IN THE MATTER OF THE HEALTH AND SOCIAL CARE BILL 2011

AND IN THE MATTER OF THE DUTY OF THE SECRETARY OF STATE FOR HEALTH TO PROVIDE A NATIONAL HEALTH SERVICE

EXECUTIVE SUMMARY OF OPINION

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1. It is clear that the drafters of the Health and Social Care Bill intend that the functions of the Secretary of State in relation to the NHS in England are to be greatly curtailed. The most striking example of this is the loss of the duty to provide services pursuant to section 3 of the NHS Act 2006, which is currently placed on the Secretary of State. This will be transferred to the commissioning consortia, and reformulated accordingly. In real terms this means that, effectively, the government will be less accountable in legal terms for the services that the NHS provides.

2. Currently, the duty in section 3(1) has been delegated to Primary Care Trusts (PCTs). However, this is pursuant to statutory powers of delegation (for example under section 7 of the NHS Act 2006), and these powers can be exercised in a different way, or not exercised at all, if the Secretary of State so chooses.

3. Effectively, the duty to provide a **national** health service would be lost if the Bill becomes law. It would be replaced by a duty on an unknown number of commissioning consortia with only a duty to make or arrange provision for that section of the population for which it is responsible. Although some people will see this as a good thing, it is effectively fragmenting a service that currently has the advantage of national oversight and control, and which is politically accountable via the ballot box to the electorate.

4. As set out in case law relating to the 2006 Act and its predecessor, the NHS Act 1977, when the Secretary of State or his delegates carries out the section 3(1) duty to provide services, the duty to promote a comprehensive health service in England, under section 1(1), has to be borne in mind at all times. There will be severance between the two duties, if the Bill becomes law, as the bodies that will have the duty to arrange services pursuant to section 3(1) (the commissioning consortia) do not have a duty to promote a comprehensive health service.

5. The Secretary of State's functions are reduced to a series of powers and duties related to provision, but not including provision itself, except in limited circumstances. The exercise of all these functions, however, is subject to an autonomy or "hands off" clause. This provides that in exercising his functions the Secretary of State must, so far as is consistent with the interests of the health service, act with a view to securing that the consortia, the NHS Commissioning Board and others are free to exercise their functions

and to provide services in the manner that they consider most appropriate, and free from unnecessary burdens. This kind of wording means that the Secretary of State only has the power to act when steps to be taken are "really needed" or "essential", rather than because the Secretary of State thinks something is desirable or appropriate.

6. A court would expect the Secretary of State to demonstrate why no other course of action could be followed, which is a high test to meet. If the Secretary of State attempts to use his or her powers to impose requirements on commissioning consortia, for example, then there could well be a judicial review challenge from a consortium which opposed the requirements on the basis that they infringed the principle of autonomy and could not be justified as necessary or essential. This approach replaces the, more or less, unfettered power that the Secretary of State currently has to make directions, for example to PCTs.

7. Under the proposed new section 3(1)(d) and (e), it would be for individual consortia to decide what services under those subsections (services for pregnant and breast feeding women and children, and services for people suffering from illness, and aftercare and prevention) it is appropriate to be provided as part of the health service. This function is currently delegated to PCTs by the Secretary of State and so there is already room for different PCTs to reach different conclusions on what is appropriate. But the Secretary of State currently can give directions to PCTs as to the carrying out of these functions.

8. Under the Bill, this would be a lot more difficult in relation to consortia given the "hands off clause." Encouraged by the structure and clear intention of the Bill to give consortia autonomy from the Secretary of State, there is a real risk of an increase in the "postcode lottery" nature of the delivery of some services, depending on the decisions made by consortia in relation to these subsections. And the intention of the Bill, is that there will be very little that the Secretary of State can do about this in practice.

7. Legal challenges to the provision of health services in particular cases have always been difficult. The Bill does nothing to make the system more amenable to challenge in the courts, although the target of most legal actions will now be the commissioning consortia rather than PCTs.

