006, the 10 new SHAs similarly had no comprehensive schedule of statutory duties and powers to refer to. In some SHAs that established and maintained legally compliant arrangements, the presence of an experienced senior official charged with corporate governance responsibilities, and with previous experience of such matters, may have acted as a restraint on any irregular steps being taken at this juncture. In other SHAs that continued with technically irregular arrangements, there was no similarly experienced official to support the Chief Executive and Chair in considering these matters.

6.7 If NHS organisations had been generally more seized of the detail of their statutory duties, it is possible that SHAs would have been more likely to seek legal advice on the regularity of any functions transferred to them. In fact, there seems to have been little (if any) legal advice sought on such matters by SHAs, during either the 2002 and 2006 reorganisations. Similarly it does not appear that any of the MHTs to whom the functions were contracted by SHAs ever sought legal advice as to the regularity of these arrangements.

6.8 **Third,** the guidance on these approval functions that was issued or made available to SHAs at various stages between 1995 and 2008, either by DH or by organisations (including OSHA and the NIMHE) acting on its behalf, was not prescriptive and instructional in nature: that guidance did not emphasise the need for assurance on matters of legal compliance. This was in a general climate, particularly from the early-2000s, in which stringent efforts were being made to devolve responsibility from DH to the NHS and empower NHS organisations, and

as part of this to reduce the quantity of guidance and instruction being given to them.

6.9 Guidance such as that from the NIHME, and the Reference Guide to the Mental Health Act 1983 (at paragraph 32.34), made explicit that the approval of section 12 doctors could not be delegated to PCTs. But this only appeared at page 19 of the NIHME guidance. Both guidance documents made explicit that the delegated function of approving ACs could in turn be further delegated by SHAs to PCTs (NIHME at page 19, and Reference Guide at paragraph 32.39). Neither guidance made explicit that both these approval functions could not be delegated to an NHS Trust or Foundation Trust. (Strictly speaking, this should not have been necessary had SHAs been more alive to the fundamental principle of public law, described above, that a function cannot be delegated without express powers to do so).

6.10 Although advice to check the legality of arrangements was communicated to SHA chief executives by OSHA in December 2006, this was nine months after SHAs had taken on the section 12 approval functions from their predecessors. At no stage between 2002 and 2012 did DH require SHAs to check that their statutory responsibilities (particularly section 12 and AC approval functions) were being discharged in full compliance with the legislation.

6.11 In part, as a consequence of the above, the Boards of the SHAs established in 2002 and 2006, did not undertake rigorous audits of the discharge of their statutory functions, either as part of a due diligence exercise on inception of the SHA, on reorganisation or regularly thereafter. There was no corporate focus on assuring the legality or otherwise of contracts (or other arrangements) for delivering functions beyond the SHA's boundaries. Internal audit programmes in SHAs generally focused on matters of efficiency and effectiveness, rather than on the regularity of the exercise of powers and duties. This approach extended through the SHA Assurance exercise in 2009, when the question addressed seems to have been largely whether and how statutory duties were being discharged, rather than whether they were being discharged in full compliance with the statutory regime.

6.12 All of the above reasons for the establishment and continuation of arrangements for the section 12 and AC approval functions, in some SHAs, which were technically irregular, are also relevant to an understanding of why opportunities were not taken (as described in Section Five of this Report) to detect and correct the irregularities earlier.

6.13 In addition, until the SHA Assurance exercise in 2009, DH did not for the most part position itself as an active custodian or steward of the statutory responsibilities of SHAs, or as a scrutineer of the legal regularity of arrangements for discharging them. As a result, the SHAs were not regularly held to account by DH for the legal regularity of their

arrangements for delivering statutory functions, particularly their section 12 and AC approval duties.

6.14 The general stance of DH during this period was to lead and facilitate the development and operation of a more devolved NHS. In this devolved system, it was for NHS organisations to understand their statutory duties and powers, and to operate in full legal compliance with them, without the need for extensive explanatory and prescriptive guidance, and without independent audit of compliance from the centre other than in selected areas of high priority.

7 What principles should inform the transfer of functions in 2013 and any subsequent reorganisations?

7.1 The Secretary of State's statement to Parliament on 29 October 2012 asked me to conduct this review of delegations by SHAs that were technically irregular, to understand how this happened, and so '*that we learn any lessons to help inform the operation of the new system architecture from April 2013*.' These lessons need to be learned, as recognised in the review's Terms of Reference, '*to ensure that every part of the system employs the highest standards of assurance and oversight in the delegation of any statutory functions and authority in the future*.'

