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# **Briefing notes on Government amendments to the Health and Social Care Bill: Lords Report Stage**

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*February 2012*

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## **Introduction**

1. The Health and Social Care Bill finished its Lords Committee Stage on December 21<sup>st</sup>, 2011. Over the course of the 15 sessions, there were a number of excellent debates to which a wide range of Peers contributed and made valuable suggestions on how we could further improve the Bill.
2. The Government listened carefully to these concerns, and have brought forward a series of amendments in response. The document, and description of the amendments, is ordered thematically rather than by the order of the Bill. There are a number of amendments not described in these notes, most of which are minor and technical.
3. These briefing notes have been produced and published by the Department of Health. They are not Explanatory Notes as published by Parliament, and do not have the formal status of Explanatory Notes. A revised version of the Explanatory Notes will be published on Royal Assent.

## **A: Clearer Ministerial accountability**

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### **The Secretary of State's duty to promote the comprehensive health service**

1. A number of Peers expressed concerns during Committee over the Secretary of State's accountability for the health service in the new system. The Constitution Committee proposed a set of amendments with the aim of clarifying that the Secretary of State retains Ministerial accountability and responsibility for the health service. Following a period of constructive engagement with Peers to discuss their concerns, widespread agreement has been reached on the following amendments.
2. It has always been our intention that Ministers should remain accountable overall for the health service and we are happy to amend the Bill to put this matter beyond doubt. We therefore support the amendment to clause one tabled by Baroness Jay of Paddington.

### **Clarifying the link between CCGs and the Secretary of State's duty to promote a comprehensive health service – Amendment 34**

3. The Constitution Committee also proposed amendments to make the link clear between the duty of clinical commissioning groups (CCGs) to commission services and the Secretary of State's duty to promote the comprehensive health service. Our amendments to clause 12 provide clarification on this point and additionally:
  - a. link the CCG duty to the Commissioning Board's concurrent duty to promote the comprehensive health service and the objectives and requirements in the Government's mandate to the Board, and;
  - b. ensure the link applies to all NHS services which CCGs commission.
4. In this way, we will ensure that in exercising their duties, CCGs act consistently with three things: the discharge by the Secretary of State of his duty to promote the comprehensive health service, the Board's concurrent duty and the mandate.

**Duties of autonomy – Amendments 8, 9, 53, 54**

5. Baroness Williams of Crosby, amongst others, expressed concern about the Secretary of State’s autonomy duty as drafted in the Bill, saying, *“The autonomy clause indicates that only in the rarest circumstances would the Secretary of State interfere in that autonomy. So where would he interfere? The answer is that he would interfere if there was evidence of a significant failure. But my legal colleagues tell me that "significant failure" is a difficult bar to reach and that it is normally interpreted by the courts as meaning almost totally essential...”*<sup>1</sup>
6. The Constitution Committee drafted amendments to change the duties of the Secretary of State and the Board to promote autonomy, making them explicitly subject to the Secretary of State’s and the NHS Commissioning Board’s duties to promote the comprehensive health service and to exercise their functions so as to secure the provision of services.
7. We have always been clear that the interests of the health service must take priority when promoting autonomy and so accept the principle behind these amendments.
8. By altering the duty to a duty to have regard, it necessarily becomes subsidiary to the duty to promote the comprehensive health service. In addition, the amendments make explicit that in the event of a conflict between the desirability of autonomy and the discharge by the Secretary of State of his duty to promote the health service, it is the latter which takes precedence.
9. We have also tabled equivalent amendments to the NHS Commissioning Board’s autonomy duty in section 13F within clause 22.

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<sup>1</sup>11 October 2011: Hansard Column 1517

## **B: Education, training and research**

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### **Health Education England**

10. As promised at Committee Stage, we have now published a detailed policy framework for a new education and training system which will underpin these important amendments<sup>2</sup>. By creating Health Education England we are reinforcing the national system for education and training, and our commitment to develop an Education Outcomes Framework demonstrates our commitment to delivering quality outcomes.
11. We are committed to making progress quickly. Health Education England will be established as a Special Health Authority in June 2012. It will bring a coherent multi-professional focus to education, working with the professional regulators and professional bodies such as the Royal Colleges to strengthen standards and ensure education and training reflects best practice and local innovation. It is important that local employers can play a leading role in planning and developing their workforce and that is why we are asking them to set up Local Education and Training Boards. Health Education England will play an important role in authorising the Local Education Training Boards and will work with the Strategic Health Authorities (SHAs) to oversee their development during 2012.

