

Health & Social Care Bill 2011 House of Lords report stage

Briefing note 14

Clauses 1, 4, 12 and Schedule 2: the duty to provide, the hands-off clause, GP commissioning, and the red lines

Introduction and summary

By 3rd February 2012, 239 amendments had been tabled to the Bill to be moved on report. Of these, 165 (mainly government) amendments were tabled on 1st February 2012.

The briefing covers amendments relevant to the fundamental structural changes contained in the Bill, specifically the transfer of powers to clinical commissioning groups (CCGs) and other commissioners in place of the current delegation of powers to primary care trusts (PCTs). In it we show that:

- **the amendment to Clause 1 would not restore the duty to provide health services or to secure provision, which in association with section 3 of the National Health Service Act 2006 is the duty that underpins the current structure of the NHS;**
- **amendments to Clause 4 would still require the Secretary of State to accept the principle of autonomy;**
- **amendments to Clause 12 would not achieve the red line of CCGs, operating on behalf of the Secretary of State, having to make sure that comprehensive and equitable health care is available for everyone and being responsible for all residents living in single geographically defined areas that are contiguous, without being able to pick and choose patients;¹**
- **amendments to Clauses 24 and 25 aimed at universal coverage are oblique and messy, do not go very far, and do not address the problem of service and patient coverage at source; and**
- **amendments to Schedule 2 leave unchanged the legal basis for private companies and law and accounting firms to commission services instead of the Secretary of State.**

¹ Briefing Note 10, 'Red Lines for Peers on the NHS Bill', available here: http://www.allysonpollock.co.uk/administrator/components/com_article/attach/2012-01-09/20120109-AP_2012_Pollock_HouseOfLordsBriefing10_C1412_09Jan12.pdf

The government's continued insistence on its structural changes and its failure to provide an adequate account of why they are necessary² confirms concerns that the policy rationale has not been fully disclosed.

The government says its changes are "vital".² But this is only the case if the object is to create a system that permits alternative funding sources for services currently provided free as part of the NHS.

The heart of the policy behind the Bill to abolish the model of tax-financed universal health care on which the NHS is based is not affected by these amendments.

We therefore recommend that:

- **the amendment to Clause 1 tabled by Baroness Thornton to retain the duty to provide or secure provision in accordance with the Act is supported;**
- **the amendment to leave out Clause 4, tabled by Baroness Thornton, should be supported; and**
- **the amendments tabled by Baroness Thornton to leave out Clause 12, and by Lord Hunt of Kings Heath, Baroness Thornton, Baroness Wheeler and Lord Beecham to empower the Secretary of State to give directions to CCGs and the NHS Commissioning Board, should be supported.**

Clause 1

An amendment to Clause 1 was tabled on 30th January 2012 by Baroness Jay of Paddington, Lord Patel, Lord Mackay of Clashfern and Baroness Williams of Crosby as follows:

[In substitution for the amendments printed on sheet HL Bill 119(a)]

Page 2, line 9, at end insert—

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

This amendment is in the form proposed by the Constitution Committee in its follow-up report on the Health and Social Care Bill published on 14th December 2011. In the briefing published on 1st February 2012 by the Department of Health

² Earl Howe to Baroness Jay of Paddington, 10 October 2011. Health and Social Care Bill: 18th Report of Session 2010-12. Earl Howe asserts both that "changing the 2006 Act is vital" (paragraph 25) and that "In practice, the Bill will change little" (paragraph 8).

alongside the 137 amendments tabled by the government for report stage,³ the government states that it supports the amendment tabled by Baroness Jay (which we assume is the one referred to above).

As we stated in Briefing Note 11,⁴ this amendment would be an improvement on the amendment previously tabled by Lord Mackay of Clashfern, in that it would replace 'ultimate' with 'ministerial', and does not include the focus on intervention powers. It would make it more difficult, and probably impossible, for the Secretary of State to shake off all political responsibility for the health service in England.

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

From a legal point of view and on grounds of political effectiveness, we have concerns about the Committee's reasoning which has led to its recommending only a confirmatory declaration of political reality rather than a legal duty. These are set out in Briefing Note 11.

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

An amendment tabled by Baroness Thornton on 19th January 2012 would retain the duty to provide or secure provision in accordance with the Act, and we recommend that that is supported. Otherwise, the red line requiring the Secretary of State to have the duty to secure provision of comprehensive and equitable health care for the whole of the population of England, taking action whenever there are problems, would not be met.