7.2 The review was conducted in the context of the latter stages of the Transition Programme for the NHS Reforms, as part of which there has been a comprehensive mapping of current statutory functions across the NHS, and of the organisational locations to which they are being transferred. This is significantly different to the approach taken to transfer of functions in previous NHS reorganisations, reflecting the fact that the current reforms being implemented are more fundamental and wide-ranging than those of 2002 and 2006. Although there remain a few 'orphan' functions whose future remains to be resolved, considerable work has been and continues to be done to ensure that all of these are allocated appropriately and securely.

7.3 With particular regard to the section 12 and AC approval functions, the abolition of SHAs means that, for the first time since the 1983 Act was enacted, there are no regional, strategic or district 'health authorities' to whom the Secretary of State can delegate the functions. I understand that a decision was taken in late summer 2012 that the section 12 and AC approval functions should be discharged directly by DH from April 2013[13], rather than being delegated to another statutory body. In evidence to the review I heard concerns about whether the planning for the delivery of these approval functions from 2013 was sufficiently advanced, and that there are outstanding issues to resolve about their resourcing, particularly about the future of key staff in SHAs who currently administer the approval panels and associated processes. To the extent that the future delivery of the functions by DH builds on established panels, and the procedures for supporting them through arrangements with Trusts in some parts of the country, it is vital that any technical irregularities are avoided in designing and operating the

[13] The new legislative position is outlined in appendix A.

arrangements.

7.4 The risks surrounding the re-building and resourcing of the section 12 and AC approval functions as directly managed functions of DH are of broader relevance. To mitigate and manage these risks, not just between now and April 2013 but on a continuing basis, I recommend that a system is established in which four levels of assurance are operated. Below I set out what I mean by each of these levels, and what the particular implications are in the current stage of transition and beyond in the new NHS system. I also summarise in italics the key findings from the Review relevant to each of these dimensions of assurance.

7.5 The **first level of assurance** is concerned with the clear and secure location of responsibilities following a reorganisation. This should be the first stage in a 'due diligence' process. There should be no 'orphan functions' and all organisations taking on transferred functions, and receiving new ones, should have a full understanding of them. There is a clear onus on DH to continue to ensure that this is the case, to guarantee consistency across the NHS. Notwithstanding DH's role, NHS organisations should themselves take steps, drawing on legal advice where appropriate, to ensure that they fully understand any limitations applying to the discharge of statutory functions, particularly as to whether they can be delegated.

7.6 *In this review, I found that there was some uncertainty, particularly in 2006, as to whether SHAs were the appropriate organisational location for the exercise of section 12 approval functions. This may have had an impact on how their delivery was considered. Although there was never any doubt between 2002 and 2012 that the section 12 approval functions had been delegated by the Secretary of State to SHAs, there was less appreciation across SHAs of the clear limitations in statute on sub-delegating them further, which may have resulted in less rigorous legal scrutiny of contracts put in place for their discharge.*

7.7 The **second level of assurance** relates to the authority to exercise powers and duties. The DH and NHS bodies must all be cognisant of the duties and powers conferred upon them by Parliament, or delegated to them by the Secretary of State, and recognise that this provides the essential authorisation for all decision making and action. It is particularly vital that any DH or NHS body that plans to delegate a function, or to take steps that might constitute delegation, considers fully whether it has the legal and procedural authority to do so. Similarly, any NHS organisation which is being contracted to carry out all or part of a statutory function should take steps to ensure that it has the legal authority to enter into such a contractual or other arrangement.

7.8 *In this review I found that some SHAs went beyond their statutory authority in delegating, albeit unwittingly, the delivery of the approval functions, by extending the contractual arrangements beyond the*

administration of the processes and into formal responsibility for decision making about approvals of section 12 doctors and approved clinicians. Approval panels, which were not formally constituted as a committee of the relevant SHA(s), acted in a decision-making rather than merely advisory capacity. Three Trusts also entered into contracts for the discharge of approval functions that they did not have the statutory authority to discharge, so the arrangements around these contracts were found to be technically irregular.