### **Education and training duties for commissioners – Amendments 61, 73, 104, 117**

12. We listened to the concerns expressed by a number of Peers that the Bill did not go far enough in safeguarding the future education and training system. We agree that the Bill could say more on education and training, and have tabled amendments to place a duty on the NHS Commissioning Board and CCGs to have regard to the need to promote education and training.
13. This will help to ensure alignment between service commissioners and workforce, education and training plans, encourage collaborative working between the Board and Health Education England at a national level, and

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<sup>2</sup> Available at: <http://tinyurl.com/6odw2sr>

Local Education and Training Boards and CCGs at a local level, and promote the use of service contracts to support good education outcomes.

**Duties to promote research – Amendments 11, 68, 103**

14. The Bill currently places a duty on the Secretary of State, the Board and CCGs to have regard to the need to promote research within the health service. A number of Peers suggested that the duties as worded were not strong enough. In particular, Lord Willis stated that “*the Bill should say simply, "The Secretary of State must promote". That is a clear definition, a clear statement of intent.*”<sup>3</sup>
15. On reflection, we agree that this wording more accurately reflects the intention for the clause. Therefore, we have tabled this amendment to amend the duties on the Secretary of State, the Board, and CCGs to require each to promote research within the health service.

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<sup>3</sup> 9 Nov 2011 : Hansard Column 273

## **C: Integration and competition**

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### **Cooperation and integration – Amendments 193-195**

16. In response to recommendations of the NHS Future Forum, the Government amended the Bill to place a duty on Monitor to exercise its functions with a view to enabling integration in the provision of health services, as well as between health and social care, where this would improve quality or efficiency or reduce inequalities. During debates on this during Committee, we agreed to consider how these provisions could be strengthened.
17. Our proposed amendments would establish express power for Monitor to set and enforce licence conditions for the purpose of enabling integration, and for the purpose of enabling cooperation, in line with the requirements of the existing *Principles and Rules for Cooperation and Competition*<sup>4</sup>.
18. This would allow Monitor to use its licensing powers to support integration and cooperation where it was in the interest of patients.

### **7-yearly reviews by the Competition Commission – Amendment 185**

19. Baroness Williams of Crosby, Lord Marks of Henley-on-Thames, Lord Clement-Jones and Lord Patel tabled an amendment during Committee which probed whether the Competition Commission's role conducting 7-yearly reviews of the healthcare sector was appropriate in light of changes made in response to the NHS Future Forum. Lord Whitty also indicated concern about this provision by proposing clause stand part debates on the relevant clauses.
20. During the debate, Baroness Thornton said with regard to Competition Commission reviews that, '*We fear that this provides a disproportionate incentive on Monitor to develop competition.*'<sup>5</sup>
21. We are therefore proposing amendments which would ensure that the reviews would be concerned with the effectiveness – not development – of competition in realising benefits for NHS patients.

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<sup>4</sup> Available at: <http://tinyurl.com/35jbe7v>

<sup>5</sup> 13 Dec 2011 : Hansard Column 1111



### **Monitor's role in overseeing commissioning regulations – Amendments 179, 180**

22. Clause 73 provides for regulations that could place requirements on commissioners regarding good practice in procurement, promoting patient choice and preventing anti-competitive conduct.
23. The Government's stated intention is that regulations under Clause 73 would give commissioners a full spectrum of options in the procurement of clinical services. It would be for commissioners to decide how to use these tools: in securing services that best meet the needs of their patients; in securing continuous improvements; and, in reducing inequalities. These regulations would not set a presumption either way that services should be open to competition, or not open to competition.
24. This approach would give commissioners flexibility in determining how best to discharge their duties, working within a framework of rules to ensure transparency and value for money. The onus would be on commissioners to act transparently and to be able to demonstrate the rationale for their decisions in terms of patient benefits. Therefore, commissioners would decide if, when and how to use competition, as a means to an end, in improving services<sup>6</sup>.
25. Baroness Williams of Crosby, Lord Marks of Henley-on-Thames, Lord Clement-Jones and Lord Patel tabled an amendment during Committee seeking to require Monitor to also consult on its enforcement guidelines and that any subsequent revisions of those guidelines be approved by Secretary of State.
26. We have therefore tabled amendments which would require Monitor to consult publicly on how it proposes to enforce the regulations, as well as on compliance with the regulations. Approval of each revision of guidance by the Secretary of State would not be consistent with the Secretary of State's role in relation to Monitor. However, our amendments would ensure that any subsequent revisions of that guidance would be consulted on.