IN THE MATTER OF THE HEALTH AND SOCIAL CARE BILL 2011

AND IN THE MATTER OF THE DUTY OF THE SECRETARY OF STATE FOR HEALTH TO PROVIDE A NATIONAL HEALTH SERVICE

OPINION

Introduction

1. I am asked to provide an Opinion by 38 Degrees as to the effect that the Health and Social Care Bill (the Bill) (as currently promulgated) would have on the key duties of the Secretary of State for Health in relation to the National Health Service (NHS) as set out in the National Health Service Act 2006 (NHS Act 2006).

2. The concern of 38 Degrees, Kath Dalmeny, Eamann Devlin, Joe Short and many others, is that the Bill will have the effect of removing from the Secretary of State's functions the overarching duties which ensure that the NHS is delivered

to the population of England, and by replacing those duties with much less comprehensive functions placed on other bodies much less able to ensure that a comprehensive health service is delivered.

3. I will begin this Opinion by analysing the existing functions in the NHS Act 2006 before explaining the changes that the Bill will make.

The NHS Act 2006

4. The NHS Act 2006 was a consolidating Act which essentially continued functions which were prominent in the NHS Act 1977. Many of the functions of course have an even longer history. Some of the case law I refer to below is based on the NHS Act 1977, but the points which are made apply also to the 2006 Act.

5. From the point of view of individual rights, it is well known and well documented that the nature of the duties as set out in s1-3 of the NHS Act are difficult to interpret in a way which gives any particular individual the right to a particular service. The duties are often described as ―target" or ―general" duties. Thus section 1 NHS Act 2006 says

> **1 Secretary of State's duty to promote health service**
> (1) The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement–
> (a) in the physical and mental health of the people of England, and
> (b) in the prevention, diagnosis and treatment of illness.
> (2) The Secretary of State must for that purpose provide or secure the provision of services in accordance with this Act.
> (3) The services so provided must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.

6. In *R v North and East Devon Health Authority, ex p Coughlan* [2001] QB 213, Lord Woolf commented, at paragraph 22 that

> It will be noted that section 1(1) does not place a duty on the Secretary of State to provide a comprehensive health service. His duty is "to continue to promote" such a service

7. Thus the ~~"p~~purpose" set out in s1(2) NHS Act 2006 for which the Secretary of State must provide or secure the provision of services, is the promotion of the comprehensive health service, rather than the delivery of such a service.

8. Section 2 of the NHS Act 2006 actually adds very little other than empower (rather than impose a duty upon) the Secretary of State to provide services or do anything else he considers appropriate to discharge his duty. This includes issuing guidance that trusts must have regard to; : see R v North Derbyshire Health Authority, Ex p Fisher (1997) 38 BMLR 76 , 80–81, 89–90, per Dyson J.

9. Section 3(1) is the main duty for the provision of health services. The duty is again described in general terms (rather than in terms of providing services to individuals who have particular needs), but it is, at this point in the statutory framework at least, very much a function which rests with the Secretary of State. It also lists the services that must be provided. Thus, section 3 reads as follows:-

> **3 Secretary of State's duty as to provision of certain services**
> (1) The Secretary of State must provide throughout England, to such extent as he considers necessary to meet all reasonable requirements–
> (a) hospital accommodation,
> (b) other accommodation for the purpose of any service provided under this Act,
> (c) medical, dental, ophthalmic, nursing and ambulance services,
> (d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service,

(e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service,
(f) such other services or facilities as are required for the diagnosis and treatment of illness.

