

RESPONSE TO STAKEHOLDER QUESTIONS ON THE FUTURE ROLE AND FUNCTIONS OF THE SECRETARY OF STATE FOR HEALTH AND TO THE MEMORANDUM SUBMITTED BY PETER RODERICK TO THE PUBLIC BILL COMMITTEE ON THE HEALTH AND SOCIAL CARE (RE-COMMITTED) BILL

1. Following the Re-committal of the Health and Social Care Bill (“the Bill”)¹, the Department of Health is aware of a number of stakeholder questions on the future role and functions of the Secretary of State for Health. This note explains the changes to clause 1 of the National Health Service Act 2006 (“the 2006 Act”), proposed by the Bill and sets out a response to the 18 questions posed by the evidence submitted by Peter Roderick, a public interest lawyer, in a memorandum to the Public Bill Committee in July 2011. This is a technical document written predominantly for a legal audience. The introduction sets out the legal changes and policy intention behind the changes.

Introduction - The role of the Secretary of State

2. The Secretary of State will continue to be responsible – as now – for promoting a comprehensive health service. The wording of section 1(1) of the 2006 Act will remain unchanged as it has since the founding NHS Act of 1946. That duty has stood the test of time for more than 60 years. It is the core duty that underpins the NHS – it has never changed, we were not going to change it, and the Bill now makes that very clear.

¹ Reference to the Health and Social Care Bill 2011 is to the version as amended on re-committal in the Public Bill Committee. The Bill can be downloaded from the Parliament website – www.parliament.uk

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3. The Bill strengthens the overall accountability of the Secretary of State for Health, including new duties to oversee the health service (clause 48) and report annually on the performance of the health service (clause 49).
4. There has been some confusion about Secretary of State's duty in section 1 (2) of the 2006 Act to 'provide or secure the provision of services in accordance with this Act'. Contrary to the suggestions made by some, this duty is not fundamental to the comprehensive health service. It is simply a means of achieving the overarching aim of promoting a comprehensive health service; not the test of whether the aim is being achieved. This duty is not and never has been a stand-alone duty to provide or secure the provision of services. The phrase 'in accordance with this act' means that the actual functions of providing and securing the provision of services are set out elsewhere in the 2006 Act. The duty to provide services is primarily conferred by section 3 of the 2006 Act, and section 12 allows services to be commissioned, rather than provided directly. The Secretary of State does not, in practice, fulfil these duties personally under the current system, as they are delegated to Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) under section 7 of the 2006 Act.
5. In terms of the duty to provide, it is worth reflecting on what such a duty actually entails. In the past, the Secretary of State, or health authorities to which he delegated his functions, have provided hospital or other services directly. But that is no longer the case. The Department of Health is not a provider of NHS services – it has neither the staff nor facilities to make NHS services directly available to the public.
6. Further, it has been a long shared policy aim of all the main parties in England to secure the commissioner/provider split in NHS services, to avoid conflicts of interest and maximise value for money for patients and taxpayers. This separation is almost complete and once PCTs stop providing services, Secretary of State's section 1(2) duty to provide would no longer be necessary. Even without the rest of the Government's modernisation programme, there would be a case for removing it, so that

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the legal framework accurately reflects the practical realities. In effect, the removal of the duty to provide is nothing more than a reflection of the long-held intention of successive governments to bring about the commissioner/provider split in NHS services. It does not in any way undermine Secretary of State's accountability or responsibility for the health service which remains unchanged since the founding of the NHS.

7. The proposed new arrangements set out more clearly where responsibility should lie, rather than relying on a system of delegation. Under the Bill, the function of arranging the provision of NHS services (i.e. commissioning) is given directly to the NHS Commissioning Board ("the Board") and clinical commissioning groups. Secretary of State's role is to set objectives for the NHS and to ensure that functions conferred on bodies lower down the system are being carried out effectively so as to meet those objectives. If Secretary of State were to retain those powers in parallel, it would enable him to cut across the Board and clinical commissioning groups, undermining the mandate and the stability of the system and opening the door to political micromanagement.
8. The revised duty in clause 1(2) in the Bill – to exercise his functions under the Act so as to secure that services are provided – ensures that the Secretary of State retains ultimate responsibility for securing the provision of services. He will do this, for example, through his functions of setting objectives and standing rules for commissioners, his ability to intervene in the event of significant failure, to report annually on the performance of the comprehensive health service, and to hold the Arm's-Length Bodies (ALBs), such as the Board and the regulators, to account. The Secretary of State will therefore continue to have a role in commissioning, and take action to secure that provision of health services continues to take place if commissioners fail to do so.
9. The Secretary of State will also continue to remain legally liable for the exercise of his functions. This means that he could be the subject of a claim for judicial review by an affected member of the public if he fails to

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carry out his statutory duty under the legislation, including his duty to exercise his functions so as to secure the provision of health services under proposed new section 1(2) of the 2006 Act (as set out at clause 1 of the Bill).

