These notes refer to the Health and Social Care Act 2012 (c.7) which received Royal Assent on 27 March 2012

HEALTH AND SOCIAL CARE ACT 2012

EXPLANATORY NOTES

COMMENTARY ON SECTIONS

Part 1 – The Health Service in England

The health service: overview

Section 1 - Secretary of State's duty to promote comprehensive health service[1]

65. This section amends section 1 of the NHS Act, which contains the Secretary of State's duty to promote a comprehensive health service designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of mental and physical illness.

66. Section 1 of the NHS Act now has four subsections. The Act introduces a new *subsection (3)* and makes changes to *subsections (1)* and *(2)*. The Act also makes a technical drafting change to subsection (4) which does not affect its meaning.

67. *Subsection (1)* retains the duty on the Secretary of State to promote a comprehensive health service. This is the core duty, dating back to the founding NHS Act of 1946, which makes the Secretary of State accountable for the health service. The Secretary of State must bear the duty in mind whenever he exercises any of his functions.

68. The Act inserts the words "physical and mental" in front of "illness" in section 1(1)(b). This change serves to emphasise that a comprehensive health service is one which addresses mental as well as physical illness.

69. This section replaces *subsection (2)* of the existing section 1 of the NHS Act (which imposes a duty on the Secretary of State, for the purposes of promoting a comprehensive health service (as set out at subsection (1)), to "provide or secure the provision of services in accordance with this Act", with a duty to "exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act". This reflects the fact that the functions of commissioning services and the provision of services will no longer be delegated by the Secretary of State, but will be directly conferred on the organisations responsible for performing them. The Secretary of State's role is to ensure that these functions are being carried out effectively; he or she retains ultimate responsibility for securing the provision of services through the exercise of his functions, such as his powers to set objectives for the NHS Commissioning Board (through the mandate to the NHS Commissioning Board under new section 13A), to oversee the effective operation of the health service and to intervene in the event of significant failure (see new section 13Z2).

70. Prior to the amendments made by this Act, the Secretary of State's duty to provide services under section 3 of the NHS Act was for the most part not fulfilled by the direct provision of services by the Secretary of State or by bodies to which he delegated

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1 ***Further information about the interpretation of these sections can be found on the Department of Health website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_129415.***

that function. This duty was instead almost entirely discharged by using the power (in section 12 of the NHS Act) to enter into arrangements with other persons or bodies to provide services - in other words by commissioning a service and not by direct provision of a service. The majority of service provision is carried out by NHS trusts and foundation trusts, which have their own statutory functions of providing services under existing legislation, or by independent providers under contract. The only services that were directly provided under the Secretary of State's duty were those that PCTs provided prior to their abolition, where the Secretary of State's function of providing services was delegated to the PCT.

71. The change made by the Act to subsection (2) of section 1 of the NHS Act largely reflects changes in the delivery of health services which have been implemented by successive governments over a period of approximately 20 years. In the past, the Secretary of State, or the health authorities to which he delegated his functions, have provided hospital or other services directly (the Secretary of State and SHAs are not providers of NHS services). However, in recent years there has been a move towards securing a commissioner/provider split in NHS services. This separation is almost complete. Once PCTs stop providing services, the Secretary of State's section 1(2) duty to provide services (which he delegates to SHAs and PCTs) would no longer be necessary. Under the new arrangements, which seek to complete the implementation of the commissioner/provider split, the Secretary of State, the NHS Commissioning Board and CCGs would not have the function of providing NHS services. The NHS Commissioning Board and CCGs would be responsible for arranging services (that is for their commissioning and not for their provision).

72. The Secretary of State and local authorities will have powers to both commission and provide public health services, under their new functions in relation to the protection of public health and health improvement.

73. New subsection (3) of the amended section 1 clarifies that the Secretary of State retains ministerial responsibility to Parliament for the provision of the health service.

74. Subsection (4) of the amended section 1 maintains the principle that health services must be free of charge, unless charges are specifically provided for in legislation. Subsection (4) is slightly amended from the NHS Act; this is a drafting change, consequential on subsection (2). The only difference in the wording is to refer to services which are “part of the health service” rather than to the services which the Secretary of State provides or secures. ‘Services which are part of the health service’ cover all services commissioned by the NHS Commissioning Board, CCGs, and, in relation to public health, local authorities.

Section 2 - The Secretary of State’s duty as to improvement in quality of services

75. This section inserts new section 1A into the NHS Act. This new section creates a duty on the Secretary of State to act with a view to securing continuous improvement in the quality of individuals’ healthcare.

76. Subsection (1) of new section 1A details the duty on the Secretary of State to exercise the functions conferred on the Secretary of State in relation to the health service in a way that would secure continuous improvements in the quality of services provided as part of the health service. This includes both the Secretary of State’s public health functions (the prevention of illness and the protection or improvement in public health) and those functions that the Secretary of State exercises in relation to the NHS along with the NHS Commissioning Board and CCGs (the diagnosis and treatment of illness). Any service that is associated with both public health and the NHS, such as screening, also comes within the ambit of this duty. The duty is therefore comprehensive. In discharging this duty, the Secretary of State must have regard to the NICE quality standards.

77. Subsection (2) of new section 1A specifies that, in discharging this duty, the Secretary of State must focus on securing continuous improvement in the quality of outcomes

achieved from health services. This duty is also placed on the NHS Commissioning Board and on CCGs by later sections in this Part. In keeping with the policy set out in the White Paper *Equity and Excellence: Liberating the NHS*[2], the outcomes are to focus particularly on the effectiveness, safety and patient experience aspects of healthcare (subsection (3) of new section 1A).

Section 3 - The Secretary of State's duty as to the NHS Constitution

78. Section 3 inserts new section 1B into the NHS Act, placing a duty on the Secretary of State to have regard to the NHS Constitution when exercising his functions in relation to the health service. Therefore when discharging any of those functions, the Secretary of State must do so with regard to the principles, values, rights and pledges in the NHS Constitution. The NHS Constitution is included in the list of defined expressions in section 276 of the NHS Act, directing readers of the Act to the definition at subsection (2) of new section 1B.

Section 4 The Secretary of State's duty as to reducing inequalities

79. This section inserts new section 1C into the NHS Act, which places a further duty on the Secretary of State when exercising his or her functions in relation to the health service. The duty is for the Secretary of State, when exercising his functions in relation to the health service, to have regard to the need to reduce inequalities between the people of England in respect of the benefits that may be obtained by them from the health service. This would include consideration of the need to reduce inequalities in access to health services and the outcomes achieved. This duty encompasses the Secretary of State's functions in relation to both the NHS and public health and relates to all the people of England.

80. Equivalent duties to consider the need to reduce inequalities are placed on the NHS Commissioning Board and on CCGs in later sections in this Part. This includes consideration of the need to reduce inequalities in access to health services and the outcomes achieved.

81. Later sections in this Part require the Secretary of State, the NHS Commissioning Board and CCGs to include in their annual reports an assessment of how effectively they have discharged their duties as to reducing inequalities.

82. In addition, later sections in this Part require the NHS Commissioning Board and CCGs to include in their business plan (NHS Commissioning Board) and commissioning plans (CCGs) an explanation of how each of them proposes to discharge their respective duties, in the exercise of their functions, to have regard to the need to reduce inequalities. The duty imposed by new section 14Z16 of the NHS Act requires the NHS Commissioning Board to include in the annual performance assessment of CCGs an assessment of how well CCGs have discharged their duties as to the need to reduce inequalities.

Section 5 - The Secretary of State's duty as to promoting autonomy

83. This section inserts new section 1D into the NHS Act. It seeks to establish an overarching principle that the Secretary of State should act with a view to promoting autonomy in the health service. Subsection (1) of new section 1D identifies two constituent elements of autonomy: freedom for bodies/persons in the health service (such as CCGs or Monitor) to exercise their functions in a manner that they consider most appropriate (new section 1D(1)(a)), and not imposing unnecessary burdens upon those bodies/persons (new section 1D(1)(b)). The section provides that when exercising his functions in relation to the health service, the Secretary of State must have regard to the desirability of securing these aspects of autonomy so far as consistent with the

2 Copies are available in the Library, and from the Department of Health website at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

interests of the health service. Subsection (2) of new section 1D makes clear that in the event of a conflict between those aspects of autonomy, on the one hand, and the discharge by the Secretary of State of his duties to promote the comprehensive health service and as to securing the provision of services on the other, it is the latter which take precedence.

84. This duty would therefore require the Secretary of State, when considering whether to place requirements on the NHS and local authorities, 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.

85. The duty covers the arm's-length body sector and commissioners and providers of NHS services. Although the Secretary of State will not in future have the same direct relationship with providers of NHS services as he has under existing legislation with NHS trusts, he will still have certain functions which impact on providers. For example, he will be able to require certain terms to be included in contracts entered into by the NHS Commissioning Board and CCGs for the provision of NHS services, by virtue of regulations made under new section 6E of the NHS Act.

86. Section 23 of the Act inserts new section 13F into the NHS Act, placing a parallel duty on the NHS Commissioning Board to promote autonomy.

87. These duties are intended to address the policy outlined in *Liberating the NHS: Legislative Framework and Next Steps*[3] to:

"enshrine the principle of autonomy at the heart of the NHS" by "maximising the autonomy of individual commissioners and providers and minimising the obligations placed upon them, in a way that is consistent with the effective operation of a comprehensive health service

Section 6 – The Secretary of State's duty as to research

88. This section places a duty on the Secretary of State to promote research on matters that are relevant to the health service and to promote the use within the health service of evidence obtained from research. Parallel duties to promote research and the use of research evidence are also placed on the NHS Commissioning Board and on CCGs by later sections in this Part.

Section 7 – The Secretary of State's duty as to education and training

89. Section 7 inserts a new section 1F into the NHS Act subsection (1) of which places a duty on the Secretary of State to exercise certain functions so as to secure that there is an effective system for the planning and delivery of education and training to people employed, or considering becoming employed, in the health service, or in activities connected to it. The duty would apply to education and training for all healthcare professionals delivering health care including doctors, dentists, nurses, midwives, pharmacists, healthcare scientists and the allied health professions. It would also cover trainee professionals at the start of their career, before they enter employment in the NHS.

90. Subsection (2) of new section 1F places a requirement on any person commissioning services as part of the health service to include in the arrangements made for the provision of those services a duty on the provider to co-operate with the Secretary of State in discharging his duty as to education and training. If a Special Health Authority is discharging that duty on behalf of the Secretary of State (such as the planned Special Health Authority - Health Education England), then the duty will relate to co-operation with that body.

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91. Subsection (3) lists the Acts which contain functions which must be exercised by the Secretary of State so as to discharge the duty in subsection (1).

Section 8 – Secretary of State's duty as to reporting on and reviewing treatment of providers

92. This section inserts a new section 1G into the NHS Act to impose a duty on the Secretary of State to report on and review the treatment of providers of NHS services.

93. Subsection (1) requires the Secretary of State to lay a report before Parliament on any matter, including taxation, which might affect either the ability of NHS health care providers to provide health care services for the purposes of the NHS or the reward available to them for doing so. This report has to be laid before Parliament within 12 months of Royal Assent to this Act.

94. Subsection (2) provides that the report must include recommendations as to how any identified differences in the treatment of NHS health care providers could be addressed.

95. Subsection (3) requires the Secretary of State to keep under review the treatment of NHS health care providers as respects any matter mentioned in subsection (1).

Section 9 - The NHS Commissioning Board

96. This section inserts new section 1H into the NHS Act. This section establishes a new body to be known as the National Health Service Commissioning Board. The NHS Commissioning Board will be an independent body, which will hold CCGs to account for the quality of services they commission, the outcomes they achieve for patients and for their financial performance. The NHS Commissioning Board will have the power to intervene where there is evidence that CCGs are failing or are likely to fail to discharge their functions. The specific functions of the NHS Commissioning Board, such as commissioning specialised services, are conferred by provision made elsewhere in the Act.

97. Like the Secretary of State, the NHS Commissioning Board will be subject to the duty to promote the comprehensive health service (as set out in section 1 of the NHS Act). However, in relation to the NHS Commissioning Board this duty would not apply to those services falling within the public health functions of the Secretary of State or local authorities.

98. Subsection (3) of new section 1H provides that, in order to fulfil this general duty, the NHS Commissioning Board has two specific functions:

    a) Firstly, it must commission services in accordance with the NHS Act. The services which the NHS Commissioning Board may, by regulations, be required to commission are described in new section 3B and include services which can be more effectively commissioned at national level, or which it would be inappropriate or impractical for CCGs to commission. Those services could include some dental services, specialised services, prison health services and health services for the armed forces. The NHS Commissioning Board will also be responsible for commissioning primary care services and high secure psychiatric services.

    b) Secondly, when exercising functions in relation to CCGs (for example, when issuing commissioning guidance under new section 14Z8), the NHS Commissioning Board must do so in such a way as to secure the provision of services.

99. *Subsection (2)* introduces Schedule 1.

Schedule 1 - The National Health Service Commissioning Board

100. This Schedule inserts new Schedule A1 into the NHS Act. This new Schedule makes provision for the constitution and establishment of the NHS Commissioning Board. Paragraph 1 provides that the NHS Commissioning Board (a non-Departmental public body) is not to be regarded as a servant or agent of the Crown.

101. Paragraph 2 makes provision about the membership of the NHS Commissioning Board.

102. Sub-paragraph (3) of paragraph 2 requires that the number of executive members of the NHS Commissioning Board must not exceed the number of non-executive members. This would mean that where there were resignations, suspensions or other departures of non-executive members, it might be necessary to appoint additional members or remove members from the NHS Commissioning Board to ensure that the number of executives was less than the number of non-executives.

103. Paragraph 3 provides that the executive members of the NHS Commissioning Board must be appointed by the non-executive members. Sub-paragraph (2) requires that the appointment of the chief executive receives the approval of the Secretary of State. Sub-paragraph (3) provides that the chief executive and the other executive members must be employees of the NHS Commissioning Board. Sub-paragraph (4) requires that the Secretary of State appoints the first chief executive of the NHS Commissioning Board. The other remaining first executive members will therefore be appointed by the non-executive members.

104. Paragraph 4 makes provision about the terms of appointment and tenure of office of non-executive members of the NHS Commissioning Board which are equivalent to those for members of Monitor under Schedule 8 to the Act: the terms of their appointment will set out the detail of the basis on which non-executive members will hold and vacate office. In sub-paragraph (2) provision is made to enable a non-executive member to resign at any time by giving notice to the Secretary of State and sub-paragraphs (3) and (4) enable the Secretary of State to remove or suspend non-executive members from office on grounds of incapacity, misbehaviour or failure to carry out their duties as a non-executive member.

105. Sub-paragraphs (5) and (6) specify that the maximum term of appointment for non-executive members of the NHS Commissioning Board is 4 years and that a person who ceases to be a non-executive member is eligible for re-appointment.

106. Paragraph 5 sets out the procedural requirements to be complied with when the Secretary of State suspends a non-executive member of the NHS Commissioning Board under the power in *sub-paragraph 4 (4)*.

107. Paragraph 6 provides that the Secretary of State has power to appoint an interim chair where the chair is suspended. The NHS Commissioning Board will have no power to appoint an interim chair but could choose in practice to appoint a deputy chair (regardless of any suspension of the chair).

108. Paragraph 7 requires the NHS Commissioning Board to pay to the non-executive members such remuneration, pensions, allowances or other gratuities as the Secretary of State may determine. Sub-paragraph (3) provides that, where a non-executive member of the NHS Commissioning Board ceases to be a non-executive member and the Secretary of State decides that there are exceptional circumstances for that person to receive compensation, the NHS Commissioning Board is required to make compensation payments of such amount as Secretary of State may determine with HM Treasury approval.

109. Paragraph 8 gives the NHS Commissioning Board powers to appoint employees.

110. Paragraph 9 provides that the NHS Commissioning Board can employ staff on such terms and conditions and pay such remuneration, pensions or allowances as it may

determine. In common with the other arm's-length bodies covered by this Act (for example, NICE and the Information Centre), the NHS Commissioning Board will be required to seek the approval of the Secretary of State for its policies on the payment of remuneration, pensions and allowances to staff before making a determination under this paragraph.

111. Paragraph 10 provides that the NHS Commissioning Board may appoint committees and sub-committees, and pay remuneration and allowances to those members of a committee or sub-committee who are not employees of the NHS Commissioning Board.

112. The NHS Commissioning Board may hold property on trust and paragraph 11 confers a power on the Secretary of State to appoint trustees to oversee the management of any property held on trust.

113. Paragraph 12 provides that the NHS Commissioning Board is to regulate its own procedure and must make any arrangements that it considers appropriate for the discharge of its functions. The NHS Commissioning Board may, for example, use this power to manage the risk of a conflict of interest by preventing executive members from being involved in determining their own pay.

114. Paragraph 13 gives the NHS Commissioning Board the power to arrange for the exercise of any of its functions on its behalf by:

a) any non-executive member,

b) any employee (including any executive member), or

c) one of its committees or sub-committees.

115. Paragraph 14 gives the Secretary of State power to require the NHS Commissioning Board to provide the Secretary of State with such information as the Secretary of State requires, in such form, and at such time or within such period, as the Secretary of State considers is necessary to delivery of the Secretary of State's functions in relation to health services.

116. Paragraph 15 requires that the NHS Commissioning Board must keep proper accounts and proper records in relation to the accounts (in such form as the Secretary of State may direct with the approval of HM Treasury). The chief executive of the NHS Commissioning Board is to be its accounting officer.

117. The NHS Commissioning Board sits within the Department of Health accounting and budgeting boundaries and the Department requires information to effectively and efficiently manage its financial position against, for instance, Departmental Expenditure Limits. In addition, the Department has a responsibility to provide information on those bodies for which it is accountable in order to meet requirements that may be set by HM Treasury and others on both financial and non-financial matters.

118. Paragraph 16 requires the NHS Commissioning Board to prepare consolidated annual accounts in respect of each financial year. Consolidated annual accounts should contain the NHS Commissioning Board's own annual accounts and separately a consolidation of the NHS Commissioning Board's own annual accounts and the annual accounts of each CCG.

119. Sub-paragraph (3) of paragraph 16 requires the NHS Commissioning Board to submit the consolidated annual accounts to the Secretary of State and to the Comptroller and Auditor General for audit to a timetable prescribed by the Secretary of State, who will remain accountable to HM Treasury for the Department's Departmental Expenditure Limit. The Department's annual Resource Account must be prepared in accordance with the accounting rules and instructions set out by HM Treasury in its annual Financial Reporting Manual (FReM). In turn, the accounts of all bodies that are consolidated into the Department's Resource Account must be prepared in accordance with the same HM Treasury accounting framework. The Secretary of State therefore requires powers to

ensure that the NHS Commissioning Board's accounts, including the consolidation of its accounts with those of CCGs, are prepared in accordance with the requirements set by HM Treasury.