7.9 The **third level of assurance** is about capability and capacity. An organisation that understands its statutory duties and powers, and is fully seized of the authorities with which both it and the other organisations with which it works operate, must also be resourced and equipped for the work. This is particularly the case when key functions are transferred to new organisations, with no intrinsic corporate experience and memory to draw on in their discharge. Functions that may be deemed 'lower priority' may also be impaired by insufficient investment in the means to carry them out.

7.10 *In this review I found that SHAs were sometimes successor organisations to health authorities, which had located virtually all the specialist experience and knowledge relating to the section 12 and AC approval functions beyond their organisational boundaries. I did not find that the delivery of the functions was compromised anywhere; in fact, the evidence is that any delegated arrangements worked effectively throughout the period concerned. However, the salience of the section 12 approval functions does not appear to have been at the forefront of SHA attention, for example, in terms of any Board time spent in assuring themselves about these matters.*

7.11 The **fourth level of assurance** is about continuing audit. Once the functions of NHS organisations are settled, understood and resourced, it is vital that there is periodic audit of their discharge. Without this, there is a risk that any problems with the effective, efficient and legally compliant delivery of statutory functions will neither be identified nor dealt with. This can happen through a combination of internal audit, national DH exercises like the SHA assurance exercise in 2009, and independent external audit of the delivery of functions by local auditors and the National Audit Office (NAO) as part of the NAO's value for money study programme. It is particularly important that such audits address matters of legal compliance and regularity, as well as matters of regularity, probity, efficiency and effectiveness.

7.12 *In this review we found limited evidence of the section 12 and AC approval functions of SHAs being subject to either internal or independent audit. To the extent that there were such audits, they did not pick up any issues of legal irregularity in the arrangements for their discharge.*

7.13 The section 12 approval functions that have been the focus of this review concern vitally important statutory functions and arrangements for approving doctors for the purpose of assessing patients for detention under the 1983 Act. Four out of the 10 SHAs that were established in 2006 either continued with or established arrangements for discharging these functions, which were subsequently found to be technically irregular. There has never been any suggestion that the detention of any patient was clinically inappropriate. As the Secretary of State made clear to Parliament, "*we believe that no one is in hospital who should not be, and no patients have suffered because of this*."

7.14 However, the seriousness of the irregularities that were found in 2012, and which the SHAs have assured the Department have now been regularised, should not be underestimated. I believe that the four levels of assurance which I have set out above provide a framework for continuing due diligence, which can mitigate the risk of any similar irregularities arising in the new NHS structures that come into force from April 2013.

7.15 In the course of this review it has been emphasised by many of those who gave evidence that the DH should have a clearly delineated plan, both for the lodging (where necessary through transfer) of **all statutory functions** (and associated resources) to organisational locations in the new system by April 2013, and for ensuring that they are discharged effectively, efficiently and lawfully by those organisations beyond April 2013. It is not for this review to design such a plan, but I believe that the assurance framework, which I have set out, can provide the basis for developing such a plan, which I recommend that the Department now takes forward.

7.16 Whilst it is for executive management to devise and implement the necessary action, it is, in my view, particularly important that, unlike SHAs in 2002 and 2006, successor organisations from 1st April 2013, many of which will be newly constituted, undertake a systematic programme of due diligence. The purpose of this programme will be for all organisations to provide documentary and auditable assurance to their managements and to the Department that:

- all the functions and responsibilities currently undertaken by sender organisations have been systematically and comprehensively mapped to receiver organisations;

- any legal authorities necessary to discharge the functions or to provide the services for which receiver organisations will be responsible, or which they may be contracted to provide, have been reviewed and are in place, either properly delegated or newly created; and

- receiver organisations have in place the competence, sufficient capacity and adequate infrastructure to deliver their outcomes effectively and efficiently. This should include knowledge and

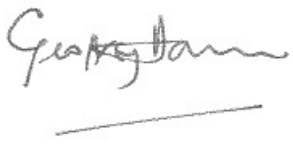
experience of governance and corporate affairs alongside operational management to ensure compliance with statutory obligations.

7.17 I also recommend that future assurance and audit work, in addition to the familiar domains of regularity, probity, value for money and effectiveness, includes a specific review to confirm that any legal authorities necessary to support the delivery of functions or services continues to be in place or is correctly delegated.