Clauses 4 and 22 (s.13F)

An amendment to Clause 4 – the hands-off Clause - was also tabled by the same peers on the same day, as follows:

Page 3, leave out lines 4 to 6 and insert—

³ The briefing and the amendments are available from here:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132469

⁴ http://www.allysonpollock.co.uk/administrator/components/com_article/attach/2012-01-09/20120109-AP_2012_Pollock_HouseOfLordsBriefing11_C1412_09Jan12.pdf

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

This amendment is also in the form proposed by the Constitution Committee in its follow-up report, and replicates an amendment tabled in identical terms on 22nd December 2011 by Baroness Jay, Lord Patel and Baroness Thornton.

On 1st February 2012, the government tabled its own two amendments to Clause 4, as follows:

Page 3, line 5, leave out from “must” to end of line 6 and insert “have regard to the desirability of securing, so far as consistent with the interests of the health service—”

Page 3, line 11, at end insert—

“() If, in the case of any exercise of functions, the Secretary of State considers that there is a conflict between the matters mentioned in subsection (1) and the discharge by the Secretary of State of the duties under section 1, the Secretary of State must give priority to the duties under that section.”

The government’s amendments are in the form proposed by Earl Howe in his letter to peers dated 12th January 2012, which we covered in Briefing Note 12.⁵

The amendment to Clause 4 tabled by Baroness Jay *et al.*, and those tabled by the government, would remove one of main concerns about the hands-off clauses: the duties in Clause 1 (as presently formulated) could not be superseded and would take precedence. However, both sets of amendments retain the principle that autonomy is desirable, would require the Secretary of State to accept that principle, and he or she would be able to give considerable weight to it if so minded.

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

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

⁵ http://www.allysonpollock.co.uk/administrator/components/com_article/attach/2012-01-17/Pollock_HouseOfLords_HSCB_Briefing12_HoweLetter_17Jan12.pdf

- professional registration and licensing, for example when making regulations under the Medical Act 1983, to the extent that these relate to the health service.

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

In addition, commercial providers of health care would continue to have a basis for judicial review of what would become the highest-level NHS decisions, such as the content of the standing rules and the mandate. Commercial providers might also have a basis for seeking EU law and WTO trade law protections, from whose legally-mandated 'necessity tests' the concept of 'unnecessary burdens' appears to be derived.

We recommend that the amendment to leave out Clause 4, tabled by Baroness Thornton on 22nd December 2011, should be supported. Otherwise a new and still significant constraint will be placed on the Secretary of State inhibiting him or her from taking action whenever there are problems.

Similar amendments have been tabled by the same peers and by the government to Clause 22: new s.13F which is the equivalent provision in relation to the NHS Commissioning Board. For some reason that we are unaware, the amendment tabled by the peers does not make clear that the Board's hands-off duty would be subject to its duty to promote a comprehensive health service concurrently with the Secretary of State.

We also recommend that the amendment to leave out Clause 22: section 13F, tabled by Baroness Thornton on 22nd December 2011, should also be supported.

Clause 12

An amendment to Clause 12 was also tabled on 30th January 2012 by Baroness Jay of Paddington, Lord Patel, Lord Mackay of Clashfern and Baroness Williams of Crosby, again in line with the Constitution Committee's follow-up report, as follows:

Page 6, line 38, at end insert—

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

The government has also tabled an amendment to Clause 12 which was proposed by Earl Howe in his letter of 9th January 2012:

Page 7, line 17, at end insert—

“() After subsection (1E) insert—

“(1F) In exercising its functions under this section and section 3A, a clinical commissioning group must act consistently with—

(a) the discharge by the Secretary of State and the Board of their duty under section 1(1) (duty to promote a comprehensive health service), and

(b) the objectives and requirements for the time being specified in the mandate published under section 13A.”

The peers' amendment would go some way to repairing the legal damage caused by decoupling the duty to promote from the duty to provide. The government's proposed additional duty to act consistently with the mandate would also go some way to repairing the broken link between a minister or a Health Select Committee and the commissioning of services to patients. But because those services would be delivered by commercial providers under contracts, any such repair would be of limited utility.

Neither amendment, however, would put CCGs under a duty to promote a comprehensive service, and it is difficult to see how meaningful or effective these would be because no CCG would have an England-wide remit.