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<sup>6</sup> Further information is set out in *Protecting and Promoting Patients' Interests: the role of sector regulation* (Department of Health; December 2011)

### **Matters to have regard to – Amendments 168-172**

27. During Committee, Baroness Murphy, Baroness Thornton and Lord Beecham tabled amendments that sought either to rationalise or cut down the list of matters that Monitor would have to have regard to in carrying out its functions, as currently set out in clause 64. Baroness Murphy stated that *“Experience from other sectors suggests that if too many policy priorities are set, the regulator can become confused about its primary objectives, which can reduce its effectiveness.”*<sup>7</sup>
28. Our amendments therefore seek to rationalise the list of matters at clause 64 in order to provide further clarity as to Monitor’s priorities. The proposed amendments make clear that the need to maintain the safety of people who use healthcare services would be paramount amongst the matters that Monitor must have regard to in carrying out its duties.
29. The amendments also combine the subsections on continuous improvements in quality and efficiency, and omit subsection (h) on the desirability of promoting investment by NHS providers, since unlike the other matters this is not an end in itself and is not relevant in all circumstances.

### **Secretary of State’s powers to intervene in individual cases under the Competition Act or the Enterprise Act– Amendment 175**

30. Clause 69 enables the Secretary of State to intervene if Monitor were to fail significantly to perform its functions, although he would not be able to intervene in individual cases. However, it would not be appropriate for the Secretary of State to perform Monitor’s concurrent functions under competition law which could, for instance, involve undertaking investigations and enforcement action in individual cases under the Competition and Enterprise Acts. This amendment therefore clarifies that the Secretary of State could not intervene to perform these functions. If Monitor failed to perform these functions the Office of Fair Trading could use its concurrent powers to do so.

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<sup>7</sup> 13 December 2011: Hansard Column 1195

## **D: Health inequalities and quality improvement**

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### **Strengthening the Government's commitment to reducing inequalities and improving the quality of services in the Bill – Amendments 68, 112, 144**

31. We listened to a number of Peers who were keen that the Bill said more about health inequalities. Baroness Tyler, for example, said “*I look forward to hearing the Government giving an even stronger commitment to tackling health inequalities*”<sup>8</sup>. We agree that the Bill needs to send a stronger message about the Government's commitment to reducing health inequalities and improving the quality of services, and are therefore proposing the following set of amendments on the Secretary of State and commissioners.
32. **Amendment 144** would mean the Secretary of State must include in his annual report an assessment of how effectively he has discharged his inequality and quality improvement duties. The Secretary of State has an important role to play in the oversight and stewardship of the health service and so it is only right that he should include an assessment of how well the Government is fulfilling its duties around reduction of health inequalities and quality improvement.
33. We are also putting forward **amendments 68 and 112** to require the NHS Commissioning Board and CCGs to include an assessment in their annual reports of what they have done to fulfil their health inequalities duties.

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<sup>8</sup> 7 Nov 2011 : Hansard Column 78

## **E: Greater role for patients**

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### **Duties on the Board and on CCGs to promote patient involvement – Amendments 56, 97, 98**

34. The Bill as currently drafted creates new duties for the NHS Commissioning Board and CCGs in relation to promoting opportunities for patients to be fully involved in decisions about the services they receive as individuals. As Baroness Finlay observed, *“for the involvement of patients, it is important to differentiate between public involvement and the involvement of each individual patient in the management of their care and treatment.”*<sup>9</sup> These duties are therefore intended to complement the duties in the Bill on the NHS Commissioning Board and CCGs in relation to public involvement and consultation - which replicate the duties that currently apply to SHAs and Primary Care Trusts (PCTs).
35. Lord Warner and a number of other Peers felt that, as it stands, the Bill does not do enough to reflect the Government’s commitment to the principle of “no decision about me, without me”. We have also heard similar messages from groups such as the Health Foundation and National Voices.
36. We have therefore tabled amendments to new section 13H and new section 14T of the 2006 Act to make it clear that the duties on the NHS Commissioning Board and CCGs in relation to promoting the involvement of each patient apply to decisions related to the prevention and diagnosis of illness in the patient and any care or treatment they receive. This drafting follows the language used in defining the health service, so as to encompass the full range of activity that could be provided as part of the health service.
37. The amendments also impose an obligation on the NHS Commissioning Board to issue guidance to CCGs on the discharge of their duty under new section 14T, to which CCGs must have regard. This will ensure that support will be made available to CCGs on best practice in securing effective patient