7.18 To the extent that the Department will itself be a receiver organisation, it should undertake a similar due diligence programme. If the Department intends, as part of the transition, itself to exercise the discharge of functions, including those under the Mental Health Act 1983, the Department must be assured that it understands what exercising those functions will entail, and that it has sufficient capacity and capability to undertake these functions from 1st April 2013.

7.19 The Department, and each statutory body whose accounts are consolidated in the Department's Annual Accounts, is required to compile a Governance Statement as part of its annual accounts. I recommend that all bodies should include material in their Governance Statements, for 2012-13 and for all subsequent years, which confirms that any arrangements in place for the discharge of their current statutory functions have been checked for any irregularities, and that they are legally compliant. Bodies, including the Department, which will be 'receivers' of new functions in 2013-14, or which will discharge functions (like the section 12 and AC approval functions) that were formerly delegated, should confirm in their Governance Statements that they have carried out due diligence on these functions, and have established legally compliant arrangements for discharging them.

Dr Geoffrey Harris 19 December 2012



Chairman, NHS South of England

Appendix A

Future legislative provision

General

Provisions relating to approval functions will be found in sections 12 to 12ZC Mental Health Act 1983 ("the 1983 Act"). Sections 12ZA to ZC were inserted by section 38 Health and Social Care Act 2012 and will come into force on 1st April 2013.

Exercise of approval functions by the Secretary of State

The function of approving "section 12 doctors" and ACs has, since 1983, been vested in the Secretary of State (see sections 12 and 145(1) of the 1983 Act.

Prior to 2013, by virtue of regulations made under the NHS Act 1977 and directions issued under the NHS Act 2006, those functions were exercised by Strategic Health Authorities (in respect of ACs, Strategic Health Authorities could lawfully sub-delegate the exercise of the function to Primary Care Trusts).

Under the new NHS architecture, the approval functions remain vested in the Secretary of State under section 12 et seq. and section 145(1) of the 1983 Act. Under section 12(2) the Secretary of State is to approve, for the purpose of section 12, practitioners "having special experience in the diagnosis or treatment of mental disorder". Under section 145(1) ACs are defined as persons " approved by the Secretary of State (in relation to England) to act as an approved clinician for the purposes of the Act". In other words, in England, such persons are to be approved by the Secretary of State.

Insofar as these functions are vested in the Secretary of State – and to that extent – they are unaffected by new sections 12ZA to ZC of the 1983 Act.

In exercising the functions, the Secretary of State may make use of "Advisory Panels" (see below). Such panels must act in a purely advisory manner and cannot actually exercise the approval function.

The Secretary of State retains the approval functions even though other persons or bodies may be exercising approval functions, under sections 12ZA to ZC of the 1983 Act, at the same time – and separately from – the Secretary of State.

Exercise of approval functions by "other persons"

Section 12ZA enables the Secretary of State to enter into an agreement with another person under which an approval function is to be exercised by that person.

For these purposes "approval function" is defined as the function of approving doctors under section 12(2) of the 1983 Act and that of approving ACs. An agreement can cover one or both functions.

"*Person*" is not restricted in scope. It is wide enough to include an individual or a corporate body. For example, it could include the CQC, the Royal College of Psychiatrists or an organisation established for the purpose of carrying out the approval function. As a body corporate qualifies as a person, corporate NHS bodies would do so. Equally by necessary implication, a person could include a panel of persons.

"*Agreement*" is also drafted widely. There is no required form of agreement i.e. a contract, under seal. Theoretically it could be oral – however, that is not a realistic prospect for audit and legal certainty reasons.
7
The agreement can –

(i) cover the approval function in general, or only to a more limited extent;
(ii) be made with different people in relation to different parts of the country, or (for ACs) in relation to the approval of people from different professions;
(iii) be for a fixed period, or may specify how decisions about the termination of the agreement will be made;
(iv) include arrangements for Secretary of State to make payments to the other party.

An agreement cannot give the other party a right to go on exercising the approval function against the Secretary of State's wishes. The Secretary of State may at any time issue an instruction requiring the other party to stop approving people (either at all, or to a specified extent). The agreement may include provision for the Secretary of State to pay the other party compensation if this were to happen.

Instructions on exercise of the function:

The Secretary of State may issue instructions as to the exercise of the approval functions. Those instructions have to be published. Where the Secretary of State does so, the other party has to comply with those instructions.

