**Health & Social Care Bill 2011**

**Briefing note 4**

**House of Lords Committee stage**

**Clauses 3, 4, 6 and 7 for debate on Monday 7th and Wednesday 9th November 2011**

## Recommendations

With a view to ensuring that clinical commissioning groups (CCGs) would be responsible for planning and commissioning comprehensive services for all people in contiguous geographic areas throughout England, as primary care trusts (PCTs) do at present, and to retaining constitutional control, **we recommend**

- **on Clause 3 that amendments should be tabled to Clauses 7 and 10 to base CCG responsibility on contiguous geographic areas, thereby making monitoring of inequalities, and implementation of strategies to reduce inequalities and research on inequalities reduction feasible;**
- **on Clause 4 that peers should support the Liberal Democrat / Labour / cross bench notice of intention to oppose the Question that Clause 4 stand part of the Bill;**
- **on Clause 6 that this Clause is revisited in the light of resolution of Clause 1 and the constitutional issues;**
- **on Clause 7 that an amendment should be tabled to give CCGs the duty to promote a comprehensive health service in their area.**

## Introduction

### CCG responsibilities do differ substantially from PCTs: registered populations will not be based on all residents within an area.

Lord Howe has sought to reassure peers that CCG responsibilities will not differ substantially from those of PCTs:

> My noble friend asked me a yes or no question: are CCGs just like PCTs? In terms of population responsibility, the responsibilities are very similar. CCGs are responsible for patients on the registered lists of their constituent practices as well as having specific area-based responsibilities, as I pointed out, linked to their unique geographic coverage (Lords Hansard, 02 Nov2011: Column 1270).

However, Lord Howe and David Nicholson, the NHS Commissioning Board shadow chief executive, have made clear that unlike PCTs **CCG areas are indeterminate and their responsibilities not comprehensive.**

Lord Howe stated in the Lords that CCGs will differ from PCTs in the following ways:

- **CCGs will not be formed on the basis of responsibility for all residents within a contiguous geographic area**: "It is possible for individuals within that area to be registered with a GP practice which is a member of a different CCG. It would therefore be the responsibility of that other CCG (Lords Hansard, 02 Nov 2011: Column 1271)."
- **CCG responsibilities for services for all people in their area are not defined, apart from emergency care**: "We must also ensure, when we exercise the power to set out other persons for whom a CCG has responsibility, to provide through regulations that a CCG has responsibility for ensuring that everyone in its area can access urgent and emergency care (Lords Hansard, 02 Nov 2011: Column 1267)."

David Nicholson confirmed the government's position that in future residents in an area or in the same household may be able to choose their CCG on the basis of services provided by GPs. He said on the Today Programme (BBC Radio 4, 31 Oct 2011, 06:54):

> We will publish information about general practices so you will be able to see what your general practice provides as compared with other GPs in the area and nationally … If you've got a long-term condition you might want to think in future about different GPs and whether they're providing a full range of services for particular people with long term conditions.

**Clause 3 (Amendments 21 - 33)**

Clause 3 would impose a brand new duty on the Secretary of State to have regard to the "need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service." (A similar, though slightly different duty would be placed on the NHS Commissioning Board under Clause 20: new s. 13G).

This duty could be strengthened by requiring the Secretary of State to have a duty to reduce inequalities.

However, the problem with this Clause (and with new s. 13G) is that the duty would not be capable of effective fulfillment.

Public health analysis and needs assessment require comprehensive area based population data. This is the basis of current health system mechanisms for resource allocation and for the commissioning of public health measures designed to prevent or ameliorate systematic inequalities - both between groups of residents in an area and across and among areas - with respect to access to resources and services and their use and outcomes. Census estimates, adjusted for factors such as age and deprivation are used as the denominator for the population in such analyses. **In future, public health analysis will not be able to be carried out in this way, because of the proposed shift from area-based (PCT) to GP list-based (CCG) structures.** Denominators which rely on GP registrations to promote reductions in inequalities are inherently problematic because continuous enrollments and disenrollments affect accuracy, as does patient selection; the denominator will not be representative of all people in a geographically bounded area. Without the geographic population focus it will not be

possible to monitor inequalities.