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<sup>9</sup> 28 Nov 2011: Hansard Column 50

involvement and indicates the Government's clear commitment to this objective.

### Membership of Healthwatch England – Amendment 226

38. A number of Peers were concerned about the location of Healthwatch England within CQC, and its ability to act independently on behalf of service users and the public. We strongly believe that Healthwatch England, as a statutory committee, will be able to represent the interests of patients at the national level, through setting its own strategic priorities and having editorial independence.
39. However, we agree with Baroness Cumberlege, who stated that; *“If this combined perspective, to be embedded in regulation, is to work well, it is essential that Healthwatch cannot be dictated to or steered by the CQC.”*<sup>10</sup> .
40. On reflection, we agree with the amendment Baroness Cumberlege tabled in Committee on this matter. The amendment ensures that the majority of Healthwatch England members must not be from CQC. The amendment also clarifies that the regulations on membership of Healthwatch England may provide for members to be appointed if they satisfy certain criteria, which could include results of elections.
41. In response to concerns about the detail of the membership of Healthwatch England we also published a consultation on January 26<sup>th</sup>, 2012. The consultation document requests responses from the public on key membership issues, such as the number of people that will form the Healthwatch England committee.
42. The consultation will run for 6 weeks, ending on the 2<sup>nd</sup> March, which will ensure that the resulting regulations could be laid in sufficient time to allow the establishment of Healthwatch England in October 2012.
43. To give the fullest explanation of the aims and policy intention for Healthwatch England, the Department also published a narrative<sup>11</sup> setting out how Healthwatch England will function within, and work with, CQC, which we hope will allay a number of the concerns that have been raised.

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<sup>10</sup> 22 Nov 2011 : Hansard Column 978

<sup>11</sup> Available at: <http://tinyurl.com/86ksxth>

### **Healthwatch England budget**

44. Peers, such as Baroness Jolly and Lord Harris of Haringey, and stakeholders including the National Association of LINKs Members, brought to our attention concerns that the funding of Healthwatch England would not be sufficiently transparent within the CQC budget.
45. The Department of Health's funding to Healthwatch England will be accounted for by the CQC Chief Accounting Officer. However, to enhance transparency on the allocation of this funding, the Department of Health will allocated a separate Grant-In-Aid for Healthwatch England and require the CQC to account separately for the Grant-In-Aid it receives for its CQC activities and the funding it receives to support Healthwatch England. This will enable funding for Healthwatch England to be readily identified.
46. This will not require a change to the primary legislation, but we will set out this position in the formal framework agreement between the Department of Health and the CQC.

### **Healthwatch England and local Healthwatch relationship – Amendment 229**

47. We have carefully considered Lord Harris's points about the relationship between Healthwatch England and local Healthwatch. Lord Harris suggested from his experience that it would be difficult for an organisation "*making advice and recommendations at a national level [to keep] the local organisations, on whose advice those recommendations were based, fully informed of what we were saying and doing.*"<sup>12</sup>
48. The Bill provides that Healthwatch England must publish an annual report on the way it has exercised functions. It must lay a copy of this report before Parliament and send a copy to the Secretary of State. This amendment would ensure that Healthwatch England will also have to send copies of its annual report to local Healthwatch organisations. This amendment has been tabled to ensure that local Healthwatch is kept abreast of the national 'picture'.