10. These changes to Secretary of State's duties do not reduce the extent or coverage of the health service. The functions which are currently delegated from the Secretary of State to SHAs and PCTs, in particular the duty to commission the services listed in section 3 of the 2006 Act, are simply given directly by the Bill to the Board and clinical commissioning groups. These new organisations will be under obligations to commission services which are materially the same as the duties on SHAs and PCTs under the current system. Patients will continue to have the same rights and entitlements in relation to NHS services as now and we are strengthening the role of the NHS Constitution so it is fully embedded in the way the NHS works, empowering patients and the public. Services will remain free at the point of use except where legislation specifically sets out exceptions – for example, prescription charging and dentistry.

Questions submitted by Peter Roderick

The Secretary of State's duties

(1) To ask the Secretary of State to specify each of the functions conferred by the National Health Service Act 2006, as that Act would be amended if the Health and Social Care Bill as Re-committed to the Public Bill Committee was to be enacted, which he must exercise so as to secure that services are provided for the purposes of promoting a comprehensive health service in accordance with section 1(1) of the Act

11. In a letter to Emily Thornberry MP on Wednesday 29 June 2011, the Government attached a table setting out the Secretary of State's functions under the National Health Service Act 2006 ("the 2006 Act"), as amended by the Health and Social Care Bill 2011 ("the Bill"). A slightly revised and updated version is attached – this reflects the changes that were made to the Bill during Re-committal.

(2) To ask the Secretary of State if he will specify the reason or reasons why section 1(2) of the National Health Service Act 2006, which requires him to provide or to secure provision of health services, needs to be amended.

12. Section 1(2) needs to be amended to reflect the changes to the legal framework for the NHS made by the Bill. In particular –

- The functions relating to commissioning services are to be conferred direct on the Board and clinical commissioning groups (see clauses 10 to 3), rather than relying on the current system of directions to Primary Care Trusts (PCTs) to perform the Secretary of State's functions (see sections 3, 7 and 12).
- The Secretary of State, the Board and clinical commissioning groups will not have the function of providing NHS services. The

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Board and clinical commissioning groups are to be responsible for arranging services (i.e. commissioning not provision).

- The Secretary of State will secure the provision of services by exercising his functions in relation to other bodies, rather than the function of providing or commissioning services being conferred on the Secretary of State by the 2006 Act and then delegated to NHS bodies by directions.

13. The Government's policy is that responsibility for commissioning NHS services should be imposed clearly in primary legislation on the relevant bodies, not on the Secretary of State, who does not in practice commission (or provide) services under the current system. Generally it should not be for Secretary of State to confer or remove those functions. In the Government's view, outside of the cases of significant failure or emergencies (which are catered for in the Bill), the Secretary of State should not have the power to step in and remove the commissioning functions of the Board or a clinical commissioning group, or the power to step in to carry out the functions of the Board or a clinical commissioning group in their place, when these functions have been conferred upon them by Parliament. The Bill therefore removes the current system under which the functions of PCTs and SHAs are delegated by the Secretary of State by directions.

14. Under the Bill, the Secretary of State retains a responsibility for securing the provision of services for the purposes of the health service, but in relation to the NHS services² he will carry out this responsibility by exercising the powers conferred by the Bill: for example, his powers to issue a mandate (new section 13A), make standing rules (new section 6E) and intervene in the case of Board failure (new section 13Z1). The Board will have a concurrent duty to promote the health service and a duty as to

² The Secretary of State may secure public health services by providing or arranging services himself, under new sections 2A and 2B (see clauses 8 and 9).

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securing the provision of services, combined with various powers including the power to intervene in cases of clinical commissioning group failure (new sections 1E and 14Z19).