10. In the *Couglan* case which I have cited above, Lord Woolf had the following to say about s3

> 23 It will be observed that the Secretary of State's section 3 duty is subject to two different qualifications. First of all there is the initial qualification that his obligation is limited to providing the services identified to the extent that he considers that they are *necessary* to meet all reasonable requirements. In addition, in the case of the facilities referred to in (d) and (e), there is a qualification in that he has to consider whether they are appropriate to be provided "as part of the health service"….
>
> 24 The first qualification placed on the duty contained in section 3 makes it clear that there is scope for the Secretary of State to exercise a degree of judgment as to the circumstances in which he will provide the services…..In certain circumstances he can exercise his judgment and legitimately decline to provide….services.
>
> **25 When exercising his judgment he has to bear in mind the comprehensive service which he is under a duty to promote as set out in section 1. However, as long as he pays due regard to that duty, the fact that the service will not be comprehensive does not mean that he is necessarily contravening either section 1 or section 3. The truth is that, while he has the duty to continue to promote a comprehensive free health service and he must never, in making a decision under section 3, disregard that duty**, a comprehensive health service may never, for human, financial and other resource reasons, be achievable. Recent history has demonstrated that the pace of developments as to what is possible by way of medical treatment, coupled with the ever increasing expectations of the public, mean that the

resources of the NHS are and are likely to continue, at least in the foreseeable future, to be insufficient to meet demand.

11. However, in *R (Booker) v NHS Oldham* [2010] EWHC 2593 (Admin) another judge having cited the *Coughlan* case, explained the s3 duty in a slightly different way when he said

> 23….Section 3 creates an enforceable duty to provide care facilities for those who are ill or have suffered illness subject to the qualification that the secretary of state or the PCT as his delegate need not provide such services where he or it does not consider they are reasonably required or would be necessary to meet a reasonable requirement

12. The *Booker* case was a case where it was possible to enforce the duty: the PCT had argued, unsuccessfully, that ongoing health services to quadriplegic woman were not a ~~"r~~easonable requirement" because she was indemnified for the purposes of paying for services privately by an insurance company.

13. The qualification added, of course, very much dilutes the enforceability of the duty described by the judge, but nevertheless the duty lies directly with the Secretary of State, or with a body (see below) that the Secretary of State has chosen to delegate it to.. Thus, section 7 NHS Act 2006 reads:-

> **7 Distribution of health service functions**
> (1) The Secretary of State may direct a Strategic Health Authority, a Primary Care Trust or a Special Health Authority to exercise any of his functions relating to the health service which are specified in the directions.
> (2) The Secretary of State may direct a Special Health Authority to exercise any functions of a Strategic Health Authority or a Primary Care Trust which are specified in the directions.
> (3) The functions which may be specified in directions include functions under enactments relating to mental health and care homes.

14. The duties set out in Sections 1 and 3 of the 2006 Act are executed on behalf of the Secretary of State by Primary Care Trusts pursuant to Section 7 of the 2006 Act and the NHS (Functions Of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements (England)) Regulations 2002 . Thus, in practice, it is the PCTs which decide which services are prioritised in each local area, on behalf of the Secretary of State. How this works was described *R v North West Lancashire Health Authority ex p A* [2000] 1WLR 977 where Auld LJ said at p 991D:

> –As illustrated in the *Cambridge Health Authority* case [1999] 1 WLR 898 and *Coughlan's* case [2001] QB 213 , it is an unhappy but unavoidable feature of state funded health care that regional health authorities have to establish certain priorities in funding different treatments from their finite resources. It is natural that each authority, in establishing its own priorities, will give greater priority to life-threatening and other grave illnesses than to others obviously less demanding of medical intervention. The precise allocation and weighting of priorities is clearly a matter of judgment for each authority, keeping well in mind its statutory obligations to meet the reasonable requirements of all those within its area for which it is responsible …
>
> However, in establishing priorities — comparing the respective needs of patients suffering from different illnesses and determining the respective strengths of their claims to treatment — it is vital for an authority: (1) accurately to assess the nature and seriousness of each type of illness; (2) to determine the effectiveness of various forms of treatment for it; and (3) to give proper effect to that assessment and that determination in the formulation and individual application of its policy."