120. Sub-paragraph (4) of paragraph 16 requires the Comptroller and Auditor General to examine the consolidated annual accounts of the NHS Commissioning Board and lay copies of the accounts, along with a report on them, before Parliament.

121. Additional provision is made in paragraph 17 for the Secretary of State, with the approval of HM Treasury, to require in-year 'interim' accounts to be prepared and for the Secretary of State to direct that these are audited.

122. Paragraph 18 makes provision in relation to the NHS Commissioning Board's seal.

Section 10 (new section 1I) -Clinical commissioning groups

123. As set out in *Equity and Excellence: Liberating the NHS*[4], the Act will create a comprehensive system of CCGs. Their purpose would be to commission most NHS services, supported by and accountable to the NHS Commissioning Board.

124. This section inserts new section 1I into the NHS Act. The new section provides that there are to be corporate bodies to be known as clinical commissioning groups (CCGs). Subsection (1) of new section 1I provides that CCGs will be established in accordance with Chapter A2 of Part 2 of the NHS Act and subsection (2) sets out that CCGs will have the function of commissioning services for the purposes of the health service in England in accordance with the NHS Act.

Arrangements for provision of health services

Section 11 - The Secretary of State's duty as to protection of public health

125. This section places a new duty on the Secretary of State for Health to protect public health through the insertion of a new section 2A into the NHS Act.

126. Subsection (1) of new section 2A requires the Secretary of State to take appropriate steps to protect the public in England from disease or other dangers to health. 'Other dangers to health' might include contamination, radiation (ionising or non-ionising), chemicals, poisons and the health effects of climate change (such as flooding and heat waves). The approach taken in the Act is an 'all hazards' approach in that the Act does not exhaustively list the dangers to health from which the Secretary of State must protect the public. This is to ensure that provision will continue to be effective as new threats to health emerge.

127. Subsection (2) of new section 2A lists some of the steps that the Secretary of State might take to protect public health. These include carrying out research into disease, providing laboratory services, providing information and advice to the public about dangers to health and providing national vaccination and screening programmes. As well as vaccination and screening, the Secretary of State would also be able to provide other services – for example, the provision of treatment for tuberculosis – for the prevention, treatment or diagnosis of illness, if the Secretary of State considered it an appropriate step to protect public health. Many of the activities falling within this provision are currently carried out by the Health Protection Agency, which is abolished in Part 2.

128. Subsections (3) and (4) of new section 2A require the Secretary of State to consult the Health and Safety Executive, and have regard to its policies, when taking steps to protect public health under subsection (1) in relation to a radiation matter in respect of

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4 Copies are available in the Library, and from the Department of Health website at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

which the Health and Safety Executive also has a function. This ensures consistency of action, for instance in a radiation incident.

Section 12 – Duties as to improvement of public health

129. This section concerns the duties and powers of the Secretary of State and of local authorities in relation to the improvement of public health. Improving health could include smoking cessation or weight loss services, for example, or the provision of advice and information to help people who want to adopt healthier behaviour.

130. The section inserts a new section 2B into the NHS Act. The new section gives certain local authorities a duty to take appropriate steps to improve the health of the people who live in their areas, and gives the Secretary of State the power to take appropriate steps to improve the health of the people of England. The nature of the duty is that if a local authority considers a step appropriate to improve public health, they must take that step under the new provision, even if the activity had previously been carried out under other local authority powers. The local authorities who are subject to the duty are defined in subsection (5) – primarily county councils, London borough councils and unitary authorities (district councils where there is no county council). District councils in counties with a county council are not subject to the duty. This definition of local authority is also applied elsewhere in the Act.

131. Subsection (3) of the new section lists some of the steps to improve public health that local authorities and the Secretary of State would be able to take. These include providing information and advice (for example giving information to the public about healthy eating and exercise), providing facilities for the prevention or treatment of illness (such as smoking cessation clinics), providing financial incentives to encourage individuals to adopt healthier lifestyles (for instance by giving rewards to people for stopping smoking during pregnancy), and providing assistance to help individuals minimise risks to health arising from their accommodation or environment (for example a local authority may wish to improve poor housing where this impacts on health).

132. Subsection (4) provides that the steps which local authorities may take include making grants or lending money to organisations or individuals - for example, voluntary sector organisations – when that would be an appropriate way of using resources to improve public health. For example, a local authority could choose to make a grant to an organisation that offered tailored health promotion advice to a particular minority ethnic community. The Secretary of State has existing grant-making powers that will continue (section 64 of the Health Services and Public Health Act 1968).

Section 13 - Duties of clinical commissioning groups as to commissioning certain health services

133. This section amends section 3 of the NHS Act to provide for the duties of CCGs in relation to commissioning certain health services.

134. CCGs would be the appropriate commissioners under the NHS Act, unless there is a duty on the NHS Commissioning Board to commission that service. Subsections (1) and (2) amend section 3 of the NHS Act to provide that CCGs 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.

135. The persons for whom CCGs will be responsible are set out in new section 3(1A) – that is, those persons who are provided with primary medical services by a member of the CCG and those persons who usually reside in the CCG's area and are not provided with primary medical services by another member of any CCG. Under new section 3(1B), persons who have a prescribed connection with the CCG's area or who have previously been provided with a service by a member or former member of a CCG, may also be the responsibility of a CCG, where regulations so provide. This could, for example,

include people who are receiving continuing healthcare for a long term condition. New section 3(1C) makes it clear that the regulation-making power in new section 3(1B) must be exercised so as to provide that CCGs are responsible for providing emergency care to everyone present in their area.

136. New section 3(1D) provides that regulations may provide that CCGs do not have responsibility for certain people or cases that would otherwise meet the criteria in new section 3(1A). It is intended that this power will be exercised, for example, in order that people who are resident in Scotland, but registered with a practice that is a member of a CCG are not the responsibility of a CCG for these purposes. Subsection (8) of section 13 of the Act makes these regulations subject to the affirmative procedure in Parliament.

137. New section 3(1E) sets out that CCGs are not under a duty to commission a service or facility if the NHS Commissioning Board is under a duty to do so.

138. New section 3(1F) requires that CCGs in exercising their functions under this section, and section 3A of the NHS Act 2006 (inserted by section 14 of the Act), must act consistently with the duty on the Secretary of State, and the NHS Commissioning Board, under section 1 of the NHS Act to promote a comprehensive health service, and with the mandate published by the Secretary of State under section 13A of the NHS Act (inserted by section 23 of the Act).

Section 14 - ***Power of clinical commissioning groups as to commissioning certain health services***

139. This section inserts a new section 3A into the NHS Act. Subsection (1) of that new section provides a power for a CCG to commission such services or facilities as it considers appropriate for the purposes of the health service that relate to securing the improvement in the physical and mental health of the persons for whom it has responsibility and the prevention, diagnosis and treatment of illness of these people.

140. Subsection (3) provides that sections 3(1A), 3(1B) and 3(1D) of the NHS Act apply for the purposes of determining the persons for whom a CCG has responsibility. Subsection (2) makes clear that a CCG may not exercise these powers where the NHS Commissioning Board has a duty to commission services under either section 3B (Secretary of State's power to require the NHS Commissioning Board to commission services) or 4 (high security psychiatric services) of the NHS Act.

Section 15 - ***Power to require Board to commission certain health services***

141. This section inserts new section 3B into the NHS Act which confers a regulation-making power on the Secretary of State to require the NHS Commissioning Board to commission certain services as part of the health service, to such extent as it considers necessary to meet all reasonable requirements. The types of services that the NHS Commissioning Board may be required to commission are specified in this section, and it allows other services to be specified in the regulations.

142. Prior to the amendments made by this Act, most NHS services were commissioned by PCTs. In future it is intended that CCGs will commission most health services and the NHS Commissioning Board will have duties to commission certain other health services. Where the NHS Commissioning Board has this function, CCGs would not be able to commission those services.

143. The NHS Commissioning Board would be responsible for the commissioning of primary medical, dental, ophthalmic and community pharmaceutical services, and this is set out in Part 6 of the Act.

144. The section provides that regulations may require the NHS Commissioning Board to commission certain other services as part of the health service.

145. Firstly, regulations under new section 3B may require the NHS Commissioning Board to make arrangements for the provision of such dental services as are prescribed. The regulations may for example provide that the NHS Commissioning Board commission dental services other than those it is required to commission under Part 5 of the NHS Act (as amended by Schedule 4). Part 5 of the NHS Act refers to "primary dental services" and under this section the NHS Commissioning Board could, for example, be required to arrange for the provision of "secondary dental services" such as community dental care and hospital dental services which PCTs prior to their abolition commissioned.

146. Secondly, regulations under new section 3B may require the NHS Commissioning Board to commission health services for members of the Armed Forces and their families. The Ministry of Defence, through the Defence Medical Services, provides primary care services to all members of the Armed Forces and a small number of families resident in England. The NHS currently provides community services, and non-elective and elective secondary services, to the Armed Forces. Regulations under new section 3B would describe the types of services to be provided by the NHS Commissioning Board to members of the Armed Forces or their families.

147. Thirdly, this section provides that regulations under new section 3B may require the NHS Commissioning Board to make arrangements for the provision of healthcare services to people detained in prisons in England or other accommodation of a prescribed description. The provision of primary care services to prisoners in England will be covered separately by the NHS Commissioning Board's functions in relation to primary care.

148. Lastly, regulations under new section 3B may require the NHS Commissioning Board to make arrangements for the provision of such other services or facilities as may be prescribed. It is intended that the services covered by this regulation making power will, for example, include services commonly described as "specialised services" for rare conditions, which under existing legislation are commissioned nationally by SHAs and regionally by groups of PCTs for each SHA region because of their low volume and high cost.

149. Subsection (2) of the new section provides that a service or facility may be prescribed under section 3B(1)(d) only if the Secretary of State considers it appropriate for the NHS Commissioning Board (rather than CCGs) to commission the service, taking into account the factors specified in subsection (3).

150. The Secretary of State could take into account the fact that one or more of the factors specified could suggest one course of action, while others could suggest something different- for example, suggesting the NHS Commissioning Board should be the commissioner for some specialised services which may not be expensive but may be low volume. The Secretary of State will take a view on the weight of the factors in order to decide whether the NHS Commissioning Board is the appropriate commissioner. The Secretary of State will be obliged to seek advice appropriate for enabling him to determine which services should be commissioned by the NHS Commissioning Board under this section, including from people or bodies with appropriate expertise and from the NHS Commissioning Board itself.

Section 16 - *Secure psychiatric services*

151. High security psychiatric services are provided to patients who are liable to be detained under the Mental Health Act 1983 and are judged to require treatment in conditions of high security on account of their dangerous, violent or criminal propensities. They are currently provided in England at three hospitals – Ashworth, Broadmoor and Rampton – which are each part of an NHS trust.

152. This section amends section 4 of the NHS Act, which concerns the provision of high security psychiatric services. *Subsection (2)* removes from the Secretary of State the duty to provide high security services and places a duty instead on the NHS

Commissioning Board to arrange for the provision of these services. *Subsection (3)* stipulates that providers of high security services must be approved for that purpose by the Secretary of State.

153. This section also gives the Secretary of State a power to give directions to providers of high security services about their provision of high security services. It is intended that this power will be used in practice in a limited fashion in relation to issues such as safety and security, and children visiting high security hospitals. The existing directions issued in relation to high security services by the Secretary of State are the High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) 2011 and the Visits by Children to Ashworth, Broadmoor and Rampton Directions 1999, which deal with risk assessment and safeguarding.

154. *Subsection (4)* of the section also enables the Secretary of State to give directions to the NHS Commissioning Board about the way it exercises its functions in relation to high security services. It is intended that this power would be used in a limited manner to ensure that the NHS Commissioning Board, in commissioning high security services, would take into account any conditions which might be set by the Secretary of State, including directions to providers and to ensure that there is sufficient capacity to meet the demands of the criminal justice system.

Section 17 - Other services etc. provided as part of the health service

155. This section transfers responsibility for a number of public health activities from the Secretary of State, and confers a new duty on the Secretary of State to make arrangements for the supply of blood and human tissues. The section amends section 5 of, and Schedule 1 to, the NHS Act, which provides for the Secretary of State to provide various health services and carry out other activity in relation to the health service.

156. *Subsections (3) to (8)* amend the provisions of Schedule 1 relating to children. The provisions transfer the Secretary of State's existing responsibilities for the medical inspection and treatment and the weighing and measuring of school children. Responsibility is transferred to the local authorities which have a duty to improve public health under new section 2B. This would include school nursing services.

157. *Subsection (8)* amends paragraph 7B(1) of Schedule 1 to the NHS Act to extend the power of the Secretary of State to make regulations relating to the processing of information resulting from any weighing or measuring of children under regulations under paragraph 7A of that Schedule to include any other prescribed information relating to the children concerned. It also extends paragraph 7B(2) to allow the Secretary of State to require any person exercising functions in relation to weighing and measuring to have regard to guidance relating to information prescribed under sub-paragraph (1).

158. *Subsection (9)* inserts a new paragraph 7C into Schedule 1 and confers on the Secretary of State the duty to make arrangements for the collection, screening and supply of blood (and related services) and for the facilitation of organ or tissue transplantation services. The Secretary of State has responsibility for this under his existing functions under sections 2 and 3 of the NHS Act, but the new paragraph 7C ensures that the Secretary of State continues to have responsibilities for those arrangements despite the changes to those sections made by this Act. As now, the functions would be performed by NHS Blood and Transplant, a Special Health Authority, rather than by the Department of Health.

159. *Subsections (10) and (11)* amend paragraphs 9 and 10 of Schedule 1 so as to transfer to CCGs the Secretary of State's existing responsibility for the supply of wheelchairs and other vehicles to people with a physical disability. In practice PCTs arrange these services now, and the Department's view is that the responsibility for those services is more consistent with CCGs' other duties than with local authorities' health improvement duties.

160. *Subsection (12)* makes a consequential amendment to paragraph 12 of Schedule 1, which confers a power on the Secretary of State to provide a microbiological service (to help control the spread of infectious diseases). The power to provide such a service now falls under the Secretary of State's health protection duty under new section 2A; paragraph 12 will however continue to provide that he can carry on related activities and charge for such activity.

161. Finally, *subsection (13)* substitutes a new paragraph 13 of Schedule 1, which relates to the conduct of research into health-related matters by, or with the assistance of, the Secretary of State. The new paragraph 13 enables the NHS Commissioning Board, CCGs and local authorities, as well as the Secretary of State, to conduct, commission or fund such research or assist others to do so. For example, this would enable the NHS Commissioning Board and CCGs to assist valuable research designed to improve health care, by providing the NHS costs associated with research in the NHS, which are currently provided by PCTs through the normal commissioning process. Local authorities would only be able to use the power in relation to their public health activities.

162. While new paragraph 13 enables the Secretary of State, the NHS Commissioning Board, a CCG or a local authority to obtain and analyse data or other information, it does not require the bodies holding the information to supply it and does not set aside any obligation of confidentiality that might apply to those bodies.

Section 18 – ***Regulations as to the exercise by local authorities of certain public health functions***

163. This section inserts a new section 6C into the NHS Act, giving the Secretary of State powers to make regulations requiring local authorities to exercise certain public health functions. In particular, the Secretary of State is able to specify the particular public health services, facilities or other steps that one, several or all local authorities must provide or take. The regulations would be subject to the affirmative procedure and would therefore have to be approved by Parliament.

164. *Subsection (1)* of the new section enables the Secretary of State to make regulations requiring a local authority to exercise, in relation to their area, any of the Secretary of State's public health functions, that is functions under section 2A (duty to take steps to protect public health), section 2B (power to take steps to improve public health) or Schedule 1 (such as providing contraceptive services).

165. *Subsection (2)* enables the Secretary of State to make regulations specifying the particular public health services, facilities or other steps that local authorities must provide or take under their duty to improve public health (new section 2B) or their duties under Schedule 1 (such as arranging medical treatment of school pupils).

166. The Secretary of State could use this power to - for example - ensure long-term, national availability of a service or respond to a serious local concern about a lacuna in service provision. *Subsection (4)* of the new section clarifies that if the Secretary of State provided in regulations that local authorities had to undertake health protection activity, the Secretary of State will still be able to carry out that protection activity. The Secretary of State will also be able to require or allow local authorities to exercise functions of his that are ancillary to the functions he delegates under new section 6C (e.g. making facilities available to service providers or voluntary organisations under section 12 of the NHS Act).

167. *Subsection (5)* provides that when a local authority exercises the Secretary of State's public health functions under regulations under new section 6C, any liabilities incurred will be enforceable against the authority (and no other individual or body). Similarly only the authority will be able to enforce any rights acquired in the exercise of those functions. The effect, in particular, is that the local authority and not the Secretary of

State will be liable for the acts or omissions of the authority when exercising such functions.

Section 19 - *Regulations relating to EU obligations*

168. This section inserts new section 6D into the NHS Act, providing the Secretary of State with powers to confer functions by means of regulations and to direct the NHS Commissioning Board and CCGs in respect of EU obligations connected to the health service. Under the current system, the Secretary of State has the power to delegate certain aspects of his functions relating to EU obligations to PCTs and SHAs, and to direct them in the exercise of these and other functions to ensure compliance with EU law. This section makes new arrangements for the NHS Commissioning Board and CCGs, in view of the abolition of PCTs and SHAs.

169. *Subsection (1)* of the new section gives the Secretary of State a power to require, by means of regulations, the NHS Commissioning Board or a CCG to exercise a specified EU health function. As *subsection (2)*(a) specifies, an "EU health function" refers to any function which may be exercised by the Secretary of State to implement EU obligations relating to the health service. For example, the Secretary of State might delegate to CCGs the function of authorising patients in England to go to another EU state for their treatment under section 6B of the NHS Act. However, the Secretary of State may not require the NHS Commissioning Board or a CCG to exercise any functions relating to the making of subordinate legislation (such as regulations) for the purposes of implementing EU obligations.

170. Further to the power to delegate some of the Secretary of State's functions relating to EU obligations, *subsection (3)* of the new section provides that the Secretary of State may also direct the NHS Commissioning Board and CCGs about the exercise of any of these delegated functions. This would allow the Secretary of State to indicate to the NHS Commissioning Board and CCGs the manner in which the delegated functions should be carried out in order to remain compliant with EU obligations. The Secretary of State could direct an individual CCGs in this way if necessary.

171. Making regulations under subsection (1) would not prevent the Secretary of State from exercising the delegated EU health functions himself *(subsection (4))*. In addition, this section ensures that the NHS Commissioning Board or CCGs would be liable in the domestic courts for their actions where they are exercising EU functions delegated to them under this section *(subsection (5))*.