15. In addition, the Government's policy is that neither the Secretary of State, nor the NHS bodies responsible for securing local services, should be providing NHS services – i.e. the Department, the Board and clinical commissioning groups should not be directly managing NHS hospitals or other facilities, nor employing the staff providing NHS services. This reflects the outcome of a long shared policy aim of all the main parties in England to secure the commissioner/provider split in NHS services, to avoid conflicts of interest and maximise value for money for patients and taxpayers. PCTs commission rather than provide the majority of their services, and once PCTs complete the process of transferring their community health services provider arms, the separation will be complete. In these circumstances, the Secretary of State's section 1(2) duty to provide would no longer be necessary, nor would it be appropriate in the light of the policy that neither the Secretary of State nor NHS commissioners would be providing NHS services. Even without the rest of the Government's modernisation programme, there would be a case for removing the duty to provide, so that the legal framework accurately reflects the practical realities.

(3) To ask the Secretary of State if he will consider not abolishing the "duty to provide or to secure provision" of health services placed on him by section 1(2) of the National Health Service Act 2006

16. The Secretary of State is not abolishing the duty in section 1(2) of the 2006 Act. The duty is being modified to reflect the changes to the legal framework for the NHS. The Secretary of State will continue to have a duty to secure the provision of services. See the answer to the previous question.

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(4) To ask the Secretary of State to specify those elected persons or bodies which would determine (a) those services, and (b) the level of those services, which would be provided in accordance with the National Health Act 2006 if the Health and Social Care Bill was to be enacted.

17. Secretary of State would remain ultimately accountable for securing the provision of services. In future, in relation to the NHS, rather than having a duty to provide or arrange services directly himself, which he then delegates to NHS bodies, the Secretary of State will be exercising his duty through his relationship with the NHS bodies. For example, the Secretary of State will set the mandate for the Board (see new section 13A), report annually on the performance of the comprehensive health service (clause 49), and keep under review the effectiveness of the ALBs, such as the Board and the regulators (new section 247B inserted by clause 48 of the Bill).

18. The decisions as to what services are provided and the level of services to be provided would rest primarily with the Board and clinical commissioning groups, just as those decisions rest now with SHAs and PCTs. But those bodies would not have a general discretion as to what services to provide. The Board and clinical commissioning groups would be required to provide services to such extent as they consider necessary to meet the reasonable requirements of the persons for whom they are responsible. This is the same as for PCTs under the current framework, who assess reasonable requirements and determine what NHS services are to be made available locally. Unlike PCTs, the Board and clinical commissioning groups would not be subject to Secretary of State directions, in accordance with the Government's policy that the Secretary of State should not directly manage or interfere in local services.

19. The Board and clinical commissioning groups would however be subject to a range of other controls, which will affect their decisions. The Board would have a duty to seek to achieve the objectives set for it in the mandate published annually by the Secretary of State, and to comply with

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any requirements imposed on it for that purpose. In addition, the Department will produce an NHS Outcomes Framework and the Board would have a statutory duty to have regard to the document when discharging its duty as to improvement in quality of services (new section 13E), including when it prepares commissioning guidance for clinical commissioning groups. Clinical commissioning groups would in turn have a duty to have regard to the Board's guidance (new section 14Q(4)). Both the Board and clinical commissioning groups will be subject to the standing rules (new section 6E).

20. The national requirement to fund certain treatments recommended by the National Institute for Health and Clinical Excellence (NICE) would remain in place. At present, this is effected by Secretary of State directions to PCTs made under section 8 of the 2006 Act (not the 2006 Act itself). In the new system this would be replaced by requirements imposed by regulations (see clause 240 of the Bill). Other statutory restrictions would also be relevant: for example, the Board and clinical commissioning groups would be subject to public law principles and would be public bodies subject to the Human Rights Act 1998 and the statutory public sector equality duty under section 149 of the Equality Act 2010.
21. In addition, the Bill strengthens democratic accountability by providing for the establishment of local authority Health and Wellbeing Boards. In these Boards, local councillors, clinical commissioning groups, Directors of Public Health, Adult Social Services and Children's services as well as local HealthWatch will assess need and agree joint health and wellbeing strategies to meet that need, to which the groups must have regard when drawing up their commissioning plans for their local population.