15. However, the Secretary of State retains direction making powers in s8 of the NHS Act 2006. These directions can be about any aspect of the delivery of services or the functions which have been delegated to these bodies by the Secretary of State. For example, the Secretary of State can direct which

treatments approved by NICE (see below) should be funded. There is no statutory fetter on how or when the Secretary of State can use this power.

> **8 Secretary of State's directions to health service bodies**
> (1) The Secretary of State may give directions to any of the bodies mentioned in subsection (2) about its exercise of any functions.
> (2) The bodies are–
> (a) Strategic Health Authorities,
> (b) Primary Care Trusts,
> (c) NHS trusts, and
> (d) Special Health Authorities.

16. In summary then, these provisions contain an aspirational target duty in section 1 of the NHS Act 2006 to promote a comprehensive NHS, which the Secretary of State must always bear in mind when fulfilling the duty in s3 NHS Act 2006. That duty itself is also a general or target duty (these terms are often used interchangeably) rather than an individual duty, as it is couched in terms that mean that it is the Secretary of State's opinion as to what is necessary to meet ~~"r~~easonable requirements" for health services as a whole. In certain circumstances, though, a service user may be able to enforce at least the continuation of a service where, for example, an unlawful factor has been taken into account in deciding whether there is a reasonable requirement for the service. Such cases are, however, rare and the majority of the case law in this area consists of cases where judicial review claims have been unsuccessful.

17. In practice, the Secretary of State delegates his or her functions to PCTs, but this is something for which there is a power and not a duty, and so the Secretary of State retains overall control of the health service, which is reinforced by the additional power to give directions to PCTs and other bodies.

The Health and Social Care Bill 2011

18. Having set out the essential features of the duty to provide in the NHS Act 2006, and some of the case law which has interpreted those functions, I now turn the changes which are proposed in the Bill.

19. The Bill ended its re-committal in the Public Bill Committee on 14 July 2011, and what follows discusses the Bill as it now stands after that date. The Bill amends the NHS Act 2006 rather than repealing it, although some sections are replaced completely.

20. Thus, section 1 NHS Act 2006 will reads as follows if it is passed in its current form as proposed in the Bill:-

> **1 Secretary of State's duty to promote comprehensive health service**
> (1) The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—
>
> (a) in the physical and mental health of the people of England, and
>
> (b) in the prevention, diagnosis and treatment of illness.
>
> (2) For that purpose, the Secretary of State must exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act.
>
> (3) The services provided as part of the health service in England must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed."

21. Thus, there is no change at all in section 1(1), but as explained above the only duty her on the Secretary of State is to "promote" the comprehensive health service, rather than to provide for it, secure its provision, or make arrangements for such a service.

22. However, section 1(2) would have two changes from the NHS Act 2006 as it is currently enacted. Firstly, for the purpose of promoting a comprehensive health service, the duty is now only to ~~"s~~ecure that services are provided in accordance with this Act" rather than ~~"p~~rovide or secure the provision of services". I think this reflects the very important aspect of the Bill that may well have escaped public notice, and this is the intention clearly contained in the Bill that the Secretary of State is no longer to be involved in the direct provision of services. There is no secret about this. It is made express first by paragraph 7 of the Explanatory Notes to the Bill which states that

> 7. Part 1 sets out a framework in which functions in relation to the health service are conferred directly on the organisations responsible for exercising them and the Secretary of State retains only those controls necessary to discharge core functions. The Secretary of State will continue to be under a duty to promote the comprehensive health service, but the focus of the role of the Secretary of State will shift to public health, and there will be a responsibility (with local authorities) to protect and improve public health.

