Health & Social Care Bill 2011
House of Lords Report Stage

Briefing Note 11 on Clauses 1, 4 and 12 (formerly 10), and the Constitution Committee's follow-up report

Summary

The Constitution Committee's follow-up report on the Health and Social Care Bill published on 14th December 2011 has led to amendments having been tabled for Report stage to Clauses 1, 4 and 12 (previously Clause 10).

Clause 1: We recommend that the amendment to Clause 1 which reflects the Committee's recommendation is supported as far as it goes, despite concerns we have about its legal limitations and political effectiveness; and that a further amendment is tabled to make section 1(2) of the NHS Act 2006 a free-standing duty to secure provision.

Clause 4: We recommend that the amendment tabled by Baroness Thornton to delete Clause 4 (the hands-off Clause) is supported, rather than the amendment based on the Committee's recommendation. This is because the latter would accept the desirability of autonomy, would give commissioners and commercial providers opportunities to challenge government decisions by way of judicial review and would open up possible EU and WTO trade law challenges.

In addition, the hands-off Clause would continue to apply to all ministerial functions in relation to the health service. This means that the Secretary of State would *still* be obliged to accept and consider the desirability of not imposing unnecessary burdens in relation to (for example) the standing rules and the mandate and in relation to:

- public health functions of local authorities, for example, when making regulations about those functions under Clause 17: new s.6C(2);
- education, training and research, for example when exercising functions so as to secure that there is an effective system for the planning and delivery of education and training under Clause 6: new s.1E, and on promoting research under Clause 5: new s.1D; and
- professional registration and licensing, for example when making regulations under the Medical Act 1983, to the extent that these relate to the health service.

It should be clarified whether Clause 4 is intended to have the effect of requiring local authorities, educational establishments and professional registration and licensing bodies to demonstrate why the requirements of their various policies are necessary; or whether, rather, such bodies are intended to be amongst those persons upon whom unnecessary burdens are not to be imposed.

Clause 12: We further recommend that the amendment to Clause 12 based on the Committee's recommendation should be supported, as it goes some way to repairing the legal damage caused by de-coupling the duty to promote from the duty to provide. But a CCG would not be under a duty to promote a comprehensive service in its area, and it is difficult to see how meaningful or effective the amendment would be because no CCG would have an England-wide remit.

We continue to have serious misgivings about the role of CCGs, and the questions we posed in Briefing Note 6 remain to be answered. When they are answered, we expect that further amendments will be necessary. We set these out again in the Appendix to this Briefing Note.

The Bill would transform the English NHS from a nationally-mandated public service required of the government under primary legislation into a service based on commercial contracting, underpinned by ministerial and local discretion and secondary legislation, and exacerbated by non-accountability to Parliament of commissioners and providers. Abolition of the duty of the Secretary of State to provide or secure provision of health services is the seminal change which brings this transformation about. The Constitution Committee's amendments fall short of preventing it.

Clause 1: the Secretary of State's duty

The Committee proposed to introduce a new section 1(3) into the National Health Service Act 2006. Baroness Jay of Paddington, Lord Patel and Baroness Thornton have since tabled an amendment in identical terms, by inserting the following into Clause 1:

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

This amendment would be an improvement on the amendment previously tabled by Lord Mackay of Clashfern, in that it would replace 'ultimate' with 'ministerial', and does not include the focus on intervention powers. It would make it more difficult, and probably impossible, for the Secretary of State to shake off all political responsibility for the health service in England.

The amendment would not, however, restore the Secretary of State's duty to provide or to secure provision in accordance with the Act.

From a legal point of view and on grounds of political effectiveness, we have concerns about the Committee's reasoning which has led to its recommending only a confirmatory declaration of political reality rather than a legal duty.

From the legal point of view, we are concerned that the Committee inaccurately stated in paragraph 6 of its report that:

> *"Clause 1 of the Bill substitutes for section 1 of the NHS Act 2006 a new section under which the Secretary of State must 'secure that services are provided' but which no longer includes a duty on the Secretary of State to provide services".*

Clause 1 of the Bill provides that for the purpose of promoting a comprehensive health service 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".