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(5) To ask the Secretary of State if he will specify each provision in the Health and Social Care Bill as re-committed to the Public Bill Committee that would impose a duty to provide or to secure provision of health services in England on any public or private body

22. There are a number of relevant provisions in the Health and Social Care Bill as amended, on Re-committal, in Public Bill Committee.

- Section 1 of the 2006 Act, as amended by the Bill, would impose a duty on the Secretary of State to exercise the functions conferred by the Act so as to secure that services are provided in accordance with the Act.
- Section 1E of the 2006 Act (as inserted by clause 6) would impose on the Board –
 - the function of arranging for the provision of services for the purposes of the health service in accordance with the Act;
 - a duty to exercise its functions in relation to clinical commissioning groups so as to secure that services are provided for the purposes of the health service in accordance with the Act.
- Section 1F of the 2006 Act (clause 7) would impose on clinical commissioning groups the function of arranging for the provision of services for the purposes of the health service in accordance with the Act.
- Section 2A (clause 8) would impose on the Secretary of State a duty to take steps as he considers appropriate for the purpose of protecting public health. The steps that may be taken include the provision of health services.
- Section 2B (clause 9) would impose on certain local authorities a duty to take steps as they consider appropriate for the purpose of improving public health. The steps that may be taken include the

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provision of health services. Local authorities would be required to provide any services or take other steps specified by the Secretary of State in regulations made under new section 6C (clause 15).

- Section 3 (as amended by clause 10) would impose on clinical commissioning groups the duty to arrange for the provision of hospital and other health services to such extent as they consider necessary to meet the reasonable requirements of the persons for whom they have responsibility. The services to be provided and the extent to which they must be provided are the same as under the current PCT system.
- Section 3B (clause 12) would provide for regulations to impose on the Board the duty to arrange, to such extent as it considers necessary to meet the reasonable requirements, the health services listed in paragraphs (a) to (d) of section 3B(1).
- Section 4 (clause 13) would impose on the Board a duty to arrange for the provision of high secure psychiatric services.
- Schedule 1 (clause 14) would impose –
 - on local authorities, the duty to provide medical and dental inspection and treatment of school pupils;
 - on Secretary of State, the duty to arrange contraceptive services; and
 - on clinical commissioning groups, the duty to arrange for the provision of wheelchairs and other vehicles for disabled persons.
- Section 6E(2)(a) (clause 17) would enable Secretary of State to require the Board or clinical commissioning groups to arrange for specified services to be provided. The government intends to use this power, alongside others in this section, to replicate the current

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set of arrangements for NHS Continuing Healthcare and certain patient rights under the NHS Constitution.

- Sections 83, 99, 115 and 126 (as amended by Schedule 4 to the Bill) would impose on the Board duties to secure the provision of, primary medical services, primary dental services, primary ophthalmic services and pharmaceutical services. These duties are currently imposed directly on PCTs, not the Secretary of State.

23. It should also be noted that section 25 and section 43 (as amended by clause 168) would continue to set out that the function and purpose of NHS trusts and NHS foundation trusts is to provide goods and services for the purposes of the health service in England.

(6) To ask the Secretary of State to specify his functions in the Health & Social Care Bill which would guarantee (a) that additional services and facilities for the care of pregnant women, breastfeeding women, and young children, required to be provided by him now in accordance with section 3(1)(d) of the National Health Service Act 2006, will continue to be provided as a part of the health service, and (b) that those services will be provided equally throughout England without geographical variation.

24. The provisions in the Bill will ensure that these functions will continue. The only difference between the current system, and future arrangements, will be who is responsible for carrying them out.

25. Clauses 9 and 10 are the provisions which ensure that the services and facilities for the care of pregnant women, breastfeeding women and young children required to be provided now in accordance with section 3(1)(d) of the 2006 Act, would continue to be provided as a part of the health service. Clause 10 amends section 3 of the 2006 Act so that clinical commissioning groups would have responsibility for arranging those services, in respect of the persons for whom they are responsible (i.e. the patients of their constituent practices, unregistered patients usually living

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in their area and other persons as may be set out in regulations). The duty would be to provide those services to such extent as they considered necessary to meet reasonable requirements of the persons for whom they are responsible. This is in essence the same as the current duty on PCTs.