23. And by paragraph 66 of the Explanatory Notes which states

> 66. Currently, the Secretary of State is directly responsible for providing or securing the provision of all health services as set out in the NHS Act, a function which is largely delegated to Strategic Health Authorities and Primary Care Trusts (PCTs) under section 7 of the NHS Act. However, the new commissioning structure proposed by the Bill means that this would no longer be the case. Instead, the Secretary of State would have the duties described above. Direct responsibility for securing the provision of these services would be conferred on the Board and commissioning consortia by new section 1D of the NHS Act, inserted by clause 5 and new section 1E, inserted by clause 6 of the Bill.

24. The government recommends this structure on the basis that it will prevent political interference. However, another way of looking at it of course is that it removes political accountability, the only real control that ordinary voters can have on the way the NHS is delivered.

25. This can be compared with the position in relation to public health services for which as paragraph 67 of the Explanatory Notes states the –Secretary of State would however remain directly responsible" .

26. The second change is that the duty is now a duty to exercising the functions conferred by the Act as it will be amended. So, if the Bill were to confer no functions on the Secretary of State then this particular duty would have no teeth at all. More specifically, as explained below, the Secretary of State is to lose the main duty to provide services currently set out in s3 NHS Act 2006 (see above) and so the duty to promote a comprehensive health service will lose the most important function by which this is to be achieved (see further below).

27. I do not think that clause 1(3) has any substantive changes to s1(3) of the NHS Act 2006.

28. There are then a series of clause which add sections to the NHS Act 2006 after section 1. Thus, there will be a new section 1A under which the Secretary of State will have a duty to exercise functions so as to secure continuous improvement in the quality of services in relation to both illness and public health. There is a similar duty placed on the National Commissioning Board by what would be a new s13D to the NHS Act 2006. The Secretary of State and the NHS Commissioning Board are to be required to have regard to the quality standards that will be commissioned by them from the National Institute for Health and Care Excellence (NICE). NICE itself, which is currently constituted as a Special Health Authority by subordinate legislation, would become a body set up by the new statute (see Part 8 of the Bill) with members appointed by the

Secretary of State. (I do not think that this change of status will change the nature of NICE). The exact relationship between NICE and commissioning consortia appears to be something which will be developed through regulation making powers which are set out in the Bill. How this will work is presently uncertain as the the regulations have not yet been drafted.[1]

29. Section 1B is a duty on the Secretary of State to have regard to the need to reduce inequality which I doubt adds anything to the public sector equality duty to be found in s149 of the Equality Act 2010.

30. However, what is proposed to be a new section 1C of the NHS Act 2006, does seem to me to be of importance. This would read

> ~~1~~C Duty as to promoting autonomy
>
> In exercising functions in relation to the health service, the Secretary of tate must, so far as is consistent with the interests of the health service, act with a view to securing—
>
> (a) that any other person exercising functions in relation to the health service or providing services for its purposes is free to exercise those functions or provide those services in the manner that it considers most appropriate, and
>
> (b) that unnecessary burdens are not imposed on any such person."

31. Therefore, so long as the Secretary of State does not think that it is inconsistent with the interests of the NHS, s/he must positively act to allow any other person exercising health service functions to do so in the way that that person thinks appropriate. This is what I described in conference as a ~~h~~ands off" clause. Although the Secretary of State keeps some form of oversight, it is the other persons and bodies delivering the health service whose views are important as to

[1] A criticism that is sometimes made of statutes that rely on regulations to be drafted later the Secretary of State is that it is not possible from the statute itself to see the detail of how a particular system will work.

how those services are to be delivered. This is further explained in the Explanatory Notes as follows

> 74. This clause seeks to establish an overarching principle that the Secretary of State should act with a view to promoting autonomy in the health service. It identifies two constituent elements of autonomy: freedom for bodies/persons in the health service (such as commissioning consortia or Monitor) to exercise their functions in a manner they consider most appropriate (1C(a)), and not imposing unnecessary burdens from those bodies/persons (1C(b)). The clause requires the Secretary of State to act with a view to securing these aspects of autonomy in exercising his functions in relation to the health service, so far as is consistent with the interests of the health service.
>
> 75. This duty would therefore require the Secretary of State, when considering whether to place requirements on the NHS, to make a judgement as to whether these were in the interests of the health service. If challenged, the Secretary of State would have to be able to justify why these requirements were necessary.