**The apparent thrust of all the tabled amendments to Clause 3 is to be welcomed from the point of view of strengthening and clarifying the duty. However, none of them would ensure that reductions in systematic inequalities as regards resource allocation, and access to, use of, and provision of services would, in reality, be achieved for as long as CCG responsibility is not geographically bounded and serving all people in that area.**

**We recommend that amendments should be tabled to Clauses 7 and 10 to ensure CCG responsibility is on the basis of a contiguous geographically bounded area. This will make monitoring of inequalities and implementation of strategies to reduce inequalities and research on inequalities reduction feasible. (Amendment 59A would go some way to remedying this problem, but is limited in its application.)**

**Clause 4 (Amendments 34 – 38)**

The proposed 'duty as to autonomy' in Clause 4 would require the Secretary of State *"so far as is consistent with the interests of the health service"* in exercising his or her functions to act with a view to securing that any other person exercising functions in relation to the health service or providing services is *"free"* to do so in the manner they consider most appropriate and that *"unnecessary burdens are not imposed on"* them. (Clause 20: new s. 13F would impose the same duty on the NHS Commissioning Board.)

**This would substantially fetter the Secretary of State**, impose a much higher legal test of the necessity of an action than currently, and increase the freedom of the NHS Commissioning Board, CCGs, and providers. It would restrict the content of the standing rules (Clause 17: s. 6E) and of the mandate (Clause 20: s.13A), which would be the most significant ministerial powers remaining were the Secretary of State's duty to provide health services to be abolished under Clauses 1 and 10.

Clause 4 could also limit the minister's power to extend coverage of people and services for whom CCGs are responsible (regulations under Clause 10(3): s. 3(1B)) or require the Secretary of State to exercise the power to exclude people from CCG responsibility, and thus from the health service (regulations under Clause 10(3): s. 3(1D)).

None of the tabled amendments seek to disapply the Clause to key powers such as the making of the standing rules, the mandate, and people for whom CCGs will and will not have responsibility. Nor do they seek to reverse the duty from one of positively acting to one of refraining from certain acts. Rather, they propose some very minor word changes which do not go to the heart of the Clause's effect.

**We recommend that peers should support the Liberal Democrat / Labour / cross bench notice of intention to oppose the Question that Clause 4 stand part of the Bill.**

**Clause 6, and Schedule 1 (Amendments 48 - 59)**

Clause 6 establishes the NHS Commissioning Board as an independent body corporate with responsibility for holding CCGs to account. Schedule 1 provides that the Board is not to be regarded as a servant or agent of the Crown, and that its property is not to be regarded as property of the Crown. If the Board is not a servant or agent of the Crown and does not have the key duties of the Secretary of State, then the link between the Secretary of State and the NHS is severed.

The creation of a body independent of the Secretary of State to hold health service commissioners to account is inconsistent with the current duty of the Secretary of State to provide health services throughout England and drives a coach and horses through parliamentary accountability for around £100 billion of annual public expenditure. **None of the tabled amendments deals adequately with this inconsistency or the constitutional issues.**

**We recommend that this Clause is revisited in the light of resolution of Clause 1 and the constitutional issues.**

**Clause 7 (Amendments 59A - 60A)**

Clause 7 provides for the establishment of CCGs, with the function of arranging for the provision of services for the purpose of the health service in England.

If, however, Clauses 1 and 10 were to be enacted as they stand, the link between the duty to promote a comprehensive health service and the duty to provide health services throughout England would be severed.

Amendment 60A appears to address this issue, by declaring that CCGs have the function of safeguarding the comprehensive provision of NHS services. It does not, however, go as far as it could in seeking to restore the link.

The NHS Commissioning Board would have the duty to promote a comprehensive health service concurrently with the Secretary of State (Clause 6), and **we recommend that an amendment to Clause 7 should be tabled to give CCGs the duty to promote a comprehensive health service to all persons in their geographic area.** (Amendment 59A would go some way to basing CCG responsibility on contiguous geographical areas, based on local authorities, but is limited in its application.)

*Clause 10 is also particularly relevant to understanding the differences between CCGs and PCTs. These issues, and questions of clarification, have been raised in Briefing 1.*

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