172. *Subsection (6)* gives the Secretary of State the power to direct the NHS Commissioning Board or CCGs about the exercise of any of their other functions in order to secure compliance by the UK with EU obligations. This power is to allow the Secretary of State to address quickly any infractions which may be triggered by, for example, the actions of an individual CCG, but for which the Secretary of State ultimately remains responsible. Being able to act quickly in such a scenario is important to avoid the costs associated with full infraction proceedings being brought against the UK by the European Commission.

Section 20 - *Regulations as to the exercise of functions by the Board or clinical commissioning groups*

173. This section inserts new section 6E into the NHS Act. This section makes provision for the Secretary of State to establish "standing rules" which would impose requirements on the NHS Commissioning Board and CCGs in the exercise of their functions. The requirements in the standing rules would be imposed by means of regulations, as outlined in *subsection (1)*. The terms used in this section are defined by subsection (10).

174. The "standing rules" are intended to allow the Secretary of State to create a rules-based framework for commissioners. They would be generic, and under subsection (8) of the new section it would not be possible for the Secretary of State to develop regulations

only affecting an individual CCG. To a large extent the purpose of the standing rules would be to allow some existing policies to be maintained in the context of the more limited powers of the Secretary of State under this Act. In exercising the regulation-making powers under this section, the Secretary of State would be bound by the duty introduced earlier in the Act to avoid unnecessary burdens on other bodies in the health system.

175. *Subsections (2)* to *(7)* of new section 6E outline the areas where the Secretary of State would have the power to make standing rules.

176. *Subsections (2)* and *(3)* of new section 6E are intended to allow the continuation of the existing arrangements for Continuing Healthcare (where the NHS is responsible for delivering a package of health and social care to individuals who have a primary health need) and the continuation of certain rights set out in the NHS Constitution, which are currently given legal effect through directions to PCTs. For example, the NHS Constitution contains a right for patients to make choices about their care, which is underpinned by directions. Subsection (2)(c) would allow this right to be underpinned by regulations instead, without any need to change the Constitution itself.

177. *Subsection (4)* of new section 6E provides a power for the Secretary of State to require certain matters to be included in the contracts that the NHS Commissioning Board or CCGs use when commissioning services from providers. This includes specifying matters which must appear in commissioning contracts entered into by the NHS Commissioning Board or CCGs, and requiring the NHS Commissioning Board to draft terms and conditions relating to those matters. Subsection (4) also indicates that regulations may require the NHS Commissioning Board or CCGs to incorporate such terms and conditions into their commissioning contracts. For example, regulations could require the inclusion of contractual requirements on resilience planning in relation to incidents affecting the public in which the health service in England plays a front line or supporting role. A further example would be technical matters required commercially, such as payment terms and notice terms.

178. *Subsection (5)* of new section 6E lists a number of provisions which must be included in the regulations. Subsection (5)(a) states that the regulations must require the NHS Commissioning Board to draft terms and conditions that it considers appropriate for inclusion in commissioning contracts. The regulations must also allow the NHS Commissioning Board to require CCGs to use such terms and conditions in their commissioning contracts ((5)(b)) and to draft model commissioning contracts ((5)(c)).

179. Under *subsection (6)* of new section 6E, the NHS Commissioning Board could be required to consult specified persons on any draft contracts that it produces.

180. *Subsection (7)* of new section 6E lists generic requirements which may be imposed on the NHS Commissioning Board or CCGs by regulations, relating to the exercise of any of their functions. Subsection (7)(a) of new section 6E allows regulations to be drafted requiring the NHS Commissioning Board or CCGs to provide specified information to specified persons in a specified manner (where "specified" means specified in the regulations). This power would allow the Secretary of State to require information to be provided to patients and the public.

181. Subsection (7)(b) of new section 6E allows for regulations that would secure compliance with EU obligations by specifying the manner in which the NHS Commissioning Board and CCGs carry out their functions. This is complementary to the previous section.

182. Finally, subsection (7)(c) of new section 6E allows for regulations to require the NHS Commissioning Board or CCGs to do such other things, in the exercise of their functions, as the Secretary of State considers necessary for the purposes of the health service. This would support the Secretary of State in the effective discharge of his/her duty to promote a comprehensive health service. To help ensure that use of this

relatively broad power is proportionate, and receives the proper scrutiny, regulations brought forward under subsection (7)(c) would be subject to the affirmative resolution procedure in Parliament (as outlined in subsection (2) of this section).

183. *Subsection (9)* of new section 6E specifies that if any regulations under this section come into force on any day other than 1st April each year, the Secretary of State must publish an explanation as to why, and lay that statement before Parliament. This is intended to create an expectation that any new regulations affecting the NHS Commissioning Board or CCGs would be aligned with the Secretary of State's annual mandate to the NHS Commissioning Board. If this were not possible, and regulations had to be introduced in the intervening period, the Secretary of State would be under a duty to explain why.

Section 21 - Functions of Special Health Authorities

184. *Subsection (2)* of this section substitutes subsection (1) of section 7 of the NHS Act. The new subsection allows the Secretary of State to direct a Special Health Authority to exercise any function relating to the health service in England. This function could be a function of the Secretary of State or any other person.

185. The Secretary of State already has powers to direct a Special Health Authority to exercise any of his/her functions relating to the health service. This provision would amend that power so that it relates to health service functions in general. This is because some of the functions currently exercised by existing Special Health Authorities, in particular the NHS Business Services Authority and the NHS Litigation Authority, would be functions of the NHS Commissioning Board or CCGs in the new system. Where the Secretary of State is directing a Special Health Authority to undertake the functions of another organisation, he must do so through regulations that are subject to the negative resolution procedure (subsection (6)).

186. For existing Special Health Authorities (NHS Blood and Transplant, NHS Business Services Authority and the NHS Litigation Authority), there would be no need to re-issue the current directions specifying their functions and they would continue in force as if given under the new power - this is provided for in paragraph 5 of Schedule 6.

187. Subsection (1A) of the amended section 7 prevents the Secretary of State from delegating the function of making orders or regulations to Special Health Authorities.

188. New subsection (1B) provides that if the Secretary of State directs a Special Health Authority to exercise a function of a person other than the Secretary of State, he must consult that person before giving the direction.

189. New subsection (1C) would give the Secretary of State the power to confer new functions on a Special Health Authority, as specified in regulations. This would provide the Secretary of State with flexibility to respond to changes over time. These regulations would be subject to the affirmative resolution procedure to ensure that Parliament would be able to scrutinise any new functions that the Secretary of State wished to confer on a Special Health Authority.

Section 22 - Exercise of public health functions of the Secretary of State

190. This section inserts a new section 7A into the NHS Act and allows the Secretary of State to delegate, by arrangement, the Secretary of State's public health functions to the NHS Commissioning Board or CCGs, or to local authorities which have a duty to improve public health (see new section 2B). "Public health functions" are functions under section 2A (duty to take steps to protect public health), section 2B (power to take steps to improve public health) or certain functions under Schedule 1 (such as providing contraceptive services).

191. Subsection (4) of the new section provides that where functions are delegated to the NHS Commissioning Board under such arrangements, the NHS Commissioning Board may in turn delegate those functions to CCGs.

192. Subsection (5) provides that when the NHS Commissioning Board, a CCG or local authority exercises the Secretary of State's public health functions under such arrangements, any liabilities incurred will be enforceable against that body (and no other individual or body). Similarly only the body which exercises the function in question will be able to enforce any rights acquired in their exercise.

193. Subsection (6) provides that the arrangements may include provision for the Secretary of State to provide funding to the NHS Commissioning Board or CCGs in relation to the delegated functions. The intention is to provide flexibility and efficiency in the way that public health services are delivered. The provision could be used, for example, to delegate responsibility to the NHS Commissioning Board for commissioning a national vaccination or screening programme.

Section 23 - The NHS Commissioning Board: further provision

194. This section inserts a new Chapter A1 into Part 2 of the NHS Act.

195. *Mandate to the Board.* New section 13A requires the Secretary of State to publish and lay before Parliament a document to be known as "the mandate" before the start of each financial year. Broadly, the mandate would set out what the Government expects from the NHS Commissioning Board on behalf of the public for that period. This would comprise a series of objectives that the Secretary of State thinks the NHS Commissioning Board should seek to achieve (section 13A(2)(a)), and any other requirements that the Secretary of State considers necessary to ensure those objectives are met (section 13A(2)(b)). The objectives must relate to the current financial year and such subsequent financial years as the Secretary of State considers appropriate. The requirements set out in the mandate will be given effect by regulations subject to the negative resolution procedure.

196. The intention is to require the Secretary of State to provide the NHS Commissioning Board with a single annual set of objectives and requirements in order to provide stability and clarity, allowing the NHS Commissioning Board to develop effective medium and long-term planning assumptions.

197. Subsection (3) of section 13A provides the Secretary of State to specify in the mandate the limits on the NHS Commissioning Board's capital and revenue resource use for the financial year, provided for in new section 223D (as inserted by the following section). Subsection (4) allows the Secretary of State also to specify any proposals as to the limits that will apply for subsequent financial years. Such information may help the NHS Commissioning Board in planning how to achieve objectives which extend beyond the current financial year. Subsection (5) enables the Secretary of State to specify in the mandate any matters that are proposed for consideration in assessing the NHS Commissioning Board's performance for that financial year. Such matters might include the achievement of the outcomes set out in the Outcomes Framework. The Secretary of State would not be able to specify in the mandate any objective or requirement which targets any individual CCG. This restriction, in subsection (6), mirrors that in relation to the standing rules (established under section 20).

198. Before specifying any objectives or requirements in the mandate, the Secretary of State must consult the NHS Commissioning Board, Healthwatch England and such other persons as the Secretary of State considers appropriate to ensure that the mandate would be effective, under subsection (8). Once the mandate is published, the NHS Commissioning Board will be under an obligation to seek to achieve the objectives and comply with the requirements specified, under subsection (7) (provided, in the case of requirements, that they are given effect to by regulations – see subsection (9)).

199. *The mandate: supplementary provision*. New section 13B of the new Chapter A1 establishes the rules around in-year changes to the mandate. Subsection (1) places a duty on the Secretary of State to keep the NHS Commissioning Board's performance in achieving the objectives and requirements in the mandate under review, which underpins the Secretary of State's responsibility to hold the NHS Commissioning Board to account.

200. Should the Secretary of State have to make any change to the limits on the NHS Commissioning Board's total capital and revenue resource use (as provided for in new section 223D, as inserted by the following section), the mandate would have to be revised accordingly to reflect these changes. However, if the Secretary of State were to alter the objectives and requirements in the mandate, then they would not necessarily be required to revise these limits.

201. Subsection (3) provides that the Secretary of State may only make other changes to the mandate if the NHS Commissioning Board agrees to the revision or if the Secretary of State feels that there are exceptional circumstances that make the revision necessary. The Secretary of State may also revise the mandate following a parliamentary general election. After altering the mandate, the Secretary of State must publish the revised document, and lay the new version before Parliament with an explanation of the reasons for making the changes, as specified in subsection (5). Any changes to the requirements in the mandate would be given effect through regulations (see subsection (4) which makes provision comparable to section 13A(9)). This would ensure that the Secretary of State remained accountable to Parliament for any changes relating to the mandate.

202. *General duties of the Board.* New sections 13C to 13P confer some general duties on the NHS Commissioning Board.

203. *Duty to promote NHS Constitution*. New section 13C places a duty on the NHS Commissioning Board to promote and raise awareness of the NHS Constitution when exercising its functions. This is in addition to the duty on the NHS Commissioning Board under the Health Act 2009 (as amended by paragraph 175 of Schedule 5) to "have regard" to the NHS Constitution. The new duty means that when exercising all of its functions, the NHS Commissioning Board has to act with a view to securing that health services are provided in a way that promotes the NHS Constitution, and is required to promote awareness of the NHS Constitution among patients, staff and members of the public. This means that not only must the NHS Commissioning Board act in accordance with the NHS Constitution but it should also ensure that people are made aware of their rights under it and that they contribute as far as possible to the advancement of its principles, rights, responsibilities and values, through its own actions and through facilitating the actions of stakeholders, partners and providers.

204. *Duty as to effectiveness, efficiency etc.* New section 13D is a duty on the NHS Commissioning Board to exercise its functions in a way that is effective, efficient and economical.

205. *Duty as to improvement in quality of services.* New section 13E puts the NHS Commissioning Board under a duty to exercise its functions with a view to improving the quality of services provided as part of the health service. This also reflects the accepted definition of quality outcomes[5] as comprising effectiveness, safety and patient experience. The NHS Commissioning Board must pursue this quality improvement objective with reference to two sets of guidance: a) "any document published by the Secretary of State for the purposes of this section", such as the NHS Outcomes Framework; and b) the Quality Standards that the National Institute for Health and Care Excellence (NICE) produces (see notes on Part 8 of the Act, below). This duty mirrors the Secretary of State's duty in new section 1A to improve quality of services as inserted earlier in this Part.

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5 For example see the NHS Outcomes Framework published by the Department of Health on 20 December 2010 - http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

206. *Duty as to promoting autonomy*. New section 13F requires the NHS Commissioning Board, in exercising its functions, to have regard to the desirability of securing, so far as is consistent with the interests of the health service, that any 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 they consider most appropriate, and that they are not subject to unnecessary burdens. This mirrors the duty placed on the Secretary of State earlier in this Part.

207. This duty would therefore require the NHS Commissioning Board, when considering how to exercise its functions in relation to CCGs such as publishing commissioning guidelines, or when determining matters to be included in contracts with healthcare providers for example, to make a judgement as to whether these were in the interests of the health service. If challenged, the NHS Commissioning Board would have to be able to justify why these requirements were desirable.

208. The duty will cover those arm's-length bodies in relation to which the NHS Commissioning Board has functions (such as NICE and the Information Centre) as well as providers of NHS services. Although the NHS Commissioning Board will not have the same direct relationship with providers of NHS services as SHAs and PCTs have under existing legislation with NHS trusts, it will still have certain functions which impact on providers. For example, it will be able to require certain terms to be included in contracts entered into either by the NHS Commissioning Board itself or by CCGs for the provision of NHS services by virtue of regulations made under new section 6E.

209. This duty is intended to address the policy outlined in *Liberating the NHS: Legislative Framework and Next Steps*, which stated among its aims to:

"enshrine the principle of autonomy at the heart of the NHS" by "maximising the autonomy of individual commissioners and providers and minimising the obligations placed upon them, in a way that is consistent with the effective operation of a comprehensive health service[6]

210. *Subsection (2)* of new section 13F makes clear that in the event of a conflict between those aspects of autonomy, on the one hand, and the discharge by the NHS Commissioning Board of its duties to promote the comprehensive health service and to exercise its functions in relation to CCGs so as to secure the provision of services on the other, it is the latter which takes precedence.

211. *Duty as to reducing inequalities.* New section 13G(1)(a) requires the NHS Commissioning Board when exercising its functions to have regard to the need to reduce inequalities between patients with respect to their ability to access health services; the NHS Commissioning Board must seek to narrow inequalities in access to health services for individuals and groups of people from which they could derive significant benefit. For example, the NHS Commissioning Board may seek to narrow inequalities in ability to access through providing guidance to CCGs on how information about NHS services are to be communicated to specific groups, on opening hours, on reducing late presentation, or about where particular services should be located in order to be more accessible to specific populations. It may also make use of reports from Healthwatch or other groups. However, it will be up to the NHS Commissioning Board to decide how it complies with this duty.

212. New section 13G(1)(b) requires the NHS Commissioning Board to have regard to the need to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services; the NHS Commissioning Board must seek to narrow clinically unjustifiable inequalities in the outcomes of health care. For example, the NHS Commissioning Board may seek to improve the outcomes of care for specific groups through guidance to CCGs on access issues, on appropriate referral practices for

6 Copies are available in the House library, and from the DH website at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

certain groups, on coordination of care, or through advising on contract specifications. As the NHS outcomes framework develops, and information on outcomes becomes more available by the protected characteristics of the Equality Act 2010 or by area deprivation or socio-economic group, it is expected that this will be increasingly helpful in guiding the NHS Commissioning Board's actions.

213. *Duty to promote involvement of each patient.* New section 13H requires the NHS Commissioning Board, in exercising its functions, to promote the involvement of individual patients and their carers and other representatives in decisions about their own care (shared decision-making). This duty is intended to address the commitment outlined in the White Paper *Equity and Excellence: Liberating the NHS* to the policy of "no decision about me without me".

214. The duty would apply to any decisions at all stages of that individual's health care, from preventative measures, diagnosis of an illness, and any subsequent care and treatment they receive. Effective involvement of patients in these decisions might include such things as opportunities for patients to participate in treatment decisions in partnership with health professionals, to be supported to make informed decisions about the management of their care and treatment and to discuss opportunities for patients to manage their own condition.

215. In addition to the commissioning of those services for which the NHS Commissioning Board will be directly responsible, it could exercise this duty through promoting the importance of involving patients in its dialogues with CCGs. The NHS Commissioning Board will also be required to publish guidance on how CCGs could discharge their equivalent duty to which CCGs must have regard.

216. *Duty as to patient choice.* New section 13I requires the NHS Commissioning Board to act with a view to enabling patients to make choices with respect to aspects of health services provided to them. The NHS Commissioning Board will be responsible for championing effective involvement and engagement in decisions about healthcare by working with CCGs, local authorities, voluntary sector groups, patient-led support groups and Healthwatch, for example. The intention is that the NHS Commissioning Board will also develop and agree with the Secretary of State the guarantees for patients about the choices they can make. In addition, the NHS Commissioning Board will be responsible for commissioning, promoting and extending information to support meaningful choice over the care and treatment that people receive, where it is provided and who provides it (including personal health budgets). This information should include patient-reported experience and outcome measures.

217. *Duty to obtain appropriate advice*. New section 13J provides that the NHS Commissioning Board must obtain appropriate advice from other professionals, so it can effectively discharge its functions. This would include, for example, obtaining advice when making commissioning decisions and when designing NHS pricing structures. In the Government response to the NHS Future Forum report, published on 20 June 2011, the Government proposed that potential sources of such advice could include clinical networks, which bring together groups of healthcare professionals to form networks that are specific to a particular health condition or profession, and clinical senates, groups of experts covering different areas of the country.

218. *Duty to promote innovation.* New section 13K places a duty on the NHS Commissioning Board, when exercising its functions, to promote innovation in the provision of health services by, for instance, encouraging both innovative commissioning and the commissioning of innovative health services. This could be achieved, for example, through the NHS Commissioning Board developing commissioning guidelines for CCGs as well as hosting some clinical networks where appropriate. New section 13K also provides for the NHS Commissioning Board to make payments as prizes in order to promote innovation in the provision of health services.

219. Innovation will originate primarily from the actions of commissioners and providers but it is intended that the NHS Commissioning Board will take a lead role in promoting it. The duty will support delivery of the NHS Commissioning Board's duty to secure continuous improvements in the quality of health care under new section 13E. This duty is similar to the duty that previously applied to SHAs.