32. This kind of wording is often used in statutes to mean that a public body only has the power to act when steps to be taken are ~~"r~~eally needed" or ~~"e~~ssential", rather than because the public body thinks something is desirable or appropriate. A court looking at this kind of wording would expect the public body (the Secretary of State in this case) to demonstrate why no other course of action could be followed, which is a high test to meet.

33. I think the reference to potential challenges at the end of this note is significant and reflects the limit of the Secretary of State's powers. If the Secretary of State attempts to use his or her powers to impose requirements on commissioning consortia, for example, then there could well be a judicial review challenge from a consortium which opposed the requirements on the basis that they infringed the principle of autonomy in the new section 1C and could not be justified as necessary or essential. This approach replaces the, more or less, unfettered power that the Secretary of State has to make directions currently to be found in s8 NHS Act 2006 (as explained above), with a duty not to interfere unless

essential to do so. It is also noteworthy that the same ~~–a~~utonomy" or ~~–h~~ands off" duty is also placed on the NHS Commissioning Board, by what would be a new s13E of the NHS Act 2006 (and it is, of course, the Board who will have closer contact with commissioning consortia than will the Secretary of State).

34. What will be s1E of the NHS Act 2006 is also important as this sets up the NHS Commissioning Board. The chair of the Board and its members are appointed by the Secretary of State. The Board will have the same promotion duty as does the Secretary of State as set out above in s1(1) above (other than in relation to the public health functions of the Secretary of State). Section 1E (3) will read

> For the purpose of discharging that duty, the Board—
>
> (a) has the function of arranging for the provision of services for the purposes of the health service in England in accordance with this Act, and
>
> (b) must exercise the functions conferred on it by this Act in relation to commissioning consortia so as to secure that services are provided for those purposes in accordance with this Act.
>
> (4) Schedule A1 makes further provision about the Board.

35. So it is the Board that has the function of ~~–a~~rranging for the provision" of services rather than the Secretary of State. The members of the Board, however, will be appointed by the Secretary of State. But the duty set out in the new s1E(3) does not set out anything about the *extent* to which services are to provided in the same way that s3(1) currently does in relation to the Secretary of State. Thus, there is no duty on the Board to provide (or event to arrange for provision of) services to meet what, in its view, are necessary to meet *all reasonable requirements*. Only the commissioning consortia will have this duty.

36. It is also noteworthy that the new ~~–c~~ommissioning consortia" will also have ~~–t~~he function of arranging for the provision of services for the purposes of the health

service in England in accordance with this Act" by way of what would be s1F of the amended NHS Act 2006.

37. But that this is not sufficient to replicate the duty in s3(1) NHS Act 2006 is clear because it is now these consortia, rather than the Secretary of State, upon which is imposed the important s3 duty which, as currently formulated, is set out above. Section 3(1) NHS Act 2006 as amended would read as follows (with the important changes in bold) :-

> **3 Duties of consortia as to commissioning certain health services**
>
> **(1)– A commissioning consortium must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.**
> (a) hospital accommodation,
> (b) other accommodation for the purpose of any service provided under this Act,
> (c) medical, dental, ophthalmic, nursing and ambulance services,
> (d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as **the consortium** considers are appropriate as part of the health service,
> (e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as **the consortium** considers are appropriate as part of the health service,
> (f) such other services or facilities as are required for the diagnosis and treatment of illness.

38. Thus, on the face of it the important duty to provide as explained above in the case of *Coughlan* and *Booker* has been transferred from the Secretary of State to the commissioning consortia. The law at present means that the Secretary of State has the power to direct that this function is carried out by PCTs or SHAs (see section 7), but the Secretary of State would always have the option to bring

the function back ~~–in~~ house" and can of course give directions to these bodies pursuant to section 8. The difference now is that the primary duty will lie with the commissioning consortia, in circumstances where the Secretary of State is also told to encourage commissioning consortia to decide for themselves the most appropriate way to do so.