Instructions could include, for example-

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- Requirements which must be met by medical practitioners in order to be approved or re-approved;
- Criteria to be applied in deciding whether to approve or re-approve;
- The type of evidence that candidates must provide;
- Procedures to be followed;
- Periods for which approval may be given;
- Records which must be kept;
- Conditions which may or must be imposed on approval;
- Circumstances in which approval is to be withdrawn or suspended; and
- Transitional arrangements.

In exercising the functions, a person who has entered into an agreement may make use of "Advisory Panels" (see below). Such panels must act in a purely advisory manner and cannot actually exercise the approval function.

N.B. The Secretary of State can exercise his approval functions separately – and independently – of any person or persons who are exercising approval functions under an agreement entered into under section 12ZA. In this respect section 12ZA refers to the functions being exercised "concurrently" and the policy intention was not to require them to be exercised "jointly".

Exercise of approval functions by the NHS Commissioning Board and Special Health Authorities

The Secretary of State may require the NHS Commissioning Board (**"**NHSCB") or any one or more Special HA to exercise one or both of the approval functions (section 12ZB).

Section 12ZB is wide enough for the Secretary of State to issue more than one "requirement". He could, for example, issue:

(i) a single requirement to the NHSCB;
(ii) a single requirement to a single Special HA;
(iii) a single requirement to two or more Special HAs;
(iv) one requirement to the NHSCB and another to one or more Special HAs.

There is nothing that compels the "requirements" to be issued at the same time. The power to issue "requirements" is not an "exerciseable once only" power.

"*Require*": this would impose a duty on the NHSCB or one or more Special HAs to exercise the function.

The Secretary of State can "require" the NHSCB or Special HA (or each such Authority where more than one is chosen) to:

(i) exercise one or both of the approval functions;

(ii) exercise the function generally, or to a more limited extent.

Where the NHSCB and/or one or more Special HAs are "required" to exercise the function, they have to to comply with instructions given by the Secretary of State. The Secretary of State has to publish those instructions.

The Secretary of State will be able to end (or vary) the requirement on the NHSCB or one or more Special HA's at any time, which would in turn end (or vary) the Board or Special HA's power to approve people.

The approval functions may also be exercised concurrently both by the NHSCB or one or more Special HAs (under section 12ZB) and by another person (under section 12ZA).

In exercising the functions, the NHSCB and one or more Special Health Authorities may make use of "Advisory Panels" (see below).Such panels must act in a purely advisory manner and cannot actually exercise the approval function.

N.B. The Secretary of State can exercise his approval functions separately – and independently of –

(ii) the NHSCB (where it is required to exercise those functions under section 12ZB);

(iii) the NHSCB (where it is required to exercise those functions under section 12ZB) and any one or more person who has entered into an agreement under section 12ZA;

(i) one or more Special HAs (where required to exercise those functions under section 12ZB);

(ii) one or more Special HAs (where required to exercise those functions under section 12ZB) and any one or more person who has entered into an agreement under section 12ZA;

(iii) the NHSCB and one or more Special HAs (where required to exercise those functions under section 12ZB);

(iv) the NHSCB and one or more Special HAs (where required to exercise those functions under section 12ZB) and any one or more person who has entered into an agreement under section 12ZA.

"Advisory Panels"

By "Advisory Panels" we mean panels of experts who-

(i) consider whether individuals have the necessary qualifications and experience to be s12 doctors or ACs;

(ii) make recommendations to the person exercising the approval functions;

(iii) act purely in an advisory capacity,

(iv) do not approve any individual themselves.

Under the provisions of s12 to 12ZC, there is nothing to stop such panels being formed to act in a purely advisory/non-appointing capacity. That would be the case regardless of who was actually exercising the approval function.

When using such "purely advisory/non-appointing" panels it is legally necessary for the person or body actually exercising the approval function to-

(i) act as more than a mere cipher in relation to the panels recommendations/suggestions;
(ii) actually "turn their mind" to the approval;
(iii) make the approval themself.

Section 12ZC

New section 12ZC gives the Secretary of State and people exercising approval functions under sections 12ZA and 12ZB the power to disclose information in connection with those functions, whether or not they would otherwise have a power to do so.