220. *Duty in respect of research.* New section 13L confers a duty on the NHS Commissioning Board in the exercise of its functions, to promote research on matters relevant to the health service and to promote the use in the health service of evidence obtained from research. The NHS Constitution confirms that the NHS is committed to the promotion and conduct of research to improve the current and future health and care of the population. To support this, the NHS Commissioning Board will be expected to promote the conduct of research and the use of evidence obtained from research when it exercises its commissioning and other functions. For example, through commissioning guidance, contracts and pricing structures, the NHS Commissioning Board could encourage providers to participate in research and to use research evidence to deliver and improve services. This is consistent with the general duty of the NHS Commissioning Board to exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, or the protection or improvement of public health.

221. *Duty as to promoting education and training*. New section 13M places a duty on the NHS Commissioning Board, when exercising their functions, to have regard to the need to promote education and training so as to assist the Secretary of State in the discharge of his related duty in new section 1F. This will also apply to any Special Health Authority supporting the Secretary of State in the discharge of his duty.

222. *Duty as to promoting integration.* New section 13N requires the NHS Commissioning Board to exercise its functions with a view to securing that health services, health and social care services, and other health-related services (for instance services such as housing that may have an effect on the health of individuals, but are not health services or social care services) are provided in an integrated way where it considers that this would either improve the quality of health services and the outcomes they achieve, or reduce inequalities in access to or outcomes from health services. This requirement would cover both integration between service types (such as between health and social care) and integration between different types of health services (such as hospital and community care). This will apply to all the NHS Commissioning Board's functions, not just its commissioning functions, including, for example, when it exercises public health functions under arrangements with Public Health England. The practical effect should be that services are integrated around the needs of the individual.

223. Subsection (3) requires the NHS Commissioning Board to encourage CCGs to enter into joint arrangements with local authorities under section 75 of the NHS Act where this would improve the quality of health services or reduce inequalities in outcomes from or access to health services. The intention is that the NHS Commissioning Board should encourage CCGs to work closely together with local authorities in arranging for the provision of integrated services.

224. *Duty to have regard to impact on services in certain areas.* New section 13O requires the NHS Commissioning Board to have regard to the likely impact of its commissioning decisions on the provision of health services to persons living in areas of Scotland or Wales that are close to the border with England. It is intended that CCGs, in practice, will also have regard to the impact of their commissioning decisions on border areas.

225. *Duty as respects variation in provision of health services.* New section 13P prohibits the NHS Commissioning Board from exercising its functions for the purpose of increasing or decreasing the market share of any particular type of provider – whether public or private sector or according to some other aspect of its status – in the provision of NHS services. This means the NHS Commissioning Board may not pursue a policy designed

to encourage the growth of a particular sector of provider. It would not prevent the NHS Commissioning Board from commissioning services from whoever it considered the most suitable provider, including new service providers, or from seeking to develop integrated services.

Public involvement

226. *Public involvement and consultation by the Board.* New section 13Q requires the NHS Commissioning Board to make arrangements to secure public involvement and consultation in: (a) the planning of commissioning arrangements; (b) the development and consideration of proposals for service change where they would have an impact on the range of services provided and / or the manner in which they are provided; and (c) decisions affecting the operation of commissioning decisions. The duty applies to the NHS Commissioning Board only as respects health services which it commissions and its plans, proposals or decisions about such services. This reflects the duty that previously applied to PCTs under section 242 of the NHS Act.

Functions in relation to information

227. *Information on safety of services provided by the health service.* Following abolition of the National Patient Safety Agency under Part 10, new section 13R will give the NHS Commissioning Board responsibility for the functions currently carried out by the Agency in respect of reporting and learning from patient safety incidents. The intention is to ensure that patient safety is embedded into the health service through CCGs and the contracts they agree with providers.

228. *Guidance in relation to processing of information.* New section 13S places a duty on the NHS Commissioning Board to publish guidance on information processing requirements, sometimes termed information governance requirements, in respect of patient information or other information obtained or generated in the course of the provision of health services. These requirements may include confidentiality and information security and risk management practice, records management, data protection, disclosure of information and information quality. Subsection (2) requires registered persons who carry out activities connected to healthcare provision to have regard to the published guidance. Information processing is as defined in the Data Protection Act 1998 and covers any possible activity involving information obtaining, holding, recording, using or sharing. Provisions within Part 10 of this Act insert new section 20A into the Health and Social Care Act 2008, which incorporates the definition of "processing" in the Data Protection Act.

Business plan and report

229. *Business plan.* New section 13T requires the NHS Commissioning Board to publish a business plan before the start of the financial year setting out how it is to exercise its functions over the coming three years with a view to achieving its statutory duties and the objectives and requirements set for it by the Secretary of State in the mandate. The NHS Commissioning Board's business plan must, in particular, set out how it intends to discharge its duties as to improvement of quality under section 13E, as to reducing inequalities under 13G and as to the involvement of the public under 13Q as well its various financial duties under new sections 223C to 223E of the NHS Act. CCGs are required to cover similar matters in their commissioning plans.

230. *Annual report.* New section 13U requires the NHS Commissioning Board to publish an annual report, as soon as practicable after the end of each financial year, on how it has exercised its statutory functions during that year. In particular, the annual report must set out how, in its view, the NHS Commissioning Board has progressed against the proposals it made in its business plan for that year and the objectives and requirements set for it by Secretary of State in the mandate. It must also include an assessment of how effectively it has discharged its duties as to improvement of quality under section 13E,

as to reducing inequalities under 13G and as to the involvement of the public under 13Q. The Secretary of State will be under an obligation to review the annual report and publish a letter in response setting out how, in the Secretary of State's view, the NHS Commissioning Board has performed for the previous year against its statutory duties and the objectives and requirements set for it in the mandate. This letter must also be laid before Parliament.

Additional powers

231. *Establishment of pooled funds.* New section 13V allows the NHS Commissioning Board and one or more CCGs to set up a pooled fund (which is made up of contributions by the bodies establishing the fund), which can be used to make payments with the agreement of the bodies contributing to the fund, towards expenditure incurred in the discharge of any of their commissioning functions. This power is intended to assist the NHS Commissioning Board and CCGs working together to discharge their functions, allowing them to share financial resources to meet expenditure requirements.

232. *Board's power to generate income***.** New section 13W confers on the NHS Commissioning Board a power to generate income for improving the health service. This enables the NHS Commissioning Board to do anything specified in section 7(2) of the Health and Medicines Act 1988. The NHS Commissioning Board will have a duty to remain within the resource limits set by the Secretary of State under new section 223D of the NHS Act and any income it generates could therefore reduce the funding required from public finances.

233. *Power to make grants etc.* New section 13X enables the NHS Commissioning Board to make payments by way of loans as well as grants to voluntary organisations that provide, or arrange for the provision of, services similar to those which the NHS Commissioning Board will be responsible for commissioning. This reflects the power that the Secretary of State has under section 64 of the Health Services and Public Health Act 1968, (exercised by SHAs and PCTs prior to their abolition). Equivalent provision is provided in the Act for CCGs under new section 14Z6.

234. *Board's incidental powers: further provision.* New section 13Y gives the NHS Commissioning Board powers to enter into agreements, acquire and dispose of property and accept gifts (including property to be held on trust for the purposes of the NHS Commissioning Board).

Exercise of functions of Board

235. *Exercise of functions.* New section 13Z confers a power on the NHS Commissioning Board to exercise any of its functions by or jointly with a Special Health Authority, a CCG or any other body specified in regulations. Regulations may specify which functions of the NHS Commissioning Board may not be exercised by or jointly with such bodies. Where functions are exercised jointly, this may be through a joint committee of the NHS Commissioning Board and the other body under arrangements agreed between them.

Power to confer additional functions

236. *Power to confer additional functions on the Board.* New section 13Z1 gives the Secretary of State the power to confer additional functions relating to the health service on the NHS Commissioning Board through regulations. These regulations would be subject to the affirmative procedure, and would enable the Secretary of State to provide for additional functions to be carried out by the NHS Commissioning Board if this were beneficial for the effective operation of the health service. A function may only be conferred on the NHS Commissioning Board if it is connected to another function of the NHS Commissioning Board.

Intervention powers

237. *Failure by the Board to discharge any of its functions.* New section 13Z2 confers a power on the Secretary of State to intervene in cases of significant failure of the NHS Commissioning Board to carry out any of its functions properly or at all. Failure to discharge a function properly would include failure to discharge that function consistently with what the Secretary of State considers to be in the interests of the health service (subsection (5)). It is in line with similar powers in the case of significant failure of the other arm's-length bodies.

238. Similar intervention powers exist in respect of Monitor and the Care Quality Commission, but with the difference that as regards those bodies the Secretary of State would not be able to intervene in a particular case - he would have to demonstrate that the failure was more widespread. This limitation is intended to maintain the independence of the regulators, but is not appropriate with respect to the NHS Commissioning Board. The NHS Commissioning Board has a wide range of functions in relation to the health service. As a result, in the event of significant failure, it might be appropriate for the Secretary of State to intervene in a particular case, for example if the NHS Commissioning Board failed to allocate funds to a particular CCG or if it failed to commission a service as required by the NHS Act.

239. The powers conferred by this new section are not intended to be powers that the Secretary of State would use regularly or routinely to intervene in the affairs of the NHS Commissioning Board.

Disclosure of information

240. *Permitted disclosures of information.* New section 13Z3 sets out categories of information obtained by the NHS Commissioning Board that it is permitted to disclose. It also deals with the relationship between the powers under the section and the rules of common law on disclosure.

241. *Interpretation.* New section 13Z4 sets out interpretation of various terms used throughout Chapter A1, including the definition of health services. Subsections (2) and (3) list those references to functions of the NHS Commissioning Board in Chapter A1, elsewhere in the Act and in other legislation that are to include public health functions that are delegated to the NHS Commissioning Board by the Secretary of State using the powers in new section 7A. Those powers and duties would therefore apply when the NHS Commissioning Board exercises any delegated public health functions.

Section 24 - Financial arrangements for the Board

242. This section inserts new sections 223B (funding of the Board), 223C (financial duties of the Board: expenditure), 223D (financial duties of the Board: controls on total resource use), 223E (financial duties of the Board: additional controls on resource use), and 223F (power to establish contingency fund) into the NHS Act. Broadly, this section sets out how the Secretary of State would fund the NHS Commissioning Board. It also sets out the general financial duties of the NHS Commissioning Board, including restrictions on the use of resources. The Secretary of State would specify annually in the mandate to the NHS Commissioning Board limits on the total amounts of capital and revenue resources the NHS Commissioning Board and CCGs could make use of in that financial year. The Secretary of State would then make payments to the NHS Commissioning Board up to an amount allotted for that year, which would be calculated by reference to the NHS Commissioning Board's spending plans against the resource limits specified in the mandate.

243. *Funding of the Board.* New section 223B provides that the Secretary of State must pay sums not exceeding the amount allotted to the NHS Commissioning Board for that year to enable it to perform its functions. The NHS Commissioning Board will be notified in writing of the amount it has been allotted for that year (the allotment). Payment of the

allotment would be subject to the NHS Commissioning Board keeping such records, pertaining to the funds, as the Secretary of State requires (new section 223B(5)).

244. The Secretary of State would only be able to make a new allotment in any given financial year, either increasing or reducing the previous allotment, under certain circumstances. Either the NHS Commissioning Board must agree to the change, a parliamentary general election must have taken place, or there must be exceptional circumstances, which the Secretary of State judges to necessitate a new allotment. Such exceptional circumstances might include a severe disease outbreak or unpredictable and substantial damage to infrastructure. The allotment would in practice be calculated by reference to the controls on resource use specified in the mandate to the NHS Commissioning Board.

245. *Financial duties of the Board: expenditure.* Under new section 223C, the NHS Commissioning Board will have an obligation to ensure that total expenditure by both the NHS Commissioning Board and CCGs (total health expenditure) does not exceed the aggregate of the amount allotted to the NHS Commissioning Board by the Secretary of State for that year, which includes the money paid to CCGs, and any income derived from other sources. This is in effect an annual "cash limit" on the total amount of cash expenditure which may be incurred by NHS commissioners.

246. The income which counts for the purposes of this limit would include, for instance, funds received as a result of the power of the NHS Commissioning Board to generate its own income (see new section 13W) or any money received by NHS Commissioning Board in order to comply with its freedom of information obligations. It would also include sums paid to the NHS Commissioning Board or to CCGs for carrying out the Secretary of State's public health functions under arrangements made between the NHS Commissioning Board and the Secretary of State under new section 7A of the NHS Act, as inserted by the previous section.

247. The Secretary of State has the power to determine by directions what will and what will not count when calculating whether total health expenditure has remained within the aggregate of the sums received and the amount allotted to it for that year. New section 223C(4) also gives the Secretary of State a power to determine in directions the extent to which, and the circumstances in which, sums received by the NHS Commissioning Board under new section 223B, or by a CCG under new section 223G, but not yet spent must be treated for the purposes of this section as part of total health expenditure, and to which financial year's expenditure they must be attributed.

248. *Financial duties of the Board: controls on total resource use.* New section 223D is concerned with the NHS Commissioning Board's annual resource allocation. Under this section, the total use of capital resources and the total use of revenue resources by the NHS Commissioning Board and CCGs in a financial year must not exceed amounts specified by the Secretary of State. The NHS Commissioning Board is placed under a duty to ensure that these total limits are not exceeded. These are known as resource allocations and the amounts would be specified by the Secretary of State in the mandate for that year.

249. The resource allocations include not only the NHS Commissioning Board's expenditure in the form of cash spending (that is, the cash spending that should be accounted for in that financial year, in line with resource accounting standards), but also consumption of other resources and the reduction in value of assets belonging to the NHS Commissioning Board (new section 223D(8)). For example, the reduction in value of a photocopier across the year, or the distribution of leaflets previously kept in storage, would be counted as part of the NHS Commissioning Board's resource allocation. This system of setting not only a cash limit on the NHS Commissioning Board expenditure but also a limit on use of resources reflects the system for controlling government resources under the Government Resources and Accounts Act 2000.

250. Subsections (4) to (6) give the Secretary of State a power to give directions that specify what descriptions of resources must be treated as capital or revenue resources, and the uses of resources that must, or must not, be taken into account, when determining whether the NHS Commissioning Board and CCGs have remained within the resource allocations for a financial year. Where the Secretary of State specifies that a particular description of resources must or must not be treated as a capital or revenue resource, or that a particular use of resources must be excluded, that applies to the other financial duties on the NHS Commissioning Board and CCGs in Chapter 3 (section 223E and new sections 223G to 223K of the NHS Act).

251. As with the allotment, the Secretary of State may only vary the resource allocations within a financial year if the NHS Commissioning Board agrees that the change is necessary, if there is a parliamentary general election, or if the Secretary of State believes there to be exceptional circumstances which demand a variation of the allocation. This is set out in subsection (7). As both the revenue and capital resource allocations will be set out in the Secretary of State's mandate to the NHS Commissioning Board, any change to them will therefore require the Secretary of State to revise the mandate and lay it before Parliament along with an explanation for the change (see new section 13B).

252. *Financial duties of the Board: additional controls on resource use.* New section 223E(3) enables the Secretary of State to specify additional limits within the total revenue resource limit on both the maximum use of resources attributable to administrative matters by both the NHS Commissioning Board and CCGs (223E(3)(a)), and the maximum use of resources by the NHS Commissioning Board on these matters (223E(3)(b)). It will be for the NHS Commissioning Board to then set an equivalent limit for each CCG under new section 223J. The matters relating to administration which count for the purposes of these limits will be set out in regulations.

253. Under new section 223E(1) and (2), the Secretary of State will also be able to set additional limits on total revenue or total capital resource use attributable to particular matters specified in directions. Subsection (5) requires that the Secretary of State may only impose such limits for the purpose of complying with limits imposed by HM Treasury. These limits relate to specific budgetary limits applied across all Government Departments on certain elements of spending. For example within the revenue Departmental Expenditure Limit (RDEL), HM Treasury applies a ring-fence to spending on depreciation. HM Treasury applies controls on Annually Managed Expenditure (AME) under which there are limits on the creation of new provisions (charges for spending that is likely to happen in future years eg clinical negligence or redundancy costs). The Department would also apply a limit on the balance of spending not covered by the specific limits, again to provide consistency with the controls applied by HM Treasury. These types of spending will fall within the total resource limits but need to be separately controlled within them.

254. The Secretary of State will be able to specify in directions certain uses of capital or revenue resources which must, or must not, count for the purposes of these limits (subsection (4)). In addition, the Secretary of State directions on what resources are to be treated as capital or revenue resources, and the uses of resources which are not to be taken into account, made under section 223D(4) and (5) apply to the limits under this section.

255. *Power to establish contingency fund.* New section 223F gives the NHS Commissioning Board a power to set up a contingency fund, using a proportion of the funds allotted to it by the Secretary of State, from which it can make payments to the NHS Commissioning Board or to CCGs to enable them to discharge their commissioning functions or to enable a CCG to discharge its other functions exercisable by virtue of regulations under section 75 of the NHS Act.

Further provision about clinical commissioning groups

Section 25 – Clinical commissioning groups: establishment etc.

256. *Establishment of clinical commissioning groups.* This section inserts Chapter A2 into Part 2 of the NHS Act, which makes further provision about CCGs. New sections 14A to 14O of the NHS Act make provision about the establishment of CCGs.

257. *General duties of Board in relation to clinical commissioning groups.* New section 14A sets out the general duties of the NHS Commissioning Board in relation to CCGs. Subsection (1) requires the Board to ensure that, at any time after the date specified by an order of the Secretary of State, all providers of primary medical services (for instance GP practices) in England are members of a CCG.

258. Subsection (2) requires the NHS Commissioning Board also to ensure that, from the date so specified by the Secretary of State, the areas specified in each CCG's constitution taken together cover the whole of England and do not coincide or overlap. This will ensure, for instance, that there is no ambiguity as to which CCG is responsible for a person that is not registered with a GP practice or who needs access to emergency healthcare.

259. Subsection (3) specifies that a provider of primary medical services for the purposes of this Chapter is a person who is a party to a contract or arrangement that is described in subsection (4), in other words, a person or organisation that holds a General Medical Services (GMS) contract, a Personal Medical Services (PMS) agreement or an Alternative Provider Medical Services (APMS) contract to provide primary medical services of a type set out in regulations – it is intended that these regulations will prescribe essential primary medical services to registered patients in core hours. Together, these subsections have the effect that all GP practices that hold an NHS contract must be members of a CCG. Where two or more individuals practise as GPs in partnership, it is the partnership that is treated as a single provider of primary medical services, not the individuals in that partnership (subsection (6)). Similarly, where two or more individuals are parties to an arrangement in subsection (4) but are not a partnership they are to be treated as one person for these purposes (subsection (7)).