26. Clause 9 inserts a new section 2B of the 2006 Act which imposes a duty on local authorities, and confers a power on the Secretary of State, to take appropriate steps to improve public health. Such steps may include the provision of services (see section 2B(3)) and some of the services currently provided under section 3(1)(b) of the 2006 Act (e.g. health visiting) may be provided or arranged under section new 2B.

27. Under the current system, each PCTs is responsible for determining the reasonable requirements of its population and what services are necessary to meet those requirements, using the resources available to it. The system already permits variations in different geographical areas, having regard to local needs and priorities, and the Bill does not change that. The reforms introduce a stronger national framework for driving quality improvement than ever before – that is one of the key objectives of the Board. NICE will set clear national standards of care, so patients can be confident that – wherever they are treated – the standard of care on the NHS will be of the same high standard, wherever they live. And this will be reflected in the Commissioning Outcomes Framework, national and best practice tariffs, model contracts, and commissioning guidance.

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(7) To ask the Secretary of State to specify his functions in the Health & Social Care Bill which would guarantee (a) that additional services and facilities for the prevention of illness, people who are ill, and ongoing healthcare for those leaving hospital, required to be provided by him now in accordance with section 3(1)(e) of the National Health Service Act 2006, will continue to be provided as part of the health service, and (b) that those services will be provided equally throughout England without geographical variation.

28. The provisions in the Bill will ensure that these functions will continue. The only difference between the current system, and future arrangements, will be who is responsible for carrying them out.

29. Clause 10 ensures that the services and facilities for prevention of illness, the care of person suffering from illness and the after-care of persons suffering from illness required to be provided now in accordance with section 3(1)(e) of the 2006 Act, would continue to be provided as a part of the health service. Clause 10 amends section 3 of the 2006 Act so that clinical commissioning groups would have responsibility for arranging those services, in respect of the persons for whom they are responsible (i.e. the patients of their constituent practices, unregistered patients usually living in their area and other persons as may be set out in regulations). The duty would be to provide those services to such extent as they considered necessary to meet all reasonable requirements. This is same as the current duty on PCTs.

30. It should also be noted that in the new system some of these services (immunisation to prevent illness) may be provided or arranged under the Secretary of State duty to take appropriate steps for the purpose of protecting the public in England from disease or dangers to health, under section 2B of the 2006 Act (see clause 9).

31. Please see paragraph 27 for further information about the geographical variation of services.

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II. Rights and entitlements to (free) health services

(8) To ask the Secretary of State if he will specify those provisions of the Health and Social Care Bill which he considers would, if enacted, affect the right and/or entitlement to health services of people in England

32. The rights and entitlements to health services of people in England remain as they are now. The people of England continue to be entitled to access NHS services, to receive NHS services free of charge subject to certain limited exceptions sanctioned by Parliament (e.g. prescription charges) and continue to have the right to expect their local NHS to assess the requirements of their local community and to commission and put in place the services to meet those needs as considered necessary. This and the other rights to access to health services set out in the NHS Constitution are not removed or altered by the Bill.

(9) To ask the Secretary of State to guarantee that if the Health & Social Care Bill was enacted, hospital, medical, surgical, nursing and ambulance services would continue to be provided as a right and/or entitlement equally across the whole of England.

33. The rights of patients and the public are set out under the NHS Constitution. We are strengthening the role of the NHS Constitution so it is fully embedded in the way the NHS works, empowering patients and the public.

34. If the Bill were enacted, the rights relating to access to health services set out in the NHS Constitution would continue. In particular, the rights to access NHS services and to expect the local NHS to assess the requirements of the local community and to commission and put in place the services to meet those needs as considered necessary would remain.

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(10) To ask the Secretary of State to specify those services which, in light of the proposed amendment in the Health and Social Care Bill to section 1(3) of the National Health Service Act 2006, would not be provided as part of the health service in England.

35. The Bill does not reduce the extent or scope of the health service. As now, the services which are provided as part of the health service are determined by NHS bodies, subject to their statutory duties the 2006 Act. There is no specified list of services which are not to be provided. The Bill does not materially alter which services must or may be provided, nor the test for determining whether a service is provided. In particular, under section 3 of the 2006 Act as amended by the Bill, clinical commissioning groups will have a duty to arrange the services listed in that section to such extent as they consider necessary to meet the reasonable requirements of those they are responsible for, just as PCTs do now, unless they are commissioned by the Board under section 3B of the 2006, as amended. The Board will have the same duties to arrange primary care services as PCTs do now.

