September 2011

Department of Health

RESPONSE TO OPINION OF STEPHEN CRAGG, PUBLISHED BY 38 DEGREES, ON DUTY OF THE SECRETARY OF STATE TO PROVIDE A NATIONAL HEALTH SERVICE

1. This note sets out the Department's response to the legal opinion ("the Opinion") of Stephen Cragg on the Secretary of State's duty to provide of 26 July 2011, as published on the 38 Degrees website. The note should be read alongside the Department's document "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 Bill" published in August 2011[1]. This note responds to the specific points made in the Opinion.

2. The Department does not agree with some important aspects of the legal analysis of the provisions of the Health and Social Care Bill. The Department notes that the advice considers clauses 1 and 10 of the Bill, but does not address many of the other provisions of the Bill which in its view are key to an understanding of the new legal framework and the role of the Secretary of State – in particular clauses 2, 17, 20, 22 and 48 of the Bill.

3. The Opinion notes that that the Secretary of State is no longer to be involved in the direct provision of (NHS) services. The Department notes that, although the Secretary of State does currently have the legal power to provide services directly, the practical reality is that Secretary of State has not been involved in direct provision for many years. The bodies to which he delegates functions, Primary Care Trusts (PCTs), provide only a

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1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_129415

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limited range of community health services and will soon stop providing services altogether. In practice, direct provision of services by the Secretary of State or the bodies to which he delegates his functions is not the fundamental basis on which the current NHS relies.

Accountability and curtailing of Secretary of State functions

4. The Opinion states that the functions of the Secretary of State in relation to the NHS have been greatly curtailed, particularly with the loss of the duty to provide services under section 3 of the 2006 Act and argues that the Government will be less accountable in legal terms for the services that the NHS provides. The Department agrees that powers of the Secretary of State have been curtailed (e.g. the removal of the power of direction) and the duty to provide has been removed. The purpose of this is simply to make clear that it should not be the responsibility of Ministers to provide or commission services directly. It is also important to note that the Bill confers on the Secretary of State additional powers which are not discussed in the Opinion, for example, the Secretary of State's power to set objectives and requirements in the NHS Commissioning Board's ('the Board's") annual mandate under new section 13A of the 2006 Act, and the power to impose requirements under the "standing rules" regulations under new section 6E. The Bill also confers additional duties on the Secretary of State in relation to the NHS (e.g. his new duties in relation to improving quality of care and reducing inequalities (clauses 2 and 3), and to keep the effectiveness of health service functions under review (clause 48)).

5. Removing the Secretary of State's duty to provide alters his political accountability but it does not remove it. The Secretary of State remains politically accountable for the NHS and legally accountable for the statutory functions conferred on him by the 2006 Act, as amended by the Bill, including in particular:

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- his duties under section 1 to promote a comprehensive health service and exercise functions as to secure the provision of services;

- his functions in relation to the Board and clinical commissioning groups (CCGs), such as allocating the funding for the NHS to the Board, setting the annual mandate for the Board and making the "standing rules" under new section 6E of the Act, which will establish core requirements for commissioners and influence how the NHS operates; and

- his others powers to make regulations in relation to, for example, primary care services and NHS charges.

The section 3 provision of services duty

6. The Opinion correctly identifies that the duty in section 3 is currently delegated to PCTs and that the exercise of these powers is subject to the control of the Secretary of State by directions. The Department's policy is that the Board and CCGs should not be subject to a power of direction so that they can use their professional expertise to act in the best interests of patients, free from political micromanagement. But this does not mean that the Secretary of State no longer has any control or influence over the NHS. Instead the vision, strategy and framework must be set through the mandate and the standing rules which are subject to a greater degree of Parliamentary scrutiny and control than directions – for example, the section 6E standing rules regulations are subject to the negative procedure, or in some cases the affirmative procedure, for statutory instruments and the section 13A mandate must be laid before Parliament.

7. The Opinion refers to a severance between the duty in section 1(1) (the duty to promote a comprehensive health service) and the duty in section 3(1) (the duty to provide/arrange services). It is also correct that, unlike the Board, CCGs will not have a duty to promote the comprehensive health service. But that does not mean CCGs can simply disregard the section 1(1) duty. It is clear from the Bill that a comprehensive health service should continue to be promoted in England. It is also clear that the key specific duties and powers in the 2006 Act (as amended by the Bill), including section 3, have been imposed or conferred so that such a service can be promoted. This means that CCGs must have regard to the duty of the Secretary of State under section 1(1) in exercising their own functions under section 3. In addition, the duties on the Board and the Secretary of State in relation to the comprehensive health service will provide justification for using the various powers they have in relation to CCGs to address concerns, such as the withdrawal of essential services or the risks of fragmentation and a "post-code lottery".