260. *Applications for the establishment of clinical commissioning groups*. New section 14B makes provision for applications to be established as a CCG to be made to the NHS Commissioning Board (subsection (1)). Under subsection (2), an application may be made by two or more persons, provided that each of them is either a provider of primary medical services (a GP contract holder) or wishes to be so and they wish to be a member of the proposed CCG. Under subsection (3), applications must include a copy of the CCG's proposed constitution, the name of the person whom the CCG wishes the NHS Commissioning Board to appoint as its accountable officer and such other information that the NHS Commissioning Board may specify. Any specification made by the Board for these purposes must be published in a document. Subsection (4) provides for persons to become applicants or withdraw from being applicants at any time before the application is decided by the NHS Commissioning Board. Subsection (5) provides that, with the agreement of the NHS Commissioning Board, applicants can modify the proposed constitution at any time before the application is determined. Subsection (6) introduces Part 1 of Schedule 1A (inserted by Schedule 2 to the Act), which makes provision about the constitution of a CCG.

261. *Determination of applications.* New section 14C provides for the determination of applications by the NHS Commissioning Board. The NHS Commissioning Board must, under subsection (1), grant an application for the establishment of a CCG if it is satisfied of the matters covered in subsection (2). These matters are:

- that the constitution complies with the requirements set out in Part 1 of Schedule 1A: for example that it sets out the name (which must meet requirements to be set out in regulations), members and area of the constitution, that it specifies

the arrangements the CCG has put in place for the discharge of its functions, and the procedures for decision making, discharging its duties in relation to conflicts of interest and ensuring effective participation by members; and that it is otherwise appropriate;

- that each member of a CCG will be a provider of primary medical services (i.e. that they will be a GP practice) on the date of establishment of the CCG;
- that the area of the CCG is appropriate;
- that the NHS Commissioning Board considers it appropriate to appoint as the CCG's accountable officer the person proposed by the applicants;
- that the applicants have made appropriate arrangements to discharge the CCG's functions; and
- that the applicants have made appropriate arrangements to ensure that the CCG will have a governing body that meets the requirements of the Act.

262. Regulations under subsection (2)(g) may set out other matters that the NHS Commissioning Board has to be satisfied about. Regulations under subsection (3) may set out factors that the Board must or may take into account when determining an application for establishment. Regulations under this subsection may also make provision about the procedure for the making and determination of applications.

263. *Effect of grant of application*. New section 14D provides for the establishment of a CCG upon the grant of an application (under section 14C). The grant of an application for establishment has the effect that the CCG is established as a statutory body and the CCG's proposed constitution then has effect. This section also introduces Part 2 of Schedule 1A, which makes further provision about CCGs.

264. *Variation of constitution*. New sections 14E and 14F make provision about the variation of a CCG's constitution. Under section 14E, a CCG may apply to the NHS Commissioning Board for its constitution to be varied. Regulations may make provision about the procedure to be followed when applying for a variation; the circumstances in which the NHS Commissioning Board must or may grant, or must or may refuse, an application; and factors the NHS Commissioning Board must or may take into account when deciding whether to grant or refuse an application.

265. Section 14F gives the NHS Commissioning Board powers to vary a CCG's constitution otherwise than on application by the CCG. The NHS Commissioning Board may change the area specified in a CCG's constitution, and may add any provider of primary medical services to, or remove any provider from, a CCG's list of members. Before exercising these powers, the NHS Commissioning Board must consult the CCG and any other CCGs that, in the Board's view, might be affected by the proposed variation. The powers can only be exercised if the CCG whose constitution is to be varied agrees to the change, or if the NHS Commissioning Board considers that it is necessary to make the variation to discharge its duties under section 14A (that is, to ensure that every provider of primary medical services is a member of a CCG or to ensure that the areas specified in the constitutions of CCGs together cover the whole of England and do not coincide or overlap). Regulations may be made setting out further circumstances in which the NHS Commissioning Board may vary the constitution of a CCG, the circumstances in which those powers can be exercised and the procedure to be followed.

266. *Mergers, dissolution etc.* New sections 14G and 14H make provision about the merger and dissolution of CCGs. Section 14G allows CCGs to apply to the NHS Commissioning Board to merge, that is for those CCGs to be dissolved and for a new CCG to be established in their place. Any application under section 14G must include a copy of the proposed constitution of the new merged CCG, the name of the person whom the CCG wishes the NHS Commissioning Board to appoint as its accountable officer, and such other information that the NHS Commissioning Board may specify.

Sections 14C and 14D, which make provision about the determination of applications and effect of grant of applications, also apply here.

267. Section 14H provides for a CCG to apply to the NHS Commissioning Board to be dissolved. Regulations under subsection (2) may make provision about the circumstances in which the NHS Commissioning Board must or may grant, or must or may refuse, applications under this section; the factors that the NHS Commissioning Board must or may take into account in determining whether to grant those applications; and the procedure for making and determining applications.

268. *Transfers in connection with variation, merger, dissolution etc.* Under section 14I, when variations, mergers or dissolutions take place, the NHS Commissioning Board may make a scheme providing for the transfer of property or staff, or any associated rights and liabilities, of the CCG to the NHS Commissioning Board or to another CCG. Section 14I also introduces Part 3 of Schedule 1A which makes further provision about transfer schemes.

269. *Publication of constitution of clinical commissioning groups*. Section 14J requires a CCG to publish its constitution. It also, under subsection (2), requires a CCG to publish a constitution if it is varied under 14E or 14F as it has been varied.

270. *Guidance about the establishment of clinical commissioning groups etc.* Under section 14K, the NHS Commissioning Board may publish guidance about how applications for establishment as a CCG should be made, including guidance as to the form, content and publication of the proposed constitutions and guidance on applications to vary, merge or dissolve a CCG). This would enable the NHS Commissioning Board, for instance, to issue guidance on how good governance principles might be reflected in a CCG's constitution.

271. *Governing bodies of clinical commissioning groups.* Section 14L specifies that each CCG must have a governing body. The governing body will have the role of assuring that the CCG has made the appropriate arrangements to ensure that it complies with its duty to act with effectiveness, efficiency and economy (new section 14Q). It must also ensure that the CCG has appropriate arrangements in place to comply with generally accepted principles of good governance as are relevant to it. These are described in subsection (2) as the 'main functions' of the governing body.

272. Governing bodies also have the function, under subsection (3)(a), of determining the remuneration, fees and allowances payable to CCG employees and others providing services to it (such as self-employed IT consultants) and of determining the allowances payable under a pension scheme established by the CCG under paragraph 11(4) of Schedule 1A (under subsection (3)(b)). Regulations under subsection (6) may require governing bodies to publish specified information in relation to such determinations In addition, the NHS Commissioning Board may publish guidance (under subsection (7)) for governing bodies on the exercise of their functions in relation to pay and remuneration.

273. Subsection 3(c) allows the CCG constitution and regulations to confer further functions upon the governing body, provided that these are connected with the main functions of the governing body.

274. Subsection (4) specifies that only the following can be members of the governing body:

- A CCG member who is an individual;
- An individual, appointed by virtue of regulations made under 14N(2);
- An individual, of a description set out in the CCG's constitution.

275. Subsection (5) allows regulations to prescribe circumstances in which a CCG must obtain the approval of its governing body before the CCG exercises specified functions.

276. *Audit and remuneration committees of governing bodies.* Section 14M requires CCG governing bodies to have both an audit committee and a remuneration committee. The audit committee has such functions in relation to the financial duties of the CCG as the governing body considers appropriate. Its role is to assist the governing body in ensuring the CCG carries out its prescribed functions appropriately.

277. The remuneration committee has the function of making recommendations to the governing body about the determination of remuneration, fees and allowances payable to CCG employees and others providing services to it and determining the allowances payable under a pension scheme established by the CCG under paragraph 11(4) of Schedule 1A. Regulations and the CCG constitution can confer additional, functions on the audit and remuneration committees, provided that they are connected with the governing body's main functions.

278. *Regulations as to governing bodies of clinical commissioning groups*. Section 14N provides a number of regulation-making powers. It is intended that regulations made under these powers will, without being overly prescriptive, set out some of the detail needed for the set-up of CCGs' governing bodies and their statutory committees.

279. Regulations may:

- specify the minimum number of members of governing bodies;
- specify certain requirements as to membership of governing bodies and their statutory committees- for example that the governing body must include the CCG's accountable officer and requirements as to membership of healthcare professionals of a prescribed description and lay persons;
- make provision as to the qualification, appointment and tenure of members of governing bodies and their statutory committees;
- make provision as to the qualification, appointment and tenure of chairs;
- specify information to be included in constitutions (in relation to paragraph 7 of Schedule 1A (as set out in Schedule 2 to the Act) which concerns the decision making process; and
- make such other provision about the procedure of governing bodies or their statutory committees as the Secretary of State deems appropriate, including as regards frequency of meetings.

280. *Registers of interests and management of conflicts of interest.* New section 14O subsection (1) requires a CCG to maintain one or more registers of the interests of members of the group, the members of the governing body, employees of the group, and members of committees and sub-committees of the group, and committees and sub-committees of the governing body. Sub-section (2) requires that the registers are published by the CCG or arrangements made by the CCG to ensure that they are available to the public on request.

281. Under subsection (3), each CCG must make arrangements to ensure that members of the group, the members of the governing body, employees of the group, and members of committees and sub-committees of the group and committees and sub-committees of the governing body declare any conflict of interest, or potential interest they may have in relation to a decision to be made by the group in the exercise of its commissioning functions,. The declaration must be made as soon as possible after the individual becomes aware of the potential conflict, and in any event within 28 days. The arrangements made by the CCG must ensure that the declaration so made is included in the appropriate register of interests.

282. Under subsection (4), the CCG must make arrangements for managing conflicts and potential conflicts of interest, so they do not influence the group's decision making, or appear to do so.

283. Under subsection (5), the NHS Commissioning Board must issue guidance for CCGs on the discharge of their functions under this section.

284. Subsection (6) requires that CCGs have regard to this guidance.

285. This section also inserts new Schedule 1A (set out in Schedule 2 to the Act) into the NHS Act.

Schedule 2 – Clinical commissioning groups

New Schedule 1A, Part 1

286. *Constitution of clinical commissioning groups.* Part 1 of new Schedule 1A makes provision for the constitution of CCGs. Paragraph 1 provides that a CCG must have a constitution.

287. Paragraph 2 provides that the constitution must specify the name and members of the CCG and the geographical area of the CCG. This geographical area is relevant (among other matters) to the CCG's commissioning responsibilities under subsection (1B) of amended section 3 of the NHS Act (for example in relation to people who are not registered with any GP practice). The geographical area is also relevant to the health and wellbeing board(s) of which it must be a member. Under paragraph 2(2), each CCG's name must comply with any requirements as may be set out in regulations.

288. Paragraph 3 provides that the constitution must specify the arrangements for the discharge of the CCG's functions, including functions in relation to determining the terms and conditions of its employees. Those arrangements may include the appointment of committees or sub-committees; the membership of these committees may include persons other than members of the CCG and its employees, such as members of the public. The arrangements may also include provision for any of the functions of the CCG to be exercised on its behalf by any of its members or employees, its governing body or a committee or subcommittee of the group.

289. Paragraph 4 provides that the constitution must specify the procedures that the CCG will follow in making decisions and the arrangements made to secure that decisions are made transparently.

290. Paragraph 5 provides that the constitution must specify the arrangements made by the group for the discharge of its duties under section 14O. .

291. Paragraph 6 sets out that the provision made by virtue of paragraphs 3 and 4 must ensure that there is effective participation by each member of the CCG in the exercise of the CCG's functions

292. Paragraphs 7 and 8 provide that CCG's constitutions must specify a number of matters as regards governing bodies.

293. Paragraph 7 provides that the constitution must specify the arrangements made by the CCG for the discharge of the governing body's functions. Those arrangements must include provision for the appointment of the audit and remuneration committees and may include arrangements for the appointment of any other committees and sub-committees of the governing body. The arrangements for the audit committee may allow for people who are not members of the governing body to sit on the audit committee. Only members of the governing body can sit on the remuneration committee. As regards other committees that may be established, the committee members may include persons who are not members of the governing body, but are members of the CCG, or individuals of a description as specified in the constitution. Arrangements specified may also include arrangements for governing body functions to be delegated to committees, individual governing body members, individual CCG members, or individuals of a description as specified in the constitution. These arrangements may

include arrangements in respect of functions delegated to the governing body by the CCG under paragraph 3(3) of the Schedule.

294. Paragraph 8 sets out that the constitution must specify: the procedure to be followed by the governing body in its decision-making, and the arrangements made to ensure transparency of decision making. In particular these last arrangements must include provision for making meetings of the governing body open to the public, except where it would not be in the public interest in relation to all or part of a meeting.

295. Paragraph 9 provides that CCGs may include other matters in their constitutions over and above those matters required to be included under Part 1. Such provision should be consistent with the provisions of the Act

New Schedule 1A, Part 2

296. New Schedule 1A Part 2 makes further provision about CCGs. Each CCG is to be a body corporate (paragraph 10) which may appoint employees on such terms and conditions as it determines, with such remuneration and other allowances in accordance with determinations made by its governing body (paragraph 11).

297. CCGs are to be granted the status of 'Employing Authorities' by amending the NHS Pension Scheme Regulations (after the passage of the Act). This means that (like other NHS bodies such as foundation trusts) CCGs would then be required to offer the NHS pension scheme to their employees, and would have to enrol their employees automatically in that scheme unless they opted out. Should any employees opt out, CCGs would have the power under paragraph 11(3) to (5) to offer alternative pension arrangements or schemes should they wish. Foundation trusts already have this power.

298. Paragraph 12 provides that each CCG must have an accountable officer, who may be either a member of the CCG or an employee. The accountable officer is appointed by the NHS Commissioning Board. They may be the accountable officer for more than one CCG. If the accountable officer is not an employee of a CCG, the CCG may remunerate and pay other allowances to the accountable officer in accordance with determinations made by its governing body.

299. The CCG may make arrangements to provide pensions, allowances and gratuities to its accountable officer, including by way of compensation in respect of loss of office or loss or reduction of total remuneration access to any pension scheme the CCG establishes (under paragraph 11(4) of Schedule 1A) – note that this would be an alternative to the NHS Pension Scheme.

300. The accountable officer is responsible for ensuring the CCG complies with its financial obligations (under new sections 223H to 223J of the NHS Act), its requirements for keeping proper accounts (under paragraph 17 of this schedule), its requirements for providing financial information to the NHS Commissioning Board (under paragraph 18) and its duty to provide information required by the Secretary of State (under paragraph 19). The accountable officer is also responsible for ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically under new section 14Q, and its duties under new section 14R in relation to improvement in the quality of services. Furthermore, the accountable officer must ensure that the CCG exercises its functions in a way which provides good value for money. Other obligations under the NHS Act may be specified in a document published by the NHS Commissioning Board for these purposes.

301. Paragraph 13 allows for payment to be made to members of the governing body of remuneration, travelling or other allowances and gratuities, as well as for provision of pensions. These arrangements may include the establishment and administration of pension schemes, or access to any pension scheme the CCG establishes (under paragraph 11(4) of Schedule 1A) and arrangements for the provision of pensions, allowances or gratuities by way of compensation for loss or reduction of total

remuneration. However, the arrangements for providing pensions, allowances or gratuities do not apply to members of the governing body who are members or employees of the CCG, or members or employees of a practice which is a member of the CCG.

302. Paragraph 14 permits a CCG to pay such travel and other allowances as it considers appropriate to members of the group who are individuals (as opposed to practices), individuals authorised to act on behalf of a member of the group in its dealings with the group, and any members of committees or sub-committees of the group or its governing body. This is intended to ensure that, where persons who are not employees undertake work on behalf of the group, they can receive expenses.

303. CCGs may hold property on trust and paragraph 15 confers a power on the Secretary of State to make an order appointing trustees to oversee the management of any property held on trust. The order may make provision for naming the trustees, the number of trustees, their term of office and any conditions of appointment. Where an order has been made, the Secretary of State may transfer property from the CCG to the trustees.

304. Paragraph 15 enables a CCG to enter into externally financed development agreements. Such an agreement is certified by the Secretary of State, who may issue a certificate where he considers that the purpose or main purpose of the agreement is the provision of services or facilities in connection with the CCG's discharge of its functions; and a person proposes to make a loan or other form of finance for another party in connection with that agreement.

305. Under paragraph 17 a CCG must keep proper accounts and records, and prepare annual accounts for each financial year. The NHS Commissioning Board may direct a CCG, with the approval of the Secretary of State, to prepare a set of accounts in respect of a "particular" period or periods of time. Powers are conferred on the NHS Commissioning Board to direct CCGs, with the approval of the Secretary of State as to the form and content of accounts, the methods and principles by which they are prepared, and the timescales for submitting audited annual accounts and any other accounts including unaudited annual accounts. Annual accounts must be audited in line with extant legislation. The Comptroller and Auditor General may examine a CCG's annual accounts and any related records, and any report on those accounts produced by an auditor or auditors. Section 306(7)(a) will ensure that the Secretary of State may, in a commencement order under section 306(4), provide that the duties to keep proper accounts and records, and to prepare annual accounts for each financial year, do not apply in relation to the whole or part of the "initial period" (the period between the coming into force of the provisions for the establishment of CCGs and the date specified by the Secretary of State by which every provider of primary medical services in England is to be a member of a CCG, proposed to be 1 April 2013). The power may be exercised in relation to all CCGs or only groups meeting certain conditions (e.g. those groups which were receiving income or incurring expenditure).

306. Paragraph 18 enables the NHS Commissioning Board to direct a CCG to supply it with information relating to its accounts, income or expenditure or its use of resources, within a specified period. The required information may include estimates of future CCG income, expenditure or use of resources.

307. Paragraph 19 requires disclosure by all CCGs to the NHS Commissioning Board of such information, in such form, and at such time or within such period, as the Secretary of State may require if the Secretary of State considers that information is necessary for the purposes of the Secretary of State's functions in relation to the health service.

308. The NHS Commissioning Board can also be required to provide, to the Secretary of State, any information obtained from CCGs.

309. Just as with the NHS Commissioning Board, CCGs sit within the Department of Health accounting and budgeting boundaries. The Department require information

to effectively and efficiently manage its financial position against, for instance, Departmental Expenditure Limits. In addition, the Department has a responsibility to provide information on those bodies for which it is accountable in order to meet requirements that may be set by HM Treasury and others on both financial and non-financial matters. Under this paragraph, it would not be possible for Secretary of State to request information from a single CCG or a "particular" group of CCGs. The Secretary of State must exercise the power in the same way in relation to all CCGs, for example by making the same request for information to all CCGs.

310. Paragraph 20 clarifies that CCGs under section 2 of the NHS Act have the power to acquire and dispose of property, enter into agreements including contracts, or accept gifts of property. Property in this sense means any possession, it is not limited to buildings or land.