36. Section 1 (3) of the 2006 Act is not materially altered by the Bill. The provision reproduced here is almost identical to the provision set out in the 2006 Act, which derives from the founding NHS Act of 1946. Services will continue to be free at the point of use where they are now. The only difference in wording is to refer to services which are part of the health service rather than the services which the Secretary of State provides or secures – this ensures that the prohibition on charging applies to the services commissioned by the Board or clinical commissioning groups. This includes all free services which are part of the health service and therefore covers services commissioned by the Board, clinical commissioning groups, and, in relation to public health, local authorities. As set out in the Government response to the Future Forum report, we have committed not to introduce any new charges during this Parliament.

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III. Commissioning

(11) To ask the Secretary of State to specify the reasons why the Health and Social Care Bill, as re-committed to the Public Bill Committee, does not impose a duty on commissioning consortia to provide or to secure provision of health services, such as medical services, nursing services and ambulances.

37. The Bill places appropriate duties on clinical commissioning groups.

Section 3 of the 2006 Act, as amended by clause 10 of the Bill, would impose a duty on clinical commissioning groups to arrange health services, such as medical services, nursing services, ambulances and the other services listed in that section, where the Board does not have a duty to arrange for the provision of such a service or facility. There is no duty to provide services, as the clinical commissioning groups will not be providing services – i.e. they would not be directly managing NHS hospitals or other facilities, nor employing the staff providing NHS services.

(12) To ask the Secretary of State to confirm that the Health & Social Care Bill, if enacted in its current form, would give the responsibility for deciding what constitutes "a reasonable level of health services" to the commissioning consortia, and removes this responsibility from the Secretary of State.

38. Under the provisions in the Bill, the Secretary of State remains ultimately responsible for promoting a comprehensive health service and for securing the provision of services. The function of commissioning services moves from SHAs and PCTs to the Board and clinical commissioning groups.

39. It should be pointed out that the statutory test here is not what constitutes "a reasonable level of health services" – the test is what is considered necessary to meet reasonable requirements. The Bill gives each clinical commissioning group the responsibility for deciding what is "necessary to meet the reasonable requirements of the persons for whom it has responsibility". Although the 2006 Act confers the current duty in section 3 on the Secretary of State, the Secretary of State has given directions to

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PCTs to exercise this function.³ The Bill, therefore, does not represent a significant change from the current position – the decision on what is necessary currently rests with local NHS bodies, not the Secretary of State.

(13) To ask the Secretary of State to specify what provisions there are in the Health & Social Care Bill to prevent commissioning consortia deciding that health services and facilities for the care of pregnant women are not a priority.

40. It is important to note that clinical commissioning groups would not have a general discretion as to what services to provide and would be bound by a number of statutory provisions set out in this Bill, and elsewhere in legislation. Clause 10 of the Bill amends section 3 of the 2006 Act so that each clinical commissioning group has a duty to arrange the provision of such services, to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it is responsible.

41. As for PCTs now, decisions as to prioritisation and the allocation of available resources will be a matter for the groups, subject to various significant restrictions. Each group must act in accordance with the duty as stated in section 3 of the 2006 Act as amended by the Bill and in accordance with the ordinary principles of public law. In addition, a group would be subject to various other controls under the Bill: in particular, the group must have regard to the Board's commissioning guidance (new section 14V, clause 22), have regard to NICE advice or guidance and comply with its recommendations (regulations under clause 236(8)), and comply with the standing rules (new section 6E, clause 17). Other statutory restrictions would also be relevant: for example, a clinical commissioning group would be a public body subject to the Human Rights

³ See section 7 of the 2006 Act and the National Health Services (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) Regulations 2002 (S.I. 2002/2375)

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Act 1998 and the statutory public sector equality duty under section 149 of the Equality Act 2010.