Clause 12 is central to the policy behind the Bill, alongside Clause 1.⁶ It would remove the Secretary of State's duty in section 3 of the National Health Service Act 2006 to provide key listed health services to meet all reasonable requirements throughout England, and would remove area-based responsibilities.

This is the duty which guarantees to people in England comprehensive national health coverage, and which devolves down to area-based PCTs. Some specified services have to be provided for the benefit of everybody, PCTs have to get everybody onto GP lists, and a stable denominator for needs assessment, and resource allocation and monitoring of inequalities is ensured. These characteristics have stood the test of time.

In its place, Clause 12 would give us scores of CCGs, bodies responsible for persons on lists and other persons usually resident in unclear and potentially non-contiguous areas. No specified services would clearly have to be provided for everybody, except arguably emergency care. No body would have to get everybody onto GP lists. There would be a power to exclude persons from the health service. GP lists result in inherently problematic denominators for resource allocation, and needs assessment and monitoring of inequalities.

⁶ Briefing Note 6 considered Clause 12 in some detail, when it was Clause 10:

http://www.allysonpollock.co.uk/administrator/components/com_article/attach/2011-11-11/AP_2011_Pollock_HouseOfLordsBriefing6C10_11Nov11.pdf

These amendments would not achieve the red line of CCGs, operating on behalf of the Secretary of State, having to make sure that comprehensive and equitable health care is available for everyone and being responsible for all residents living in single geographically defined areas that are contiguous, without being able to pick and choose patients.

We therefore recommend that the amendments tabled on 22nd December 2011

- **by Baroness Thornton to leave out Clause 12; and**
- **by Lord Hunt of Kings Heath, Baroness Thornton, Baroness Wheeler and Lord Beecham to empower the Secretary of State to give directions to CCGs and the NHS Commissioning Board,**

should be supported.

One aspect of this red line has been addressed by amendments to Clause 24 and 25 tabled on 31st January 2012 by Baroness Williams of Crosby, Lord Marks of Henley-on-Thames, Baroness Baker and Lord Clement-Jones. Their amendments would insert a new sub-section into new section 14A in the following terms:

“The Board must exercise its functions under this Chapter so as to ensure that every person resident in England is required to be provided with services by a clinical commissioning group.”

and would insert a new s.14PA as follows:

*“14PA Duty to provide services by the clinical commissioning groups
Each clinical commissioning group must exercise its functions so as to ensure that every person resident in its area is provided with services by the clinical commissioning groups.”*

These amendments appear to be an oblique attempt to plug the gap caused by Clause 12 removing the duty of the Secretary of State to provide throughout England and failing to give any other body a provision duty with national coverage.

They are also messy amendments, however, which do not go very far: CCGs would arrange provision of services, not provide them; and provision of any services would appear to constitute compliance. More importantly, the problems with CCG service and patient coverage needs to be dealt with in the Clause that causes those problems, which is Clause 12. These amendments would leave Clause 12 intact, and so do not address the fundamental structural problems identified above which flow from removing the government’s duty to provide and the shift from area-based to list-based responsibilities.

Schedule 2

Amendments were tabled by the government on 1st February 2012 to require provisions on conflict of interest to be included in CCG constitutions that would apply to members of committees and sub-committees of CCGs (such as management consultants, lawyers and accountants), as well as to CCG members and employees. (see Schedule 2: new Schedule 1A, paragraphs 4(2) and 7(2)).

The government's briefing that accompanied introduction of the amendments states (paragraph 49) that these have been introduced to address concerns expressed by Baroness Barker during the Committee stage on 14th November 2011 when she 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 subcommittees. My amendment attempts to remove that potential conflict of interest."

The amendment tabled by the government, however, does not deal with Baroness Barker's key point about the unacceptability of commissioning support organisations, such as management consultants and accountants, having any role whatever in CCG decision-making. This is because it leaves in tact paragraph 3(3) of Schedule 1A, which allows such organisations or their representatives sitting on committees to exercise the functions of CCGs.

Clause 24 and Schedule 2 would set the legal basis for private companies, law and accounting firms to commission services instead of the Secretary of State providing them, and these amendments do not affect that basis. The core policy intention on commissioning therefore remains in place, and the red line of CCG statutory functions having to be carried out by NHS staff would not be achieved.

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