This is not a free-standing duty. It is not a duty on the Secretary of State to secure provision of health services. It is only a duty to exercise other functions to secure provision. The Committee implies that it is a free-standing duty.

If the other functions conferred by the Act do not impose a duty on the Secretary of State to provide or secure provision, then he or she will have no duty to provide or to secure provision.

Because Clause 12 (formerly Clause 10) of the Bill would abolish the Secretary of State's duty in section 3 of the 2006 Act to provide key listed services and would transfer it in a diluted form to clinical commissioning groups (CCGs), the legal duty to provide services would still disappear; and there would be no duty to secure provision.

As regards political effectiveness, ministers cannot be responsible to Parliament for the exercise of functions that are not theirs. In this context the Committee stated that:

> *"ministers will retain considerable powers over both the NHS Commissioning Board and over CCGs (the critical clauses are 17, 20, 44 and 49), albeit that political argument will no doubt continue over whether these powers are adequate or appropriate".*

However, there are significant limitations in most of these very important provisions, which the Committee does not mention:

- all but one of the provisions relating to the making of the standing rules as to the exercise of the functions of the NHS Commissioning Board or CCGs under Clause 17 (now Clause 19) are expressed as discretionary powers, not mandatory requirements. And the one provision that appears mandatory is to make regulations requiring the Board to draft such terms and conditions as *the Board* (not the Secretary of State) considers appropriate for inclusion in commissioning contracts. There is a significant difference between the Secretary of State having a legal duty to provide under section 3 of the Act, and being empowered to make standing rules;
- CCGs are not subject to the mandate under Clause 20 (now Clause 22:new s.13A), which is given to the NHS Commissioning Board, and this Clause gives wide discretion to the Secretary of State;
- CCGs are excluded from the general duty to keep under review the effectiveness of the health service under Clause 49 (now Clause 51); and no obligations flow from it.

In addition, the accountability of a public body, such as the NHS Commissioning Board or the CCGs, is very different to the accountability of a Minister. As the Committee stated:

> *"there is a constitutionally significant difference between ministerial responsibility to Parliament and the accountability of a public body (such as the NHS Commissioning Board) to a minister. In constitutional terms the latter can never be a substitute for the former because, in the latter case, Parliament is not involved. As the Minister correctly stated in his opening speech in the second reading debate, 'We in Parliament can only turn to the Secretary of State'. Parliament cannot call or hold the Chair of the Commissioning Board, for example, to constitutional account. A select committee can of course call him as a witness, but giving evidence as a witness to a committee and being liable to be held to account by Parliament are not the same thing."*

Parliament would not therefore be able in future to hold the Secretary of State to account for failures in the provision of health services in the way it can now, because there will be no legal duty to provide or to secure provision of those services.

Rather, MPs, Lords and Select Committees will have to rely on the duty to promote in section 1, the exercise of emergency powers and a set of powers and duties with wide discretions, which break the link between the minister and the provision of healthcare. In future, without a stand-alone duty to secure provision, Select Committees wanting to make recommendations to governments to improve services to patients will only have a miscellany of distant levers to pull.

We recommend that this amendment is supported as far as it goes, and that a further amendment is introduced to make section 1(2) a free-standing duty to secure provision.

Clause 4: the hands-off duty

The Committee proposed to amend the duty in Clause 4 by making it subject to Clause 1, and by downgrading it from a duty to act with a view to securing the autonomy of health bodies to a duty to have regard to the desirability of securing such autonomy.

Baroness Jay of Paddington, Lord Patel and Baroness Thornton have subsequently tabled an amendment in identical terms, by omitting the opening words of Clause 4 and inserting the following:

> *"Subject to sections 1(1) to 1(3), and so far as is consistent with the interests of the health service, the Secretary of State must, in exercising functions in relation to that service, have regard to the desirability of securing—"*

(An equivalent amendment has also been proposed and tabled by the same peers to new section 13F: Clause 22 (previously, Clause 20), which imposes a duty to promote autonomy on the NHS Commissioning Board.)