39. There is not room in this advice to set out the rules for commissioning consortia, but typically they will consist of groups of local GPs who have joined to provide the services which are currently provided by PCTs and other health bodies. It is the responsibility of the Board to ensure that consortia do, in fact, cover the whole of England: see the new proposed section 14A. And a consortium will be responsible for any person in its area who is not provided with services by a member of any consortium. Nevertheless there are concerns (beyond the scope of this Opinion) that consortia will be able to cherry pick patients in a way that is not possible under the current system.

40. It is noteworthy that the Explanatory Notes do not fully spell out this change. So, paragraphs 117 and 119 explain that commissioning consortia will be the ~~–a~~ppropriate commissioner" under the amended Act, but do not explain that the duty has been removed from the Secretary of State.

> **Clauses 9 and 10 - Duties and powers of consortia as to commissioning certain health services**
>
> 117. This clause amends section 3 of the NHS Act to provide for the duties of commissioning consortia (consortia) in relation to commissioning certain health services.
>
> 119. Commissioning consortia will be the appropriate commissioner under the Act unless there is a duty on the Board to commission that service. Subsections (1) and (2) amend section 3 of the NHS Act to provide that consortia must arrange for the provision of the services and facilities in section 3(1) of the NHS Act to such extent as they consider necessary to meet the reasonable requirements of the persons for whom they have responsibility.

41. The government has recently disavowed any intention of diluting the Secretary of State's role, in its response, dated 20 June 2011, to the NHS Future Forum report. Thus, the response states

> 2.8. Our policy is that the Secretary of State will be responsible – as now – for promoting a comprehensive health service. The wording of section 1(1) of the 2006 NHS Act will remain unchanged in legislation, as it has since the founding NHS Act of 1946. We will amend the Bill to make this clear.
> 2.9. We will also make clear that the Secretary of State will retain ultimate accountability for securing the provision of services, though rather than securing services directly, the Secretary of State will be exercising his duty in future through his relationship with the NHS bodies to be established through the Bill, for example the NHS Commissioning Board by way of the ~~m~~mandate".
> 2.10. We will make clear that Ministers are responsible, not for direct operational management, but for overseeing and holding to account the national bodies – in particular, the NHS Commissioning Board and the regulators – backed by extensive powers of intervention in the event of significant failure.

42. But what this response does not make clear, is that the s3(1) duty has been lost by the Secretary of State and it has not been moved to the NHS Commissioning Board. Instead it has been moved to the commissioning consortia.

43. The Secretary of State does retain the power to make regulations which mean that it is the Board rather than the commissioning consortia who provide a particular service: see the proposed new s3B. But this power only relates to a limited group of services[2], and the Bill is worded in such a way that this is

[2] (a) dental services of a prescribed description;

(b) services or facilities for members of the armed forces or their families;

(c) services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description;

(d) such other services or facilities as may be prescribed.

clearly seen as a step that would be unusual, and not apply to the provision of mainstream services.

44. The next change worth mentioning is to the nature of the duty itself. The current s3(1) fixes the Secretary of State with the duty to ~~"p~~provide" services ~~"h~~e considers necessary to meet all reasonable requirements". Not only would the new section 3(1) transfer that duty to commissioning consortia, but the duty now is to ~~"a~~rrange for the provision" of services (and not for everyone but only those for whom each consortium is responsible). It may be that this change of wording will not make too much difference: the ~~"a~~rrange for permission" formula is used already in social care statutes like the National Assistance Act 1948 (care homes) and the Chronically Sick and Disabled Persons Act 1970 (domiciliary care), and simply indicates that the public body can, for example, contract with private or voluntary sector providers for services. But the loss of an actual duty to provide (rather than to arrange for the provision) may be seen as hugely symbolic of the dilution of the powers of the Secretary of State as set out in the Bill.