311. Paragraph 21 gives CCGs the ability to execute a deed, for example, where passing a legal title, interest or right in relation to a transfer of land, under seal. It allows a CCG to authorise an individual or individuals, whose signature would authenticate use of a seal, so it would be taken as evidence that this was on behalf of the CCG. As an alternative, the CCG may authorise an individual to execute a document by signature, and this too must be taken as evidence that this was on behalf of the CCG.

New Schedule 1A, Part 3

312. Part 3 (paragraphs 22 to 26) of new Schedule 1A sets out further details in respect of property and staff transfer schemes that may be made under new section 14I. These schemes may transfer property, rights and liabilities, including those that could not otherwise be transferred, those arising after the making of the scheme, and criminal liabilities (paragraph 22).

313. A property or staff transfer scheme may also make supplementary, incidental, transitional and consequential provision (paragraph 23). New rights can be created, or liabilities imposed, in relation to the property or rights transferred. Provision may be made in the scheme about the continuing effect of things the person ("the transferor"- the person from whom the things are being transferred) has done in respect of the things transferred. Provision may also be made about the continuation of things that are being done by, on behalf of or in relation to the transferor in respect of the things transferred. Provision may also be made for references to "the transferor" in legal instruments and documents to be treated as references to "the transferee" (the person whom the things are being transferred to).

314. A property scheme may make provision for the shared ownership or use of property (paragraph 24). A staff transfer scheme may make provision that is the same or similar to the Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246) (paragraph 25). Both a property and staff transfer scheme can provide for the scheme to be modified by agreement after it comes into effect, and those modifications to have effect from the date when the original scheme comes into effect (paragraph 26).

Section 26 – Clinical commissioning groups: general duties etc.

315. This section inserts new sections 14P to 14Z24 into the NHS Act, which contain CCGs' duties, and powers, and provision for the NHS Commissioning Board to intervene in the event of failure.

316. *Duty to promote the NHS Constitution*. New section 14P imposes a duty upon CCGs both to act in the exercise of its functions (for example through their commissioning functions) with a view to securing that health services are provided in a way that promotes the NHS Constitution and to promote awareness of it among staff, patients and the public. This means that not only must CCGs act in accordance with the NHS Constitution, but they should ensure that people are made aware of their rights under it. They may also do this by contributing, as far as possible, to the advancement of the

Constitutions principles, rights, responsibilities and values, through their own actions and through facilitating the actions of stakeholders, partners and providers.

317. *Duty as to effectiveness, efficiency etc.* Under new section 14O, each CCG must exercise its functions effectively, efficiently and economically.

318. *Duty as to improvement in quality of services.* New section 14R places CCGs under a duty to exercise their functions with a view to securing continuous improvements in the quality of services provided to individuals, as part of the health service. This also reflects the accepted definition of quality[7] as comprising effectiveness, safety and patient experience. Subsection (4) requires CCGs, in discharging this duty, to have regard to any guidance issued by the NHS Commissioning Board under new section 14Z8 (on how CCGs should discharge their commissioning functions).

319. *Duty in relation to quality of primary medical services*. New section 14S provides that each CCG must assist and support the NHS Commissioning Board in discharging its duty under 13E as to improvement in the quality of services insofar as that relates to securing continuous improvement in the quality of primary medical services. In this way, each CCG would support the continuous improvement in the quality of primary medical services provided by CCG members.

320. *Duties as to reducing inequalities.* New section 14T sets out that CCGs must, in the exercise of their functions, have regard to the need to reduce inequalities between patients in access to health services and in the outcomes achieved from health services.

321. *Duty to promote involvement of each patient*. Section 14U requires CCGs in exercising their functions, to promote the involvement of patients and their carers and representatives in decisions about their own care (shared decision-making). This duty is intended to address the commitment outlined in the White Paper *Equity and Excellence: Liberating the NHS* to the policy of "no decision about me without me".

322. The duty would apply to any decisions at all stages of that individual's health care, from preventative measures, diagnosis of an illness, and any subsequent care and treatment they receive. Effective involvement of patients in these decisions might include such things as opportunities for patients to participate in treatment decisions in partnership with health professionals, to be supported to make informed decisions about the management of their care and treatment and to discuss opportunities for patients to manage their own condition. The NHS Commissioning Board must publish guidance on how to discharge this duty, to which CCGs must have regard.

323. *Duty as to patient choice*. Section 14V imposes a duty on CCGs, in the exercise of their functions, to act with a view to enabling patient choice (for example, by commissioning so as to allow patients a choice of treatments, or a choice of providers, for a particular treatment).

324. *Duty to obtain appropriate advice.* New section 14W requires CCGs to obtain appropriate advice from people who taken together have a broad range of professional expertise in relation to the prevention, diagnosis or treatment of illness, and the protection or improvement of public health to enable them to discharge their functions effectively. This could involve, for example, a CCG employing or otherwise retaining healthcare professionals to advise the CCG on commissioning decisions for certain services, or appointing professionals to any committee that the CCG may set up to support commissioning decisions. It could also involve consulting clinical networks and senates. The NHS Commissioning Board may publish guidance on the exercise of this duty to which CCGs must have regard.

325. *Duty to promote innovation.* New section 14X imposes a duty on CCGs, in the exercise of their functions, to promote innovation in the provision of health services and in

7 See, for example, the NHS Outcomes Framework published by the Department of Health on 20 December 2010, available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

making arrangements for the provision of health services. This means that not only will CCGs have to encourage new ways of thinking through commissioning, but they will also have to promote different commissioning methodologies.

326. *Duty in respect of research.* New section 14Y puts a duty on CCGs in respect of research. Each CCG must, in the exercise of its functions, promote health research and the use of evidence obtained from such research. A CCG could, for example, use evidence obtained from health research to inform its commissioning plan.

327. *Duty as to promoting education and training.* New section 14Z places a duty on each CCG in the exercise of their functions to have regard to the need to promote education and training to persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England, to assist the Secretary of State under his duty under new section 1E to secure an effective system for the planning and delivery of education and training in England for these people.

328. *Duty as to promoting integration*. New section 14Z1 gives CCGs a duty in relation to promoting integration, where it would benefit patients. They must exercise their functions with a view to securing that services are provided in an integrated way where this would improve the quality of the services, reduce inequalities of access or reduce inequalities in outcomes. In this manner, integration is not the aim itself, but a tool to encourage service improvement. This integration can be integration of health services with other health services or health services with health-related services (such as housing services where these have an effect on the health of individuals), or health services with social care services.

329. *Public involvement and consultation by clinical commissioning groups.* New section 14Z2 sets out requirements for involving the public (whether by consultation or otherwise). CCGs must make arrangements to involve individuals to whom services are being or may be provided in the commissioning process. Specifically, individuals must be involved in planning commissioning arrangements; in developing and considering proposals for changes in the commissioning arrangements, where those proposals would have an impact on how services are provided or the range of health services available; and in decisions that would likewise have a significant impact.

330. Each CCG must set out in its constitution a description of the arrangements made by it to fulfil this duty and a statement of the principles it will follow in implementing those arrangements. The NHS Commissioning Board may publish guidance for CCGs on how to discharge their duties under this section and CCGs must have regard to any such guidance.

331. The NHS Commissioning Board could, for instance, give guidance on effective ways of engaging and seeking views from members of the public, including how to engage people who do not regularly use healthcare services or are from disadvantaged communities. The NHS Commissioning Board could also give guidance to help CCGs decide in what circumstances the duty to involve might most appropriately be met by providing information and in what circumstances a CCG should actively seek people’s views through consultation.

332. *Arrangements with others.* New sections 14Z3 and 14Z4 enable CCGs to collaborate with each other and, in particular circumstances, with Local Health Boards.

333. *Arrangements by clinical commissioning groups in respect of the exercise of functions.* New section 14Z3 enables CCGs to collaborate in respect of the exercise of their commissioning functions. CCGs may make arrangements under subsection (2)(a) for one CCG to take a role as lead commissioner and exercise commissioning functions on behalf of other CCGs. CCGs may, under subsection (2)(b), exercise their functions jointly. In exercising these powers, a CCG may make payments to other CCGs, may make the services of its employees or other resources available to other CCGs, and

may establish pooled funds. Subsection (6) makes clear that these arrangements do not change the responsibility of any CCG to ensure its functions are discharged properly or any liabilities arising from the exercise of those functions.

334. *Joint exercise of functions with Local Health Boards*. Regulations may be made under new section 14Z4 to allow any prescribed functions of a CCG to be exercised jointly with a Local Health Board. Local Health Boards are the bodies responsible for commissioning and providing health services in Wales. Regulations may also make provision for any such functions to be exercised by a joint committee of the CCG and the Local Health Board. Subsection (3) makes it clear that these arrangements do not change the responsibility of any CCG to ensure its functions are discharged properly or any liabilities arising from the exercise of those functions.

335. A CCG may also provide advice or assistance to any public authority in the Isle of Man or Channel Islands, on such terms, including as to payment, as the CCG considers appropriate (section 298).

336. *Additional powers of clinical commissioning groups.* Additional powers for CCGs are set out in new sections 14Z5 and 14Z6.

337. *Raising additional income.* New section 14Z5 enables CCGs to undertake certain activities to raise additional income for improving the health service, provided that this does not significantly interfere with the CCG's ability to perform its functions. These activities are to acquire, produce, manufacture and supply goods; to acquire land by agreement and manage and deal with land; to provide instruction for any person; to develop and exploit ideas and exploit intellectual property; to do anything whatsoever which appears to the CCG to be calculated to facilitate, or to be conducive or incidental to, the exercise of any power conferred by this subsection - and to make such charge as the CCG considers appropriate.

338. *Power to make grants.* New section 14Z6 enables CCGs to make grants or loans, subject to such conditions as the CCG deems appropriate, to voluntary organisations that provide or arrange for the provision of services similar to the services in respect of which the CCG has functions.

339. *Board's functions in relation to clinical commissioning groups.* New sections 14Z7, 14Z8, 14Z9 and 14Z10 make provision for the NHS Commissioning Board to have functions in relation to assisting CCGs.

340. *Responsibility for payments to providers.* New section 14Z7 gives the NHS Commissioning Board the power to publish a document specifying the circumstances in which a CCG is liable to make payments to a provider to pay for services provided under arrangements commissioned by another CCG. This provision would, for instance, enable the NHS Commissioning Board to specify that, where a person uses an urgent care service commissioned by a CCG other than the CCG that is ordinarily responsible for that person's healthcare, the cost of that service is charged to the latter CCG. It could, for instance, decide that CCGs should be left to agree mutual arrangements for sharing costs where patients from a number of different CCGs use the same urgent care service. However, where the NHS Commissioning Board publishes such a specification, a CCG will be required to make payments in accordance with that document (subsections (2) and (3)). In those circumstances, no other CCG will be liable for the payment. Any sums payable by virtue of subsection (2) may be recovered under subsection (5) as a civil debt. Where the NHS Commissioning Board makes a specification, it may publish guidance for the purpose of assisting CCGs understand, and apply, it (subsection (6)).

341. *Guidance on commissioning by the Board.* Section 14Z8 provides that the NHS Commissioning Board must publish guidance for CCGs on the discharge of their commissioning functions (subsection (1)). CCGs must have regard to this guidance (subsection (2)). The Healthwatch England committee of the Care Quality Commission must be consulted before the NHS Commissioning Board publishes any guidance or

any revised guidance containing changes that are in the NHS Commissioning Board's opinion significant (subsection (3)).

342. *Exercise of functions by the Board.* New section 14Z9 provides that the NHS Commissioning Board may act on behalf of a CCG and arrange for the provision of services and exercise related functions, if requested to do so by the CCG (or in other words, by mutual agreement between the NHS Commissioning Board and the CCG). Regulations may provide that the power does not apply to services or facilities of a prescribed description. Subsection (3) makes provision for terms, including payment terms, to be agreed between the NHS Commissioning Board and CCGs. Subsection (4) makes clear that these arrangements do not change the responsibility of any CCG to ensure its functions are discharged properly or any liabilities arising from the exercise of those functions.

343. *Power of Board to provide assistance or support.* New section 14Z10 provides that the NHS Commissioning Board has the power to provide assistance or support to CCGs (including financial assistance and making employees or other resources of the NHS Commissioning Board available to CCGs). This assistance may be provided on such terms as the NHS Commissioning Board considers appropriate, including payment terms. The NHS Commissioning Board can impose restrictions on the use of any such assistance.

344. *Commissioning plans.* New section 14Z11 makes provision with regard to commissioning plans. Section 14Z11(1) stipulates that each CCG must prepare a plan before the start of each relevant period to set out how it will exercise its functions. The plan must, in particular, explain how the CCG proposes to discharge its duties to seek continuous improvement in the quality of services (under new section 14R) and in relation to reducing inequalities (14T) and its financial duties (under sections 223H to 223J) and also its duty in relation to public involvement under 14Z2. This plan must be published and sent to the NHS Commissioning Board before a date specified by the Board. A copy must also be sent to the relevant health and wellbeing board. In a CCG's first financial year the 'relevant period' will begin on a date specified by the NHS Commissioning Board and end at the end of that financial year, it will then be each subsequent financial year. The NHS Commissioning Board may publish guidance on consultation on, and revision of, commissioning plans, to which CCGs must have regard.

345. *Revision of commissioning plans.* Under new section 14Z12, the commissioning plan may be revised. Should the proposed revision be deemed 'significant' by the CCG, it must give a copy to the NHS Commissioning Board by a date specified by the Board and must provide the relevant health and wellbeing board with a copy having carried out consultation under new section 14Z11 (below). Where the CCG revises the plan and the changes are not significant, it must still publish the revised plan. A copy must also be provided to each relevant health and wellbeing board and the NHS Commissioning Board.

346. *Consultation about commissioning plans.* Under new section 14Z12, when preparing a commissioning plan, or making a change it deems significant, the CCG must:

- consult individuals for whom it has responsibility for the purposes of section 3 of the NHS Act, for example the people to whom its members provide primary care services and those included within the CCG's geographic area responsibilities; and
- involve the relevant health and wellbeing board.

347. It must, in particular, provide the relevant health and wellbeing board with a copy of the draft plan or revised plan (as the case may be) and consult it on whether it adequately takes the latest joint health and wellbeing strategy into account. This means that CCGs would need to discuss their plans in advance with health and wellbeing boards to help ensure that they reflected joint health and wellbeing strategies.

348. The health and wellbeing board would have to give the CCG its opinion on this. It could also give its opinion to the NHS Commissioning Board. If it did so, the CCG must be given a copy of the opinion. If the CCG went on to make further changes, this process would have to be repeated. The revised plan would have to be published and a copy given the relevant health and wellbeing board and the NHS Commissioning Board.

349. When CCGs send their commissioning plans to the NHS Commissioning Board, they would be under an obligation to include:

- a summary of the views of individuals consulted;
- an explanation of how those views were taken into account; and
- a statement as to whether the relevant health and wellbeing board(s) agreed that the plans has due regard to the joint health and well-being strategy or strategies.

350. *Opinion of health and wellbeing boards on commissioning plans*. 14Z14 enables each health and wellbeing board to provide the NHS Commissioning Board with its opinion on whether a CCG's commissioning plan has taken proper account of the relevant joint health and wellbeing strategy. If it does so, it must provide a copy of this opinion to the CCG in question.

351. *Reports by clinical commissioning groups.* Under section 14Z15, in each financial year, save the first year of operation, each CCG must prepare and provide to the NHS Commissioning Board an annual report on how it has discharged its functions in the previous financial year. The report must, in particular, explain how it has fulfilled its duties to seek continuous improvement in the quality of services (section 14R), in relation to reducing inequalities (14T), and to involve patients and the public in commissioning decisions (section 14Z2). The CCG must publish the report and present it at a public meeting. The NHS Commissioning Board can give directions, which may include further provision on the form and content of an annual report. For example, these directions could specify that the report include a review of joint arrangements with local authorities and the outcome of any consultations undertaken under 14Z2.

352. *Performance assessment of clinical commissioning groups.* New section 14Z16 specifies that the NHS Commissioning Board must conduct an assessment of how well each CCG has discharged its functions during each financial year. In particular, it must assess how well the CCG has discharged its duty to seek continuous improvement in the quality of services (under new section 14R), its duty in relation to reducing inequalities (14T), its duty to obtain appropriate advice (14W), its duty to involve and consult the public (14Z2), its financial duties (under new sections 223H to 223J) and its duty to have regard to any relevant joint health and wellbeing strategy. In assessing performance, the NHS Commissioning Board must consult each relevant health and wellbeing board on whether the CCG has taken proper account of the relevant joint health and wellbeing strategy. It must also have regard to any relevant document published by the Secretary of State, which includes the NHS Outcomes Framework, and to any commissioning guidance published by the NHS Commissioning Board. Each financial year, the NHS Commissioning Board must publish a report containing a summary of the results of the performance assessments.

353. *Power to require documents and information etc.* New sections 14Z17 to 14Z20 are concerned with the NHS Commissioning Board's powers to require and use information. The NHS Commissioning Board can use the powers in section 14Z18 and 14Z19 to require documents, information and explanations, where it has reason to believe that a CCG might have failed, might be failing or might fail to discharge any of its functions properly, or where it believes the area of a CCG is no longer appropriate (see new section 14Z17(1)). A failure to discharge a function properly for these purposes includes a failure to discharge it consistently with what the NHS Commissioning Board considers to be the interests of the health service.

354. New section 14Z18 provides that, where the conditions in section 14Z17 are met, the NHS Commissioning Board may require the provision of any information, documents, records or other items from a CCG or any member or employee of the CCG having possession or control of the item, where the NHS Commissioning Board considers that it is necessary or expedient to have this for the purposes of any of its functions in relation to the CCG. When that information is stored on a computer, it must be provided to the NHS Commissioning Board in a legible form. By virtue of subsection (5) this power does not include the power to require the provision of personal records, as defined by reference to section 12 of the Police and Criminal Evidence Act 1984. This power does not therefore permit the NHS Commissioning Board to require documentary and other records concerning an individual (whether living or dead) who can be identified from them and relating to his physical or mental health; to spiritual counselling or assistance given or to be given to him; or to counselling or assistance given or to be given to him, for the purposes of his personal welfare, by any voluntary organisation or by any individual who because of his office or occupation has responsibilities for his personal welfare; or by reason of an order of a court has responsibilities for his supervision.

355. *Power to require explanation.* New section 14Z19 sets out the NHS Commissioning Board's power, where the conditions in section 14Z17 are met, to require an explanation, either orally (at such time and place as the NHS Commissioning Board may specify), or in writing, regarding any matter relating to the CCG's exercise of its functions. That explanation can include an explanation of how the CCG is proposing to exercise its functions.

356. *Use of information*. Where the NHS Commissioning Board obtains information from a CCG in these ways, new section 14Z20 permits the NHS Commissioning Board to use this information in connection with any of its functions which relate to CCGs.