In addition, it allows information to be shared between those people (although not with third parties) even if that would not normally be allowed under the common law of confidentiality. Provided other legal requirements (such as data protection legislation) are complied with, this may, for example, allow one approving body to pass on to another approving body information it has received from, or about, an applicant, without having to obtain that applicant's consent.

Appendix B

Interview Schedule

Date	Interviewee	Position
16/11/12	Chris Dent	Corporate Affairs Lead, NHS North of England
19/11/12	Moosa Patel	Director of Corporate Affairs, NHS East Midlands and East SHA Cluster
21/11/12	Olga Senior	Director of Corporate Affairs, NHS South
21/11/12		Chair, Rotherham Doncaster and South Humber Mental Health Trust (RDASH)
	Chris Bain	Chief Executive
		Executive Director of Workforce, Organisation Development
	Dr David Goodhead	Section 12 Panel Chair
21/11/12	Anne MacDonald	Deputy Director, Mental Health Care Pathways, Department of Health
27/11/12	Prof Stephen Singleton	Interim Chief Executive, NHS North of England
28/11/12	Martin Barkley	Chief Executive, Tees, Esk & Wear Valley Mental Health Trust
	Chris Stanbury	Director of Nursing and Governance
	Mel Wilkinson	Mental Health Legislation Lead
	Dr Bernadette Wilkinson	Section 12 Panel Chair
28/11/12	David Flory	Currently Chief Executive, NHS Trust Development Authority; former Chief Executive North East, SHA
	Ralph Coulbeck	Director of Strategy, NHS Trust Development Authority
03/12/12	Barbara Hakin	Currently National Managing Director of Commissioning Development, NHS Commissioning Board; former Chief Executive of East Midlands SHA
05/12/12	Paul Jennings	Interim Chief Executive,

		Birmingham and Solihull Mental Health Trust
	Peter Lewis	Medical Director
	Chitra Mohan	Associate Medical Director
06/12/12	Corrine Taylor	Head of Corporate Affairs, West Midlands, NHS East Midlands and East SHA Cluster
07/12/12	Geraldine Strathdee	Associate Medical Director, Mental Health, NHS London
	Hugh Griffiths	National Clinical Director for Mental Health, Department of Health

Appendix C

Attendee List at 6 December 2012 workshop

Attendee	Organisation
Dr.Geoff Harris	Review Chair
Moosa Patel	Director of Corporate Affairs, NHS East Midlands and East SHA Cluster and representing HEE
Elizabeth Allen	NHS East Midlands
Corrine Taylor	NHS East Midlands and East SHA Cluster
Chris Dent	Corporate Affairs Lead, NHS North of England
Olga Senior	Director of Corporate Affairs, NHS South
Ralph Coulbeck	Director of Strategy, NHS Trust Development Authority
Bruce Calderwood	Director of Mental Health, DH
Anne McDonald	Deputy Director of Mental Health and Disability, DH
Louise Troy	Transition Programme - lead for NHS Transition, DH
Steven McDonald	Future DH, Programme Manager, DH
Paul Bridges	Deputy Director, DH Legal Services
Fiona Reid	DH Legal Services
David Blair	Corporate Management, DH
Omer Tauqir	Internal Audit, DH
Cheryl Wright	Transition Programme - NHS Transition, DH
Stephen Mitchell	Review team member and Deputy Director, Head of Governance & Regulation, DH
Ben Luscombe	Review team member and Business Manager for Karen Wheeler, DH

Bibliography

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Glossary

1983 Act	Mental Health Act 1983
AC	Approved Clinician (see145 of the Mental Health Act 1983)
DH	Department of Health
DHA	District Health Authority
FT	National Health Service Foundation Trust
MHA	Mental Health Act
MHT	Mental Health Trust
NHS	National Health Service
NHSCB	National Health Service Commissioning Board
NIMHE	National Institute for Mental Health England
PCT	National Health Service Primary Care Trust
RDASH	Rother, Doncaster and South Humber Mental Health Trust
RHA	Regional Health Authority
section 12 doctors	Registered medical practitioners approved by the Secretary of State under section 12(2) of the Mental Health Act 1983 for the purposes of section 12 of that Act
SHA	Strategic Health Authority
SoS	Secretary of State
Special HA	Special Health Authority
TEWV	Tees, Esk and Wear Valleys Mental Health Trust