42. In addition, the Department will produce an NHS Outcomes Framework. The Board would have a statutory duty to have regard to the document when discharging its duty as to improvement in quality of services (new section 13E), including when it prepares commissioning guidance for clinical commissioning groups. Clinical commissioning groups would in turn have a duty to have regard to the Board's guidance (new section 14Q(4)).
43. The Framework for 2011/12 contains outcomes measures to support care of pregnant women. In Domain 1: Preventing people from dying prematurely includes the indicator 'perinatal mortality (including stillbirths)' which relates to the outcomes of NHS care during pre-pregnancy, pregnancy, birth and immediately after birth. In Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm, the indicator 'admission of full-term babies to neonatal care' will also be used to measure the outcome of maternity care. This indicator works on the basis that if maternity care goes to plan and is safe, babies should not require specialist care where there is not a pre-planned need. The NHS Outcomes Framework is due to be refined annually, although we have stated that we envisage only a small number of indicators will change or be refined in any one year.

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(14) To ask the Secretary of State to specify the duties and powers which the Health and Social Care Bill would, if enacted, impose or confer on clinical commissioning groups in order to provide, secure provision of, or arrange for provision of health services in England; and, if no such duties and powers can be specified, to explain why that is the case.

44. There are a number of relevant provisions in the Bill as amended, on re-committal, in Public Bill Committee. See –

- Section 1F of the 2006 Act (clause 7) would impose on clinical commissioning groups the function of arranging for the provision of services for the purposes of the health service in accordance with the Act.
- Section 3 (as amended by clause 10) would impose on clinical commissioning groups the duty to arrange for the provision of hospital and other health services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility. The services to be provided and the extent to which they must be provided are the same as under the current PCTs.
- Section 3A (clause 11) would confer on clinical commissioning groups the power to arrange for the provision of services or facilities, in addition to those listed in section 3, where the group considered that the services were appropriate for the purposes of the health service.
- Paragraph 9 of Schedule 1 (clause 14) would impose on clinical commissioning groups the duty to arrange for the provision of wheelchairs and other vehicles for disabled persons.
- Section 6(1A) (paragraph 2(3) of Schedule 4 to the Bill) would confer on clinical commissioning groups the power to arrange for services to be provided outside England (e.g. enabling patients to access treatment abroad).

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- Section 6E(2)(a) (clause 17) would enable Secretary of State to require the Board or clinical commissioning groups to arrange for specified services to be provided. The government intends to use this power, alongside others in this section, to replicate the current set of arrangements for NHS Continuing Healthcare and certain patient rights under the NHS Constitution.
- Section 12ZA (paragraph 9 of Schedule 4 to the Bill) makes provision in relation to the arrangements entered into by clinical commissioning groups (in particular arrangements entered into under sections 3 and 3A). The section confirms that a group may make such arrangements with any person or body, including public authorities and voluntary organisations. Any providers of services would have to meet any relevant Care Quality Commission (CQC) registration requirements and Monitor licensing conditions. The section also enables a group to make staff or facilities available to assist such providers.
- Sections 12A to 12D (as amended by paragraph 10 of Schedule 4) would confer on clinical commissioning groups the power to make direct payments to individual patients, to enable them to purchase health services, in accordance with regulations.
- Sections 14Z1, 14Z2 and 14Z7 make provision for clinical commissioning groups to enter arrangements for joint exercise of functions other bodies, or for other bodies to exercise their functions. Clinical commissioning groups would remain legally liable for the exercise of those functions.
- Section 75 – regulations made under that section would confer on clinical commissioning groups the power to enter partnership arrangements with local authorities, including arrangements under which local authorities could exercise a group's functions in relation to arranging services.

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- The Bill confers no powers or duties on clinical commissioning groups to provide health services (as opposed to securing or arranging services), as the Government's policy is that such groups should be commissioning not providing services – i.e. the groups should not be directly managing NHS hospitals or other facilities, nor employing the staff providing NHS services.

(15) To ask the Secretary of State to explain whether, if the Health & Social Care Bill was to be enacted, a commissioning consortium could consist (a) only or mainly of companies or of individuals representing such companies, and (b) only or mainly of non-UK (including US) companies or of individuals representing such companies.

45. Under the provisions in the Bill, clinical commissioning groups will be organisations with a membership comprised of individuals and bodies and organisations that are parties to arrangements with the Board to provide primary medical services (often referred to as GP services) in England. Regulations under section 89 of the 2006 Act, as amended by clause 25 of the Bill, make it a requirement that any provider of primary medical services belongs to a clinical commissioning group. Section 14A(1) as inserted by clause 22 of the Bill will place a duty on the Board to ensure that after a date specified by the Secretary of State each provider of primary medical services must be a member of a clinical commissioning group. Therefore, in order for any individual, partnership or company to provide primary medical services under any of the three main types of primary medical services contract (which are General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) they will have to be a member of a clinical commissioning group.