357. *Intervention powers:* New section 14Z21 sets out the NHS Commissioning Board's powers to intervene in the operations of CCGs.

358. *Power to give directions, dissolve clinical commissioning groups etc*. Under new section 14Z21, if the NHS Commissioning Board is satisfied that a CCG is failing or has failed to discharge any of its functions (which includes a failure to discharge a function consistently with what the Board considers to be the interests of the health service), or there is a significant risk that it will fail to do so, the NHS Commissioning Board has powers to:

- direct the CCG to discharge a functions in a particular way and within a specified period;
- direct the CCG or the accountable officer to cease to perform any functions for a specified period;
- terminate the accountable officer's appointment and appoint another person to be accountable officer;
- vary a CCG's constitution (including by varying its area, adding any GP practice to its list of members, or removing any GP practice from its list of members); or
- dissolve that CCG.

359. Subsection (8) provides that, where a direction is given for the CCG to cease performing any specified functions, the NHS Commissioning Board may exercise those specified functions. Alternatively, the NHS Commissioning Board may direct that another CCG or the accountable officer of another CCG discharge those functions (providing the NHS Commissioning Board has consulted that CCG). Where the NHS Commissioning Board changes the constitution of a CCG or dissolves a CCG, it may make a scheme transferring any property, liabilities, or staff (as at Part 3 of Schedule 1A) of the affected CCG to the NHS Commissioning Board or another CCG. Subsection (9) sets out that where the NHS Commissioning Board exercises the function of a CCG

under subsection (8), the CCG must co-operate with the NHS Commissioning Board. Subsection (9) also provides that when a CCG's functions are being discharged by another CCG or the accountable officer of another CCG, the CCG whose functions are being discharged must co-operate with the other CCG or the accountable officer in question.

360. *Procedural requirements in connection with certain intervention powers.* New section 14Z22 impose procedural requirements which the NHS Commissioning Board must follow before dissolving a CCG under new section 14Z21(7). The NHS Commissioning Board must consult with that CCG, any relevant local authorities (defined in subsection (7)), and any other persons the NHS Commissioning Board considers appropriate; and provide those persons with a statement explaining its proposed actions and the reasons for them. The NHS Commissioning Board must, under subsection (3), publish a report in response to this consultation and, where it decides to exercise its power to dissolve a CCG, explain in the report its reasons for doing so (subsection (4)).

361. Subsection (5) of new section 14Z22 provides that regulations may be made as to the procedure that the NHS Commissioning Board must follow before exercising its powers to require information or explanation (under new sections 14Z18 or 14Z19) or before exercising the intervention powers in new section 14Z21. This will enable regulations to set out a clear, transparent set of triggers or criteria for different stages of intervention and to help ensure that the nature of the intervention is proportionate to the nature of the failure or risk.

362. Subsection (6) of new section 14Z22 provides that the NHS Commissioning Board must publish guidance setting out how it proposes to exercise its powers to require information or explanation and its powers of intervention, so as to ensure that the arrangements are clear and transparent.

363. *Permitted disclosures of information.* New section 14Z23 makes provision as to the circumstances when a CCG may disclose information obtained in the exercise of its functions. Unless the information has previously been lawfully disclosed to the public, the disclosure would be made under or pursuant to regulations under section 113 or 114 of the Health and Social Care (Community Health and Standards) Act 2003 (complaints about health care or social services), in accordance with any enactment or court order, or for the purpose of criminal proceedings, the CCG may not disclose information under section 14Z23 if to do so would be contrary to any rule of common law..

364. *Interpretation*. New section 14Z24 sets out when references to CCGs' functions include public health functions of the Secretary of State that have been delegated to them by virtue of arrangements under section 7A of the NHS Act. This list includes certain provisions of other Acts of Parliament that are amended by this Act. There is also a power for the list of provisions specified to be amended by order of the Secretary of State.

Section 27 - Financial arrangements for clinical commissioning groups

365. This section sets out the financial arrangements for CCGs, inserting new sections 223G to 223K into the NHS Act. The Secretary of State and the Department's Accounting Officer will remain accountable to Parliament for the Parliamentary Estimates of spending and to the Treasury for the Department of Health's Departmental Expenditure Limit (DEL), the annual spending limit for a government department arising from its agreed, long term financial settlement with HM Treasury. The Department will allocate resources for NHS commissioning to the NHS Commissioning Board and the NHS Commissioning Board has statutory duties to ensure that the commissioning sector as a whole lives within its spending and resource limits. The NHS Commissioning Board will in turn allocate resources to CCGs and CCGs will have a duty to live within their own spending and resource limits.

366. *Means of meeting expenditure of clinical commissioning groups out of public funds.* New section 223G sets out the NHS Commissioning Board's duties to make annual financial allotments to CCGs and, over the course of the relevant financial year, allows CCGs to draw down funding from this allotment to meet the CCG's expenditure. Subsection (1) sets out the latter duty. The funds that a CCG can draw down to meet its expenditure must not exceed the allotted amount. For these purposes, the funds that it draws down will be net of designated elements of pharmaceutical expenditure, which are paid by the NHS Commissioning Board, but which are treated as paid by the CCG (see section 51 and Schedule 3 to the Act).

367. Subsection (2) provides that, in determining a CCG's annual allotment, the NHS Commissioning Board may take into account the expenditure of the CCG during any previous financial year. This enables the NHS Commissioning Board to reduce a CCG's allotment to reflect any over-spends against its allotment in previous years, or conversely to increase that allotment to reflect any under-spends, provided that the NHS Commissioning Board keeps within its overall expenditure limit. Subsection (2) also enables the NHS Commissioning Board to take into account any amount that it proposes to hold as a contingency fund.

368. Subsection (3) provides for the NHS Commissioning Board to notify a CCG in writing of its annual financial allotment.

369. Subsection (4) allows the NHS Commissioning Board to make an in-year adjustment to a CCG's allotment, provided that it acts reasonably in line with general administrative law controls and subsection (5) provides that, where the NHS Commissioning Board allots an amount to a CCG or makes a new allotment, it must notify the Secretary of State.

370. Subsection (6) provides that the NHS Commissioning Board may direct that sums paid to a CCG as part of an increase in a CCG's allotment are spent in a certain way. The direction would apply only to the amount by which the allotment has increased, rather than the total allotment. The power might be used when, for instance, additional funds have been made available to make a specific service or therapy more widely available.

371. The NHS Commissioning Board may also give directions to a CCG in respect of charges and other sums related to the valuation and disposal of assets, which are payable to the NHS Commissioning Board. This would allow for monies from the sale of assets to be clawed back and therefore prevent CCGs from selling assets and using the proceeds inappropriately, for example by using the proceeds to fund a deficit. In practice, the monies would not be directly paid back to the NHS Commissioning Board, but the Board would deduct these amounts from the amount of capital funding provided.

372. *Financial duties of clinical commissioning groups: expenditure.* Section 223H sets out the duty for CCGs to break even on their commissioning budget, in other words to ensure that their cash expenditure in a financial year does not exceed the allotment given to them by the NHS Commissioning Board together with any other sums received by the CCG by other means. The NHS Commissioning Board has powers of direction to determine whether specified sums count for these purposes as being received by a CCG (in other words whether or not this income is treated as increasing the amount that a CCG can spend in a financial year) and whether specified expenditure made by a CCG, or sums received by a CCG from its allotment but not yet spent, must be treated for these purposes as counting towards its expenditure.

373. New section 223H also specifies that the Secretary of State may make directions requiring CCGs to use banking facilities specified in those directions for the purposes specified in those directions. It is an HM Treasury requirement that all NHS money is held in Government Banking Service (GBS) accounts. However, under this Act, the Secretary of State does not have general powers of direction over CCGs. The Government needs to ensure that firstly, all allocations to CCGs are held by CCGs in a GBS account, and secondly, that this is the account in which CCGs keep their allocation

and that the monies allocated to CCGs stay in GBS accounts until paid out (although there may be circumstances in which other commercial accounts may be held). This money is held in the GBS to offset the national debt.

374. *Financial duties of clinical commissioning groups: use of resources.* Section 223I sets out the duty for CCGs to ensure that their use of resources in a financial year does not exceed an amount specified by the NHS Commissioning Board. The NHS Commissioning Board will specify in directions a limit on capital resource use and a limit on revenue resource use. The NHS Commissioning Board can vary those limits in-year, provided that it acts reasonably in line with general administrative law principles. A CCG's use of resources will differ from its cash expenditure during a financial year. For instance, insofar as resources are consumed (e.g. a service is received) in a different year from that in which the payment for that service is made or insofar as there is a change in the value of assets belonging to the CCG, such as through depreciation. Any Secretary of State's directions under section 223D as to the descriptions and uses of resources, which must or must not be taken into account, apply for the purposes of these limits. In addition, the NHS Commissioning Board may give directions determining to which CCG a use of resources applies, when examining whether a CCG has lived within its resource limit. Where the NHS Commissioning Board gives directions to CCGs under this section, it must notify the Secretary of State.

375. The resource-use limits include not only CCGs' expenditure in the form of cash spending (that is, the cash spending that should be accounted for in that financial year, in line with resource accounting standards), but also consumption of other resources and the reduction in value of assets belonging to the CCG. For example, the reduction in value of a photocopier across the year, or the distribution of leaflets previously kept in storage would be counted as part of the CCG's resource-use limit. This system of setting not only a cash limit on the CCG expenditure, but also a limit on use of resources reflects the system for controlling government resources under the Government Resources and Accounts Act 2000.

376. *Financial duties of clinical commissioning groups: additional controls on resource use.* Section 223J gives the NHS Commissioning Board a power to direct the maximum amounts of resources a CCG may use in respect of particular matters specified in the direction or prescribed matters relating to administration. Such administration costs will, for instance, include the cost of employing or engaging staff to carry out commissioning functions or the cost of paying for an external organisation to provide commissioning support. The NHS Commissioning Board can vary any of these specified amounts and can determine by directions. the uses of capital and revenue resources that must or must not be taken into account for the purposes of any of these limits. In addition, any Secretary of State directions under section 223D of the NHS Act (inserted by section 24 of the Act), as to the description of resources which must or must not be treated as capital or revenue resources, apply for the purposes of these limits. Similarly, if the Secretary of State specifies in directions under section 223D(5) that a particular use of resources must not be taken into account, that use must not be taken into account for the purposes of the resource limits of CCGs.

377. The NHS Commissioning Board may not give directions to specify limits on the use of capital resources on specified matters, or the use of revenue resources on specified matters, unless the Secretary of State has given directions to the NHS Commissioning Board on those matters under section 223E(1) or 223E(2) of the NHS Act (inserted by section 24 of the Act).. Similarly, it may not give specify a limit the use of revenue resources for matters relating to administration, unless the Secretary of State has given a direction to the NHS Commissioning Board in relation to those matters under section 223E(3)(a) of the NHS Act.

378. *Payments in respect of quality.* New section 223K gives the NHS Commissioning Board the power to make a payment to a CCG after the end of the financial year.

379. In determining whether to make a payment and, if so, the amount, the NHS Commissioning Board must assess at least one of the following:

- quality of relevant services provided during the financial year;
- improvement in quality of relevant services provided during the financial year compared to previous financial years;
- the outcomes identified during the financial year as having been achieved from the provision at any time of relevant services; and
- improvements in outcomes, identified during the financial year as having been achieved from the provision at any time of relevant services when compared to outcomes identified in previous financial years.

380. In this way, it can both reward the performance delivered by a CCG and any improvements in performance. The NHS Commissioning Board may also take into account any relevant inequalities identified during that year and any reduction in inequalities identified during that year in comparison with relevant inequalities identified over previous financial years. Regulations may specify principles or other matters that the NHS Commissioning Board must or may take into account in assessing these factors. Further regulations may prescribe the circumstances in which the NHS Commissioning Board may decide to reduce a payment or not to make one.

381. Regulations may also prescribe how any payment made to a CCG in respect of quality may be spent, including its distribution amongst the CCG's members.

382. Each CCG must publish an explanation of how it has spent any payment made under this section.

Section 28 - *Requirement for primary medical services provider to belong to clinical commissioning group*

383. This section inserts new provisions into section 89 and section 94 of the NHS Act. *Subsection (1)* inserts new subsections (1A) to (1E) into section 89 of the NHS Act (General Medical Services (GMS) contracts: other required terms) which enable regulations made under subsection (1) of that section, which prescribe matters that may be included as required terms of a GMS contract, to include a number of further specific matters that relate to the relationship between the GMS contract holder and the relevant CCG. These matters include a requirement to be a member of a CCG and to nominate an individual to act on behalf of the contract holder in its dealings with the CCG. *Subsection (2)* makes similar changes to section 94 of the NHS Act by inserting new subsections (3A) to (3E) into that section (Regulations about section 92 arrangements).

Further provision about local authorities' role in the health service

Section 29 - *Other health service functions of local authorities under the 2006 Act*

384. This section enables the transfer to local authorities of PCTs' existing functions around dental public health, and extends to local authorities a duty to help deliver and sustain good health among the prison population.

385. *Subsection (2)* of this section amends section 111 of the NHS Act to provide for the transfer to local authorities of PCTs' existing functions in relation to dental public health (as set out in regulations made by the Secretary of State). This allows the Secretary of State to specify in secondary legislation the activity that local authorities should undertake to promote good dental public health – this might include oral health education campaigns, for example.

386. *Subsection (3)* amends section 249 of the Act to extend to local authorities a duty to co-operate with the prison service with a view to improving the exercise of functions

in relation to securing and maintaining the health of prisoners. The amendment would also enable the Secretary of State to make regulations enabling a local authority and the prison service to enter arrangements for the prison service to exercise local authority public health functions or for a local authority to exercise public health-related functions of the prison service.

387. In each case, the functions apply to those local authorities which have a duty to improve public health under new section 2B of the NHS Act. The Department's view is that the functions are consistent with the new duties for health improvement.

Section 30 - Appointment of directors of public health

388. This section requires local authorities and the Secretary of State to appoint directors of public health and makes related provision. PCTs are currently required to appoint directors of public health to provide local leadership and co-ordination of public health activity, but the section would in effect transfer that requirement to local authorities. The intention is that the director of public health role will become integral to the new public health responsibilities that this Act confers on local authorities. The provision applies to local authorities which have a duty to improve public health under new section 2B of the NHS Act.

389. The section inserts a new section 73A into the NHS Act. Subsection (1) provides that each local authority must, acting jointly with the Secretary of State, appoint a director of public health. It then defines the responsibilities of directors of public health as including:

a) the new health improvement duties that this Act would place on local authorities;

b) the exercise of any public health functions of the Secretary of State which the Secretary of State requires the local authority to exercise by regulations under section 6C of the NHS Act;

c) any public health activity undertaken by the local authority under arrangements with the Secretary of State;

d) local authority functions in relation to planning for, and responding to, emergencies that present a risk to public health;

e) the local authority role in co-operating with police, probation and prison services in relation to assessing risks of violent or sexual offenders; and

f) other public health functions that the Secretary of State may specify in regulations (e.g. functions in relation to making representations about the grant of a license to use premises for the supply of alcohol).

390. Directors of public health will be local authority employees. Local authorities will be able to dismiss their directors of public health, but only after consulting the Secretary of State (although the Secretary of State will not have a veto) (subsections (5) and (6)).

391. Where the Secretary of State considers a director of public health has failed or might have failed to carry out certain aspects of the director's responsibilities then the Secretary of State may require the local authority to take certain action. The responsibilities in question are the director's responsibilities for the exercise of the Secretary of State's public health functions which have been conferred on the local authority by regulations or agreement. The Secretary of State would not be able to take action in relation to the public health functions conferred directly on the local authority by the NHS Act (e.g. section 2B). The action which the Secretary of State may require consists of reviewing and investigating the director of public health's performance, considering any steps that may be necessary (including any that the Secretary of State may require the local authority to consider) and then reporting back to the Secretary of State on the action it has taken. See subsections (3) and (4).

Section 31 - Exercise of public health functions of local authorities

392. This section inserts a new section 73B into the NHS Act and applies to local authorities which have a duty to improve public health under new section 2B of the NHS Act. *Subsections (1)* and *(2)* require such local authorities to have regard to documents that the Secretary of State publishes for the purposes of the section, when exercising their public health functions; for example this power may be used to require local authorities to have regard to the Department's public health outcomes framework. The public health outcomes framework sets out the Government's goals for improving and protecting the nation's health and for narrowing health inequalities through improving the health of the poorest, fastest. Subsection (3) also provides that the Secretary of State may publish guidance to local authorities relating to their public health functions.

393. *Subsection (4)* provides that any document or guidance issued by the Secretary of State under this may include guidance to local authorities about the staff they employ to discharge their public health functions.

394. *Subsections (5)* and *(6)* require directors of public health to publish annual reports on the health of their local population and local authorities to publish that report. The reports are intended to help directors of public health to account for their activity and to chart progress over time.

Section 32 - Complaints about exercise of public health functions by local authorities

395. This section inserts new section 73C into the NHS Act, which gives the Secretary of State powers to make regulations setting up procedures for dealing with complaints about the exercise of public health functions by local authorities in England.

396. Subsection (1) of the new section provides for regulations to be made providing for the handling and consideration of complaints. These would apply to the exercise by a local authority of any public health functions under the NHS Act (see in particular section 11); the exercise of the Secretary of State's public health functions by a local authority; the exercise by a local authority of other functions relating to public health which are the responsibility of its director of public health; or the provision of services by another person following arrangements made by a local authority in exercising these functions.

397. Under subsection (2), the regulations may provide for who may consider a complaint. This may be the relevant local authority, an independent panel or any other person or body. It is envisaged that regulations will provide that the complaint be made to the local authority that is the subject of the complaint, where an attempt will be made to investigate and resolve the matter.

398. Under subsection (3), the regulations may provide for a complaint, or any matter raised by a complaint, to be referred to a Local Commissioner (i.e. the local government ombudsman) for consideration as to whether to investigate the complaint under local Government legislation, or to any other person or body for consideration as to whether to take action otherwise than under the regulations.

399. Subsection (4) sets out that where regulations provide for a complaint to be referred to a Local Commissioner, they may provide for the complaint to be treated as complying with the requirements of the Local Government Act 1974 as to who can complain, and the procedure for making a complaint, to a Commissioner.

400. Subsection (5) provides that supplementary provisions in section 115 of the Health and Social Care (Community Health and Standards) Act 2003 apply in relation to regulations made under new section 73C. The regulations may therefore provide for matters such as who may make a complaint and to whom a complaint may be made, the complaints which may or may not be made, and the procedure for making, handling and considering a complaint. Provision may also be made in relation to charges in relation

to the consideration of a complaint, making information available to the public about the procedures to be followed, and the disclosure of information or documents. The Department envisages making provision similar to that in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

401. Subsection (6) provides that 'local authority' has the same definition in new section 73C as in section 2B of the NHS Act; i.e. those local authorities which exercise public health functions under the Act (see section 9).