*Duty to provide a **national** health service*

8. The Bill does not mean there is no longer is no longer a **national** health service. The health service remains a national one for which Secretary of State is responsible, by virtue of section 1 of the Act. There is a transfer of the duty to provide/arrange services to CCGs, but this does not mean the health service is no longer a national one. Taken together, the Board and CCGs remain responsible for arranging the list of health services in section 3. It is clear that the duty in section 3 has been imposed so that such a comprehensive health service can be promoted and the functions of CCGs must continue to be exercised within a health service for England which the Secretary of State must promote. In addition, the Board and the Secretary of State must exercise their functions as to secure the provision of those services for the purposes of that health service. The service does retain national oversight and control, through the powers of the Secretary

of State (e.g. to set objectives and requirements under new sections 6E (standing rules) and section 13A (the mandate) and the powers of Board (including the power to set commissioning guidelines (section 14Z6) and to intervene in the event of failure (section 14Z19). In addition, the provisions of the Health Act 2009 for an NHS Constitution are retained and applied to the Board and CCGs.

Clause 4 – the duty as to promoting autonomy

9. The Opinion refers to the duty of autonomy in clause 4 of the Bill (or the "hands off" clause as it is referred to in the Opinion), and suggests that the courts would expect the Secretary of State to demonstrate that any steps he took which interfered with autonomy were "really needed" or "essential", and that no other course of action could be followed. The Department's view is that this overstates the limitation on the Secretary of State. The duty on the Secretary of State to act with a view to securing autonomy is subject to the words "so far as is consistent with the interests of the health service". This means that the interests of the health service must always take priority. That wording must also be seen in the overall context of the Bill, in particular the duties in section 1(1) (the duty to promote the comprehensive health service) and new section 1A (the duty as to the improvement in the quality of services). The effective discharge of these core duties is plainly in the interests of the health service. It would be sufficient for the Secretary of State to demonstrate that he had reasonable grounds for concluding that a course of action was the most effective way to act in the interests of the health service and fulfil a duty imposed on him by, for example, section 1, 1A or 1B of the Bill.

10. The specific purpose of the autonomy duty is to free frontline professionals to focus on improving outcomes for patients rather than looking up to Whitehall. It sets out that, when considering whether to place requirements on the NHS, the Secretary of State should always consider the impact of

his actions on health service organisations and ensure that he is acting proportionately. It does not undermine his overarching duty to promote a comprehensive health service nor does it enable ministers to abdicate responsibility for the NHS.

Section 3(1)(d) and (e) and "postcode lottery"

11. It is not correct, as the Opinion suggests, that the Bill creates a real risk of an increase in the "postcode lottery" nature of the delivery of some services, about which there is very little the Secretary of State would be able to do. The Department's view is that this to consider the various powers which the Bill confers on the Secretary of State and the Board to address such concerns. In particular, the Secretary of State's powers to impose objectives and requirements under the standing rules (section 6E) and the mandate to the Board (section 13A), and the Board's power to set commissioning guidelines to which groups must have regard (section 14Z6) and to intervene in the event that a CCG might be failing to discharge its section 3 duty properly (section 14Z15 to 19)). As explained above, the limitation on the ability of the Secretary of State to act by virtue of clause 4 is overstated. There is already huge unjustified variation across the NHS, which the reforms will help to tackle. The Board will set national commissioning guidelines based on a national outcomes framework. All parts of the commissioning system will be subject to new duties about reducing inequalities.

Legal challenges to the provision of health service

12. It is correct that CCGs would be the target of any legal challenges to decisions about the commissioning/provision of health services, but in fact this largely reflects the current situation. Under the current system, PCTs

and not the Secretary of State are the proper target of such legal challenges, even though PCTs are exercising the Secretary of State's functions. The PCTs are the bodies making decisions about local services and are therefore liable to judicial review, and paragraph 16 of Schedule 3 to the 2006 Act means that, even when exercising the Secretary of State functions, any liabilities incurred are enforceable against the PCTs and not the Secretary of State.

Miscellaneous points

13. The Opinion suggests that only CCGs and not the Board will have a duty to arrange the provision of services as necessary to meet *all reasonable requirements*. That is not correct: the Board would have that duty under regulations made under section 3B of the Act, as inserted by clause 12.

14. The Opinion suggests that the duty to "arrange for the provision of services" means that a CCG is able to make arrangements for other persons to provide services, but can also can provide services direct to patients. That is not correct. The Opinion refers to provisions of social care legislation which use similar wording in relation to local authorities, but the statutory context of those duties is different. The reference in the 2006 Act, as amended by the Bill, to "arrange for the provision [of services]" does however restrict the Board. As has been made clear in other statements made by the Department, the Board and CCGs will commission but not provide services.

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