These amendments would remove one of main concerns about the hands-off Clauses:

the duties in Clause 1 (as presently formulated) could not be superseded and would take precedence.

However, these amendments would retain the principle that autonomy is desirable, would require the Secretary of State (and the Board) to accept that principle and both would be able to give considerable weight to it if so minded.

Clause 4 applies to all ministerial functions in relation to the health service. This means that the Secretary of State would *still* be obliged to accept and consider the desirability of not imposing unnecessary burdens in relation to (for example) the standing rules and the mandate and in relation to:

- public health functions of local authorities, for example, when making regulations about those functions under Clause 17:new s.6C(2);
- education, training and research, for example when exercising functions so as to secure that there is an effective system for the planning and delivery of education and training under Clause 6: new s.1E, and on promoting research under Clause 5: new s.1D; and
- professional registration and licensing, for example when making regulations under the Medical Act 1983, to the extent that these relate to the health service.

It should be clarified whether Clause 4 is intended to have the effect of requiring local authorities, educational establishments and professional registration and licensing bodies to demonstrate why the requirements of their various policies are necessary; or whether, rather, such bodies are intended to be amongst those persons upon whom unnecessary burdens are not to be imposed.

In addition, commercial providers of health care would continue to have a basis for judicial review of what would become the highest-level NHS decisions, such as the content of the standing rules and the mandate.

Commercial providers might also have a basis for seeking EU law and WTO trade law protections, from whose legally-mandated 'necessity tests' the concept of 'unnecessary burdens' appears to be derived.[1] It would be desirable to have specialist international

[1] WTO rules for the accountancy profession are an example of "least burdensome" regulation. Their purpose is to ensure that WTO members do not allow within their jurisdictions accountancy professional regulation that restricts trade unnecessarily. The rules cover licensing and qualification requirements and procedures, and technical standards. Among other things, they require that regulations must have "a legitimate objective"; that terms of membership of professional organisations, where required, are "reasonable"; that authorities take account of qualifications acquired in other countries; and that qualification requirement exams are limited to "relevant" areas. WTO members may use a disputes settlement procedure to challenge the determination of any of these matters. (WTO (1998) Disciplines on domestic regulation in the accountancy sector. http://www.wto.org/english/tratop_e/serv_e/accountancy_e/accountancy_e.htm).

trade law advice on this aspect, not least as EU and WTO dispute resolution mechanisms would not have to apply the same deference to Parliament as would the domestic courts.

We recommend that Baroness Thornton's amendments to delete Clauses 4 and 22 (s.13F) are supported.

Clause 12: clinical commissioning groups

The Committee proposed to insert an amendment into Clause 12 (formerly Clause 10), in the following terms:

> *"( ) A clinical commissioning group must exercise its functions under this section in a manner consistent with the performance by the Secretary of State of the duty under section 1(1) (promotion of comprehensive health service)."*

An amendment in these terms has been tabled by the same peers.

For reasons stated by the Committee in paragraph 12 of its report, this is a legally significant amendment:

> *"Clause 10 removes from the Secretary of State the duty (currently contained in section 3 of the NHS Act 2006) to provide certain health services and places that duty instead on clinical commissioning groups (CCGs). Case law makes it clear that, as the law currently stands, the section 1 duty to promote a comprehensive health service must be read alongside the section 3 duty to provide certain services. Thus, if an individual wishes to challenge a decision to withdraw, relocate or ration a certain health service, a court reviewing the legality or reasonableness of that decision would consider the matter in the light of the overarching duty in section 1 to promote a comprehensive health service; such was the force of the leading Court of Appeal judgment in* Coughlan *[footnote omitted]. As the Bill de-couples the section 1 and section 3 duties (by placing them on different bodies) it is difficult to see how they could in the future be read alongside one another in the way in which they have in the past. We thus expressed concern in our earlier report that this could have the unintended consequence (contrary to the fifth criterion cited above) of weakening the legal protection afforded to the individual."*

This amendment would go some way to repairing the legal damage caused by de-coupling the duty to promote from the duty to provide, and should be supported.