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<sup>12</sup> 15 Dec 2011 : Hansard Column 1484

## F: Conflicts of interest

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### CCG conflicts of interests – Amendments 83, 85, 88, 90

49. We listened to concerns raised by Peers about the need to ensure CCGs have robust safeguards against potential conflicts of interests. Baroness Barker in particular raised a concern that CCG committees or subcommittees could contain people representing commissioning support organisations who could have potential conflict of interests. Baroness Barker said *“I have absolutely no problem whatever with people who either work for or are shareholders of commissioning support organisations advising CCGs on what to do... However, it would be unacceptable if those same people had any role whatever in the decision-making processes of the CCGs, either by being a member of a CCG board or by being a member of one of the CCG sub-committees. My amendment attempts to remove that potential conflict of interest.”*<sup>13</sup>
50. We listened to this concern and agree that the Bill could be stronger in this regard. Whilst we would not want to prohibit members of commissioning support organisations from taking part in committees or subcommittees, we agree there should be greater transparency as to potential conflicts of interest of those sitting on CCG committees or subcommittees.
51. Under the Bill as currently drafted, each CCG is required to have a constitution. The constitution must, amongst other things, make provision for dealing with conflicts of interests of members or employees of the CCG, and for dealing with conflicts of interests of members of the governing body of the group. At present this does not cover individuals who are not members or employees of the CCG or members of its governing body, who are participating in committees or sub-committees of the group or its governing body. This might for example, include clinicians, patient representatives or representatives from commissioning support organisations.

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<sup>13</sup> Hansard: 14 Nov 2011 : Column 556

*Please note that all amendment numbers in this document relate to the marshalled list*



52. We have therefore tabled amendments to ensure that all CCG constitutions must include arrangements for managing conflicts of interest of *all* members of committees or sub-committees of either the group or its governing body.



## G: Public Health

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### Status of the Director of Public Health and additional guidance-making powers – Amendments 152, 124

53. Given the importance of the leadership position of the Director of Public Health, we would expect the Director of Public Health to be of Chief Officer Status with a direct line of accountability to the head of the paid service of the local authority (usually the chief executive). During Commons Report and Lords Committee, a number of individuals felt that this status would be under threat if it were not defined in legislation. For example, Lord Patel suggested that *“if the director of public health is not directly accountable to the chief executive but to some other person and, therefore, is subordinate, their authority will be diluted”*<sup>14</sup>.
54. We have listened to these concerns and, on reflection, agree that the status of the Director of Public Health needs a stronger statutory basis. **Amendment 152** amends the Local Government and Housing Act 1989 to add the Director of Public Health to the list of statutory chief officers” in section 2 of that Act. This will make the posts “politically restricted” for the purposes of the Act and give them a status similar to the Directors of Children’s Services and the Directors of Adult Social Services.
55. In addition, **amendment 124** requires local authorities to have regard to guidance given by the Secretary of State in relation to its Director of Public Health, including guidance as to appointment and termination of appointment, terms and conditions and, management. We intend to issue statutory guidance on the responsibilities of the Directors of Public Health in the same way that guidance is currently issued for Directors of Children’s Services and Directors of Adult Social Services.

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<sup>14</sup> 5 Dec 2011 : Hansard Column 510

**New Secretary of State guidance powers in relation to public health specialists – Amendment 128**

56. A number of Peers raised concerns about the employment of other public health specialists. This amendment ensures that the Secretary of State is able to issue guidance to local authorities in relation to the appointment of officers of the local authority to discharge public health functions, their dismissal from employment, and the terms and conditions and management of such officers. This will in particular, allow the Secretary of State to produce guidance to which the local authority must have regard in relation to the employment and professional appraisal process for public health specialists employed by local authorities.

**Statutory regulation of non-medical Public Health specialists**

57. Concerns were raised at Committee and by stakeholders including the Faculty of Public Health, that there would be an anomaly across the system regarding the regulation of non-medical public health specialists.
58. We are keen to ensure that there are consistent standards across the leadership of public health at a time when they will become increasingly important leaders in local communities, and the Secretary of State announced on January 23<sup>rd</sup>, 2012, the Department's intention to statutorily regulate this group of professionals. This change will be taken forward through secondary legislation and will not be on the face of the Bill.