46. A company can hold any of these contracts, but for the two contract types (GMS and PMS) representing more than 95% of the total number (as of

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2010), ownership of the companies is restricted to people working as medical or healthcare professionals or for NHS bodies, in the UK. This would make it extremely difficult for a company based overseas to hold such contracts. The criteria in relation to the third and rarest contract type (APMS) do not contain such restrictions. However, based upon the latest national data collection, we estimate that companies hold only around 120 contracts for the provision of GP services under APMS arrangements. We do not know if any of these are based overseas. To put this in context, there are around 8,300 contracts for GP services in total.

47. It would be theoretically possible for a single clinical commissioning group to have a high proportion of members drawn from companies based overseas, but the reality is that based upon the current distribution of the individuals, partnerships and organisations providing these services, this is unlikely. For example, around 54% of contracts are entered into under GMS arrangements, which have no fixed duration, which greatly reduces the opportunities for market forces to significantly change the way in which primary medical services contracts are distributed in the medium term.
48. As part of the decision on whether to approve an application from a group of providers of GP services to become a clinical commissioning group, the Board must ensure that all proposed members will be providers of NHS GP services on the proposed approval date. The Board has the duty to ensure that all providers of NHS GP services are members of clinical commissioning groups and can assign one or more contract-holders to a proposed or existing clinical commissioning group. Aside from this, it is for these providers to decide how to form their groups.

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(16) To ask the Secretary of State to specify those provisions in the Health and Social Care Bill which would, if enacted, ensure that members of a commissioning consortium would be individual GPs in private practice.

49. The provisions as to membership of clinical commissioning groups are set out in the previous answer.

IV. Possibility of introduction of means-testing

(17) To ask the Secretary of State to specify how section 1(3) of the National Health Service Act 2006 would, if the Health & Social Care Bill was to be enacted, prevent current and future recipients of health services in England from being means-tested in respect of health services.

50. Section 1(3) of the 2006 Act, as amended by the Bill, would prevent means-testing in the same way it does now. Section 1(3) as amended would apply to the services arranged by the Board and clinical commissioning groups under sections 3, 3A, 3B, 4 and Schedule 1 of the 2006 Act, and public health services provided or arranged by Secretary of State or local authorities under their public health functions (in particular new sections 2A and 2B), just as it applies now to the services provided or arranged by the Secretary of State, SHAs or PCTs. Section 1(3) requires that such services are provided “free of charge” – this clearly prohibits requiring payment from a patient, whether on the basis of a means-test or otherwise. In addition, it would be unlawful to refuse to arrange the provision of a service to an individual on the basis that he/she has sufficient funds to pay for the service privately. That is the case under the 2006 Act and would continue to be the case under the 2006 Act as amended by the Bill. Means-testing would require substantial changes to primary legislation. In the absence of such provision and with the express prohibition on charging in section 1(3), means-testing was, is and will continue to be, unlawful.

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51. For the purpose of determining whether certain individuals on low incomes are entitled to help with travel expenses and to remission of prescription and other charges, means-testing is permitted under sections 182 and 183 of the Act; but this provision has been in the NHS Acts for some years and is not materially affected by the Bill.

(18) To ask the Secretary of State if he will specify the provisions of the Health and Social Care Bill that allow for means-testing in relation to receipt of health services; and, if none can be specified, if he will guarantee that such mean testing will not occur.

52. The provisions of the Bill do not introduce any new provision which would allow for means-testing in relation to the receipt of NHS services. Provision is already made under the 2006 Act for charging for such services, and these provisions will continue in force. New section 186A (clause 46) allows the Secretary of State to make regulations to allow local authorities for charge for public health services – but any such regulations are subject to the approval of Parliament.

53. For the purpose of determining whether certain individuals on low incomes are entitled to help with travel expenses and to remission of prescription and other charges, means-testing is permitted under sections 182 and 183 of the Act; but this provision has been in the NHS Acts for some years and is not materially affected by the Bill⁴.

54. The government has committed not to introduce any new charges during the course of this Parliament.

⁴ The provision is amended so that the regulations can extend the provision for payment of travel expenses and remission of charges to services commissioned by the Board and clinical commissioning groups.