But a CCG would not be under a duty to promote a comprehensive service in its area, and it is difficult to see how meaningful or effective the amendment would be because no CCG would have an England-wide remit.

We continue to have serious misgivings about the role of CCGs, and the questions we posed in Briefing Note 6 remain to be answered. When they are answered, we expect

that further amendments will be necessary. We set these out again in the Appendix to this Briefing Note.[2]

Conclusion

The Bill would transform the English NHS from a nationally-mandated public service required of the government under primary legislation into a service based on commercial contracting, underpinned by ministerial and local discretion and secondary legislation, and exacerbated by non-accountability to Parliament of commissioners and providers. Abolition of the duty of the Secretary of State to provide or secure provision of health services is the seminal change which brings this transformation about. The Constitution Committee's amendments fall short of preventing it.

Limited ministerial accountability is not a flaw in the Bill that can be remedied in isolation. Rather, this democratic deficit is a direct consequence of the policy behind the Bill. At present, we have a system of healthcare delivered by public bodies generally acting under statutory duties. The Bill introduces a much more discretionary and more market-based system, in which the minister, as it were, keeps his hands off services to patients. This simple difference appears to have been lost in the concerns about political micro-management, which nobody has ever argued for. The complex web of the standing rules, the mandate and the various powers and duties created by the Bill combine to reduce accountability. And the desirability of securing autonomy, together with the impact of EU competition and procurement law, will also limit the ability of Parliament to scrutinise effectively.

We recommend that peers do not allow this to happen. Further information is available in 'Red Lines for Peers on the NHS Bill, Briefing Note 10 (9th January 2012)[3]

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9th January 2012

[2] http://www.allysonpollock.co.uk/administrator/components/com_article/attach/2011-11-11/AP_2011_Pollock_HouseOfLordsBriefing6C10_11Nov11.pdf
[3] http://www.allysonpollock.co.uk/administrator/components/com_article/attach/2012-01-09/20120109-AP_2012_Pollock_HouseOfLordsBriefing10_C1412_09Jan12.pdf

Appendix: Questions about CCGs

• Why should CCG responsibility not be area-based?

• If it cannot be area-based, why is CCG responsibility for persons not made definitive on the face of the Bill?

• Who, in future, will have the task of ensuring all residents and temporary residents can be registered with a local GP?

• What will happen if GPs refuse to accept, or strike off, patients?

• Who will allocate problem patients, and patients with learning difficulties, severe disabilities, or complex mental health or physical health problems? What about asylum seekers, and the homeless and those of no fixed abode?

• Why is emergency care to be covered by regulations, not on the face of the Bill? Why are accident and ambulance services not mentioned?

• Will any of the other services currently to be provided under the NHS Functions Regulations for the benefit of all people present in a PCT area have to be arranged by the CCGs? It is intended that some services will move with public health services to local authorities, but the government should explain, category by category, what is to happen, and why is each of these services not also on the face of the Bill.

• Why is it necessary to give the government the power to exclude some persons from the health service (new section 3(1D))?

• More specifically, what categories of primary service provider does the government wish to be able to exclude from the health service? For example, new section 3(1D) would allow the Secretary of State to make regulations which took out of the health service persons receiving medical services under Alternative Personal Medical Services contracts – the one of the three basic GP contract types which is open to multinational health companies, such as United Health.

• How will the government prevent charges being made for services that are currently free for pregnant women, women who are breastfeeding, young children, the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness?

• What services will local authorities be expected to provide in terms of immunisation, child health services, public mental health services and other services as yet to be identified? How will these be defined and commissioned?

• How will public health monitoring be ensured?

• How will the interface between public health in local authorities, the National Commissioning Board and CCGs operate when the populations are not contiguous and area-based and the responsibilities and resource allocation mechanisms so unclear?