**Amendments to the Licensing Act 2003 (as amended by the Police Reform and Social Responsibility Act 2011) – Amendments 157, 158**

59. During debates on the Bill, Peers such as Baroness Finlay raised a number of concerns about alcohol policy. The Government has said that everyone has a role to play in reducing the harmful use of alcohol. The Public Health Outcomes Framework published on 23 January 2012 sets out the areas where we collectively need to make progress on public health. We have clearly signalled the importance we attach to tackling alcohol by including indicators related to alcohol such as an indicator on alcohol-related admissions to hospital (promoting reductions in both dependent and non-dependent

- drinking). We have also tabled amendments to ensure that a local authority with responsibility for health improvement will have a role to play in the licensing of premises for the sale and consumption of alcohol.
60. The Police Reform and Social Responsibility (PRSR) Act 2011 amends the Licensing Act 2003 to add PCTs to the list of existing responsible authorities with a potential role in the process for licensing premises for the sale of alcohol or certain entertainment purposes. In particular, a responsible authority may make representations when a licensing authority is considering a licence application or variation. The 2011 Act also adds PCTs to the list of bodies, which a licensing authority must consult before determining or revising its statement of licensing policy. In addition, the 2011 Act makes provision for “early morning alcohol restriction orders” and provides that a PCT is a responsible authority able to may make representations in relation to proposals for such an order. These measures allow PCTs to make a fuller contribution to reducing acute harms from alcohol. The Home Office expects the changes in the PRSR Act 2011 to come into force on 6 April 2012.
61. These amendments update the Licensing Act provisions amended by the 2011 Act to provide that a local authority with responsibility for health improvement functions will be a responsible authority, able to make representations on licence applications and proposals for early morning alcohol restriction orders. The amendments will ensure that a local authority with responsibility for health improvement will continue to have a role as a responsible authority in the future system. We expect these functions to be the responsibility of the Director of Public Health and we will consider whether this needs to be included in regulations made under section 73B(2) of the NHS Act 2006.

## H: Patient confidentiality

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### Disclosure of confidential information – Amendments 72, 115

62. These amendments clarify the circumstances in which the Board or CCGs must conform with common law confidentiality requirements, when considering whether or not to disclose information. As drafted, the Bill permits disclosure of information by the NHS Commissioning Board and CCGs in certain circumstances, and allows them to do this without considering common law. Lord Marks, Lord Harris and the BMA all drew attention to circumstances where there was the potential, if common law did not apply, for disclosure to threaten patient confidentiality.
63. We have therefore tabled these amendments to achieve an appropriate balance, between ensuring information is disclosed when required, and protecting personal confidential information. The NHS Commissioning Board and CCGs will therefore be required to consider common law confidentiality rules when determining whether or not to disclose information, except where there is the backing of statute or a court order, or where information is in the public domain.

### Collection, analysis, publication and dissemination of information – Amendments 259-290

64. The Bill also sets out powers for the Health and Social Care Information Centre (IC) to collect, analyse, publish or disseminate information. Several Peers, as well as the BMA and the NHS Future Forum, have expressed a keen interest in ensuring personal confidential information is safeguarded, while also allowing information to be disseminated for the benefit of patients and service-users. For example, Baroness Wheeler stressed the need to provide “*safeguards that are strong enough to protect patients.*”<sup>15</sup>
65. **Amendment 268** would limit the range of persons who could request the IC to collect personal confidential information. These persons must be bodies able

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<sup>15</sup> 21 Dec 2011: Hansard Column 1802

to make a mandatory request (such as Monitor, CQC or NICE) and persons to whom information may be lawfully disclosed (e.g. because they have obtained consent, have a power in statute, etc.), or where the information may be lawfully disclosed to the Information Centre.

66. **Amendment 272** would further limit the ability of the Information Centre to require confidential information from bodies providing publicly funded health or social care services. Only where a requestor is a person who may make a mandatory request to the IC (such as NICE, CQC or Monitor) or could have required the collection of information itself (e.g. through another power in statute) or to IC may the IC require provision of the information.
67. **Amendments 280, 281, 282 and 288** clarify when dissemination by the IC of information, which identifies an individual or enables the identity of an individual to be ascertained, would be permitted. These amendments align with amendments 72, 115 and 268.
68. **Amendment 289** would require the IC to publish a code of practice for health or social care bodies (or those providing publicly funded health or social care) on how to deal with person-identifiable or other confidential information.
69. **Amendments 287 and 290** clarify how the IC is to treat information derived from information it has collected, i.e. the information generated through analysing and linking information. This includes circumstances where the derived information is personal confidential information.