45. Finally, it is important to note that, pursuant to what would be the new s3(1)(d) and (e), it will be for individual consortia to decide what services under those subsections (services for pregnant and breast feeding women and children, and services for people suffering from illness, and aftercare) it is appropriate to be provided as part of the health service.

46. This function is currently delegated to PCTs by the Secretary of State and so there is already room for different PCTs to reach different conclusions on what is appropriate. But as set out above the Secretary of State currently can give directions to PCTs as to the carrying out of these functions, but under the amended Act as proposed by the Bill, this will be a lot more difficult in relation to consortia given the ~~"h~~ands off clause" set out above. Encouraged by the

structure and clear intention of the Bill to give consortia autonomy from the Secretary of State, there is a real risk of an increase in the postcode lottery nature of the delivery of some services, depending on the decisions made by consortia in relation to these subsections. And the intention of the Bill, it seems to me, is that there will be very little that the Secretary of State can do about this in practice, despite the duty to have regard to reducing inequalities set out in the new section 1B.

47. It should also be noted that any consortium which attempts to reduce the services which are considered as part of the health service, may well find itself coming into conflict with social services authorities. This is because by s254 and Sch 20 to the NHS Act 2006, if the services described in s3(1)(d) and (e) are not provided as part of the health service, then they will become –ecommunity care services" for which a social services authority will have the power to provide. Other than this, however, it will prove very difficult (because of the very wide nature of the power) to challenge the view of a consortium as to what is or is not to be provided as part of the health service under these subsections.

Conclusions

48. In conclusion, therefore, I comment as follows on the changes proposed in the Bill

    (a) It is clear that the drafters of the Bill intend that the functions of the Secretary of State in relation to the NHS are to greatly curtailed. The most striking example of this is the loss of the duty to provide services pursuant to section 3 NHS Act 2006, which is currently placed on the Secretary of State but which will be transferred to the commissioning consortia as explained above. In real terms this means that the

government will be less accountable for the services that the NHS provides;

(b) Although currently the s3(1) duty has been delegated to PCTs, this is further to statutory powers which can be exercised in a different way if the Secretary of State so chooses.

(c) Effectively, the duty to provide a **national** health service would be lost if the Bill becomes law, and would be replaced by a duty on an unknown number of commissioning consortia with only a duty to make or arrange provision for that section of the population for which it is responsible. Although some people will see this as a good thing, it is effectively a fragmenting of a service that currently has the advantage of national oversight and control, politically accountable via the ballot box to the electorate.

(d) As set out in case law relating to the NHS Act 2006 and its predecessor, the NHS Act 1977, when the Secretary of State or his delegates carried out the s3(1) duty to provide services, the s1(1) duty to promote a comprehensive health service in England had to borne in mind at all times.

(e) There will be severance between the two duties, if the Bill becomes law, as the bodies that will have the duty to provide services pursuant to s3(1) (the commissioning consortia) do not have a duty to promote a comprehensive health service in England.

(f) The Secretary of State's functions are reduced to series of powers of duties related to provision, but not including provision itself, except in limited circumstances as set out above (I have seen the list of functions of the Secretary of State if the Bill passes into law). And all these functions are subject to the autonomy or ~~"h~~ands off" clause as set out above which could lead to legal challenges from commissioning consortia which object to any steps proposed by the Secretary of State on the basis that they are a breach of the autonomy clause.

(g) Legal challenges to the provision of health services in particular cases has always been difficult (as explained above). The Bill does nothing to make the system more amenable to challenge in the courts, although the target of most legal actions will now be the commissioning consortia.

49. I hope I have answered the questions posed in a way which makes sense and is understandable, but if this is not the case I would be happy to revisit any aspect of this Opinion and to advise further.

STEPHEN CRAGG
Doughty Street Chambers
26 July 2011