## **I: DPRRC Recommendations**

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70. We accepted all of the recommendations from the Delegated Powers and Regulatory Reform Committee (DPRRC) for changes to the secondary powers taken in the Bill. These amendments fulfil this commitment.

### **Commissioning responsibility – Amendment 35**

71. Section 3 of the NHS Act 2006, as amended by the Bill, states that CCGs have responsibility for persons provided with primary medical services by a member of the group, and persons usually resident in the group’s area, who are not provided with primary medical services by a member of any CCG. Regulations under subsection (1D) enable the Secretary of State to specify that this would not apply for persons of a prescribed description, or in prescribed circumstances – for example, for persons registered with an English GP, who were resident in Scotland. Currently these regulations would be subject to the negative procedure in Parliament; following the recommendation of the DPRRC, we are making these regulations subject to the affirmative procedure.

### **Establishment of clinical commissioning groups – Amendments 74, 149**

72. Section 14A(1) of the 2006 Act inserted by clause 24 of the Bill, requires the NHS Commissioning Board to exercise its functions to ensure that at any time after a day specified by the Secretary of State in writing, every provider of primary medical services, within the meaning of this section, is a member of a CCG. The DPRRC recommended that the Secretary of State should specify this date in a Statutory Instrument, rather than simply in writing, but that this instrument need not be subject to Parliamentary procedure. These amendments therefore amend the Bill to require the Secretary of State to specify this date by an order that is not subject to Parliamentary procedure.

### **Licensing – Amendments 299, 300**

73. These amendments will make the first set of exemption regulations and the first approval of the licensing criteria by the Secretary of State subject to the

affirmative procedure, and subsequent revisions of the licensing criteria by the Secretary of State order subject to the negative procedure.

**Fluoridation – Amendments 131-136**

74. The Secretary of State has regulation-making powers to specify the circumstances when various consultation or other procedural requirements in the Bill relating to proposals for termination of fluoridation arrangements do not apply. The Secretary of State may also use direction-making powers to exempt local authorities from those requirements in relation to their proposals for termination. The intention was that these powers could be used if the supply of fluoridation needed to be terminated quickly (e.g. because of safety concerns). The DPRRC made a number of recommendations in relation to the direction-making powers.
75. Having considered the Committee’s report, we agree with the Committee’s recommendation that the power to direct given by new sections 88K(5), 88L(4) and 88M(4) of the Water Industry Act 1991 should be confined to termination proposals in individual cases, leaving any general exemptions to be dealt with in the regulations. These amendments achieve this by replacing the current provisions, which allow the direction-making powers to be exercised generally as well as in relation to a particular scheme.

**Mandate to the NHS Commissioning Board – Amendments 45, 47**

76. The Secretary of State will set objectives and requirements for the health service through the mandate to the NHS Commissioning Board. The DPRRC recommended that where the mandate sets out requirements, these should be given effect through regulations subject to the negative resolution procedure. We have tabled these amendments to bring about this change.

**Special Health Authorities – Amendments 39, 40, 137-140, 160**

77. We plan to amend clause 20 so as to prevent the Secretary of State from delegating the function of making orders or regulations to Special Health Authorities.

78. As part of this, we have also made **amendments 137-140** to clause 48. This will make it clear that the Secretary of State is not able to delegate his function of making orders or regulations specifically relating to the provision of primary medical, dental, or ophthalmic services and any functions relating to local or other pharmaceutical services to the NHS Commissioning Board, a CCG, a Special Health Authority or to such other persons or bodies as may be prescribed.
79. However, the Secretary of State is currently able to delegate his other functions to Special Health Authorities, through directions in writing, should he wish to do so. In the new system, the Secretary of State will also be able to delegate the functions of others to Special Health Authorities. The DPRRC recommended that in this case, delegation should be through directions in regulations that are subject to the negative resolution procedure and **amendment 40** makes the necessary changes to ensure this is the case.
80. Where there are existing directions from the Secretary of State to Special Health Authorities that will continue in the future system, these will remain in force. Some functions that will continue to be exercised by Special Health Authorities will not be functions of the Secretary of State in the new system. **Amendment 40** will have the effect that where functions are not Secretary of State functions, they must be conferred on a Special Health Authority by regulations. **Amendment 160** ensures that where such functions are referred to in existing directions, it will not be necessary to re-issue the existing directions as regulations.