Abolition of Strategic Health Authorities and Primary Care Trusts

Section 33 - Abolition of Strategic Health Authorities

402. This section abolishes SHAs, and repeals Chapter 1 of Part 2 of the NHS Act, which makes provision for SHAs. It is intended that SHAs will be abolished on 1st April 2013.

Section 34 - Abolition of Primary Care Trusts

403. This section abolishes PCTs and repeals Chapter 2 of Part 2 of the NHS Act, which makes provision for PCTs.

404. The commissioning functions currently undertaken by PCTs are intended to fall to other health bodies such as CCGs, the NHS Commissioning Board, or local authorities. CCGs will be responsible for commissioning the great majority of health services, while the NHS Commissioning Board will be responsible for commissioning services that cannot be solely commissioned by clinical commissioning groups, such as national specialist services, and GP services. PCT responsibilities for local health improvement will transfer to local authorities, who will employ directors of public health jointly appointed with Public Health England.

405. Following this transfer of responsibilities, PCTs will no longer have commissioning responsibilities in the NHS. The Government intends for PCTs to retain commissioning responsibility until April 2013, as CCGs become developed and established. Once CCGs are able to take on their commissioning responsibilities, it is intended that PCTs will be abolished - this is intended to occur in April 2013.

Functions relating to fluoridation of water

Section 35 - Fluoridation of water supplies

406. This section amends Chapter 4 of Part 3 of the Water Industry Act 1991 (fluoridation), as amended by the Water Act 2003. Subsections (2) to (8) amend the Act to provide for the Secretary of State to make arrangements with a water undertaker to fluoridate a water supply. However, he may only do so if a local authority has made a fluoridation proposal, consulted on that proposal, and taken a final decision in accordance with the new sections of the 1991 Act inserted by section 36.

407. *Subsection (5)* inserts new subsections (7A) and (7B) of section 87 of the 1991 Act. Subsection (7A) requires the Secretary of State to consult local authorities on the terms of any fluoridation arrangements entered into with a water undertaker. Subsection (7B) defines local authorities for the purposes of the provisions. The effect is that upper-tier authorities are responsible for fluoridation proposals – i.e. county councils, a district council for an area in England where there is no county council (which includes "unitary boroughs"), London borough councils and the Common Council of the City of London.

408. *Subsection (6)* inserts new subsections (7C) to (7F) of section 87 of the 1991 Act. These subsections require co-ordination between the Secretary of State and Welsh Ministers in relation to schemes adjoining areas either side of the border. Currently there are no cross-border fluoridation schemes between England and Wales, nor are there any proposals for any. The requirements to co-ordinate would only be in put in place once

the legislation was brought into force in relation to both England and Wales. It is for Welsh Ministers to commence the provisions in relation to Wales.

409. *Subsection (9)* inserts new subsection (3A) into section 87A of the 1991 Act (target concentration of fluoridation). Currently the target concentration for fluoridation schemes is 1 milligram per litre - 1 part per million. Subsection (9) provides for a situation where, for technical reasons, a water undertaker is unable to provide this level of concentration to an area covered by a fluoridation scheme. For example, this might apply to an area that is distant from the water treatment works at which the fluoride is added to the water. New subsection (3A) ensures that when the Secretary of State receives a notification of such a technical problem, he would have to enter new arrangements or vary existing arrangements, so as to have a lower target concentration, but only having consulted the local authorities affected. The local authorities would in practice need to consider if the benefits to oral health at this lower concentration were still equal to the cost of fluoridating the area.

410. Arrangements (contracts) for water fluoridation schemes contain complex legal and technical requirements. It is possible that there will on occasions be disagreements as to the exact terms of these requirements. *Subsection (10)* therefore amends section 87B of the 1991 Act so that in the event that the Secretary of State and the water undertaker are unable to agree the terms of an arrangement, or a variation in those terms, the Secretary of State may determine the terms of the arrangement or he could appoint an independent person to arbitrate if he so wished.

411. *Subsection (14)* amends section 90A (review of fluoridation) of the 1991 Act which relates to monitoring the effect of fluoridation schemes on the health of the population affected. The new subsection (5A) requires the Secretary of State to consult the relevant local authorities when carrying out such monitoring, and in particular before producing the report required by section 90A(1)(b) of the 1991 Act. This ensures that affected local authorities would be fully conversant with any effects identified and that the Secretary of State is provided with relevant information and views.

Section 36 - Procedural requirements in connection with fluoridation of water supplies

412. This section inserts new sections 88A to 88O into the Water Industry Act 1991 (the 1991 Act). These sections provide for a local authority or a group of local authorities, to make a fluoridation proposal to the Secretary of State. They provide for consultation on the proposal and set out the procedures and duties relevant to the taking of decisions. They also cover the variation and termination of fluoridation schemes. Finally, they contain a regulation making power in relation to the maintenance of a fluoridation scheme.

Section 88B of the 1991 Act – requirement for fluoridation proposal: England

413. Section 88B allows for a fluoridation proposal to be made by one or more local authorities in England. A fluoridation proposal is a proposal that the Secretary of State enters into arrangements with one or more water undertakers to increase the fluoride content of the water supplied by the undertaker or undertakers to a specific area. Subsection (4) allows for local authorities to propose fluoridation for their own area, or a larger area which includes some or all of their area.

Section 88C of the 1991 Act – Initial consultation etc. on fluoridation proposal

414. Section 88C applies if a fluoridation proposal is made. The proposer must consult with the Secretary of State and the water undertaker as to whether the proposal would be operable and efficient. The proposer must inform the Secretary of State of the opinion of the water undertaker. Only if the Secretary of State is of the opinion that the proposals are operable and efficient can the proposals proceed.

Section 88D of the 1991 Act – Additional requirements where other local authorities affected

415. Once the Secretary of State has agreed that the proposal is operable and efficient and the proposer wishes to take further steps in relation to the proposal, the proposer must notify all other local authorities affected by the proposal and make arrangements for the authorities to decide how to proceed. Subsection (4) requires the Secretary of State to make regulations on the details of how these decisions should be reached by the local authorities concerned. For example, the regulations might provide for voting and might further provide that votes be weighted by the proportion of population in each local authority that would be affected by the proposal.

Section 88E of the 1991 Act - Decision on fluoridation proposal

416. Section 88E of the 1991 Act provides that where the proposer decides to proceed with the proposal, it must comply with any requirements provided for in regulations as to the steps to be taken for consultation and ascertaining opinion. The proposer must then decide whether to proceed in the light of the views expressed. Subsection (6) empowers the Secretary of State to make regulations specifying the factors which the proposer must consider in deciding whether to proceed and the procedure to be followed in reaching that decision.

Section 88F of the 1991 Act - Decision-making procedure: exercise of functions by committee

417. Section 88F requires that, unless either the proposal affects only a single local authority or it affects more than one authority, but the other authorities do not wish to participate in the decision, the affected local authorities must exercise functions under section 88E of the 1991 Act either through an existing joint committee, a new joint committee or a joint sub-committee of health and wellbeing boards. Subsection (4) of section 88F of the 1991 Act empowers the Secretary of State to make regulations on the composition and procedures of these joint committees or joint sub-committees.

Section 88G of the 1991 Act– Secretary of State's duty in relation to fluoridation proposal

418. Section 88G of the 1991 Act places a duty on the Secretary of State to implement a fluoridation proposal by entering into arrangements with a water undertaker.

419. The Act ensures that the Secretary of State has initially satisfied himself that a scheme is operable and efficient (see section 88C of the 1991 Act). In addition, subsection (2) of section 88G of the 1991 Act requires that the Secretary of State be satisfied that the requirements imposed by sections 88B to 88F of the 1991 Act have been met. This does not require the Secretary of State to consider the adequacy of any steps taken for the purposes of complying with any requirement to consult or to ascertain opinion.

Section 88H of the 1991 Act – Payments by local authorities towards fluoridation costs

420. Section 88H of the 1991 Act provides a mechanism under which local authorities can be made to bear the full cost of fluoridation. Under section 88H(2) of the 1991 Act, the Secretary of State can require the local authorities affected by arrangements made by the Secretary of State for the fluoridation of water with a water undertaker to meet the Secretary of State's costs incurred under the terms of the arrangement. Subsection (4) of section 88H provides for the Secretary of State to determine what amounts are payable by each authority in the absence of an agreement between the local authorities (or by a joint committee of the local authorities or joint sub-committee of health and wellbeing boards), with a power to appoint an independent person to arbitrate if he wishes. Subsections (5) and (6) provide for requests for variations in the amounts agreed, once a fluoridation scheme is set up, to be treated in the same way.

Sections 88I to 88N of the 1991 Act -Variation and/or termination

421. Sections 88J to 88N of the 1991 Act relate to the variation or termination of arrangements for the fluoridation of water. They largely replicate the provisions concerning new fluoridation proposals in sections 88B to 88G of the 1991 Act.

422. The Secretary of State is able to vary or terminate arrangements without a proposal from a local authority, in certain limited cases. Section 88I(4) provides for regulations to be made prescribing the cases where the Secretary of State can vary or terminate arrangements without a local authority making a proposal.

Section 88O of the 1991 Act – Variation and termination

423. Subsection 88O of the 1991 Act contains a regulation-making power in relation to consultation or ascertaining opinion on the maintenance of existing fluoridation arrangements. The power also covers the procedures to be followed in relation to a proposal to maintain arrangements. The regulations must make provision requiring the Secretary of State to give notice to the water undertaker under section 87C(7) of the 1991 Act if the local authorities do not want to maintain fluoridation arrangements and the Secretary of State is satisfied that any requirements imposed by regulations have been met.

Section 37 - Fluoridation of water supplies: transitional provision

424. *Subsections (1) and (2)* provide for existing fluoridation arrangements between water undertakers and SHAs to be treated as if they were arrangements entered into by the water undertaker with the Secretary of State under section 87(1) of the 1991 Act.

425. *Subsection (3)* provides that where arrangements are to be treated as existing arrangements, payments by local authorities towards fluoridation costs are to be determined by agreement between the affected local authorities.

Functions relating to mental health matters

426. These sections make a number of changes to the Mental Health Act 1983 (the 1983 Act) in the light of the abolition of PCTs and SHAs and the other proposals in White Paper *Equity and Excellence: Liberating the NHS*[8].

Section 38 - Approval functions

427. This section amends the 1983 Act to provide new ways in which the Secretary of State's approval functions under that Act may be exercised. Previously, the Secretary of State's approval functions were delegated to SHAs, by means of directions given by the Secretary of State under section 7 of the NHS Act.

428. The Secretary of State has two approval functions. Under section 12 of the 1983 Act, the Secretary of State may approve doctors (section 12 doctors) as having special experience in the diagnosis or medical treatment of mental disorder. The Secretary of State is also responsible for approving doctors and other professionals as approved clinicians for the purposes of the Act.

429. Certain decisions under the 1983 Act may only be taken by people who have been approved in this way. For example, an application cannot be made to detain a patient under the Act unless it is supported by two medical recommendations, one of which is given by a section 12 doctor. Similarly, only an approved clinician can be the "responsible clinician" in overall charge of the case of a patient detained under the 1983 Act.

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8 Copies are available in the Library, and from the DH website at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

430. The section inserts three new sections into the 1983 Act.

431. New section 12ZA allows the Secretary of State to arrange for one or both of the approval functions to be exercised by anyone else who is willing to enter into an agreement to do so. Such an agreement may cover the approval function in general, or only to a more limited extent. For example, there may be agreements with different people in relation to different parts of the country, or (for approved clinicians) in relation to the approval of people from different professions.

432. An agreement may be for a fixed period, or may specify how decisions about the termination of the agreement will be made. However, it will not be possible for the agreement to give the other party a contractual right to go on exercising the approval function against the Secretary of State's wishes. The Secretary of State may at any time to issue an instruction requiring the other party to stop approving people (either at all, or to a specified extent). The agreement may include provision for the Secretary of State to pay the other party compensation if this were to happen.

433. The other party has to comply with other instructions given by the Secretary of State. It is for the Secretary of State to decide how these other instructions should be given, but they have to be published. In practice, at least for approved clinicians, these instructions may include rules about things such as the professions from which approved clinicians may be drawn, the competencies they must possess, and the training they must undertake before being approved. Previously, these matters were dealt with in directions to SHAs.[9]

434. Agreements under the new section 12ZA may include arrangements for Secretary of State to make payments to the other party. The Secretary of State may also make payments to other people in connection with the exercise of approval functions under the agreement. For example, the Secretary of State may agree to meet the costs of another body exercising the approval function, but also directly pay a third party to give expert advice to that body.

435. While the new section 12ZA allows for other people to exercise the approval functions by agreement, the new section 12ZB enables the Secretary of State to require the NHS Commissioning Board or any Special Health Authority to exercise those functions. The Secretary of State may require the NHS Commissioning Board or a Special Health Authority to exercise one or both of the approval functions, and (as in section 12ZA) that may apply to the function generally, or to a more limited extent.

436. It is also possible for approval functions to be exercised concurrently both by the NHS Commissioning Board or a Special Health Authority under section 12ZB and by another person under section 12ZA.

437. Like a party to an agreement under section 12ZA, the NHS Commissioning Board or Special Health Authority will have to comply with instructions given by the Secretary of State. The Secretary of State will have to publish those instructions. The Secretary of State will be able to end (or vary) the requirement on the NHS Commissioning Board or Special Health Authority at any time, which would in turn end (or vary) the Board or authority's power to approve people.

438. Where the Secretary of State requires the NHS Commissioning Board or a Special Health Authority to exercise an approval function, that function will be treated as a function under the NHS Act. That means, for example, that the Secretary of State will have to take that function into account when allocating funding to the NHS Commissioning Board or the authority. As in section 12ZA, the Secretary of State may also make payments to a third party in connection with the exercise of the approval function by the NHS Commissioning Board or a Special Health Authority.

9 The Approved Clinician (General) Directions 2008, available at www.dh.gov.uk/en/Healthcare/Mentalhealth/InformationontheMentalHealthAct/DH_106657

439. New section 12ZC gives the Secretary of State and people exercising approval functions under sections 12ZA and 12ZB the power to disclose information in connection with those functions, whether or not they would otherwise have a power to do so. In addition, it allows information to be shared between those people (although not with third parties) even if that would not normally be allowed under the common law of confidentiality. Provided other legal requirements (such as data protection legislation) were complied with, this may, for example, allow one approving body to pass on to another approving body information it has received from, or about, an applicant, without having to obtain that applicant's consent.

440. Although sections 12ZA and 12ZB give the Secretary of State new ways in which to arrange for these approval functions to be exercised, there is nothing to prevent the Secretary of State deciding to exercise them directly through the Department of Health.

441. The section also makes a number of consequential changes to the 1983 Act and other legislation to recognise the effects of the new sections 12ZA and 12ZB. In particular, it amends section 139 of the 1983 Act under which people who bring legal cases about the exercise of functions under the 1983 Act have generally to show that the person they are complaining about acted in bad faith or without reasonable care. They also generally have to obtain permission from the High Court before bringing proceedings (or, in a criminal case, the consent of the Director of Public Prosecutions). Those rules did not apply to cases against the Secretary of State, SHAs or other NHS bodies, and the effect of the amendment is that they would similarly not apply to cases against people exercising approval functions by agreement with the Secretary of State under section 12ZA. The same is true in respect of cases against the NHS Commissioning Board and Special Health Authorities as a result of a separate amendment made by this Act.

442. Nothing in this section affects the exercise of approval functions under the 1983 Act in Wales.

Section 39 - Discharge of patients

443. This section amends sections 23 and 24 of the 1983 Act, which deal with the discharge of patients from detention, supervised community treatment and other compulsory measures under that Act. It removes certain powers from the Secretary of State, the Welsh Ministers and some NHS bodies in respect of patients of independent hospitals.

444. Section 23 previously gave the Secretary of State the power to discharge from detention people who are detained in registered establishments (which, in effect, means independent hospitals). This power had its roots in long-abolished arrangements under which the Secretary of State was responsible for registering and regulating independent hospitals. The Secretary of State also had the power to discharge from supervised community treatment patients whose responsible hospital is a registered establishment. In both cases, the Secretary of State's power was exercisable in relation to Wales by the Welsh Ministers. Section 23 similarly allowed NHS trusts, NHS foundation trusts, Local Health Boards (in Wales), Special Health Authorities and PCTs to discharge patients of registered establishments from detention or supervised community treatment, but only where the NHS body concerned had commissioned the service the patient was receiving from that registered establishment.

445. The section removed all these powers from the Secretary of State, the Welsh Ministers and these various NHS bodies. It does not affect the powers under section 23 of other people (including the patient's responsible clinician and the managers of the registered establishment itself) to discharge patients. Nor does it affect patients' rights under Part 5 of the 1983 Act to apply to an independent Tribunal for their discharge. The section also made a number of consequential changes to the 1983 Act and other legislation to reflect the abolition of these discharge powers.

Section 40 - After-care

446. This section amends section 117 of the 1983 Act. That section places a duty on PCTs (in England), Local Health Boards (in Wales) and local social services authorities (in both England and Wales) to provide after-care for people who have been detained in hospital for treatment for mental disorder under the Act. They must provide such after-care, in co-operation with relevant voluntary agencies, until such time as they are satisfied that the person is no longer in need of such services, or (where applicable) for at least as long as the person remains on supervised community treatment under the Act.

447. Section 117 is a free-standing duty. Case-law[10] has established that after-care services required by this duty are provided under section 117 itself, not under the legislation under which most social services and NHS services are provided. Case-law[11] has also established that, in most cases, the duty falls on the local social services authority and PCT (or Local Health Board) for the area in which the person was resident before being detained (whether or not that body is responsible for other aspects of the person's health or social care.). If there is no such area, the duty falls on the authorities for the area to which the person is sent on leaving hospital.

448. The main effect of this section is to transfer the duty on PCTs under section 117 to CCGs. As now, the duty will fall in the first place on the CCG for the area in which the person was resident before being detained. However, the new section 117(2E) inserted into the 1983 Act by this section would allow the Secretary of State to make regulations conferring the duty instead on another CCG or on the NHS Commissioning Board.

449. These regulations could, for example, be used to ensure that the CCG responsible for section 117 after-care for a patient was the same CCG that was responsible for commissioning other health services for the person in question under the NHS Act. (At present, the PCT responsible for section 117 after-care is not always the same as the PCT responsible for other aspects of a patient's health care, especially where the patient moves while already in receipt of after-care). These regulations could also be used to deal with cases where a person's after-care needs included services of the type that the NHS Commissioning Board, rather than CCGs, was responsible for commissioning under provisions earlier in this Act. In those cases, the regulations could say that it was the Board, rather than any individual CCG, which was responsible for commissioning such services as part of the person's after-care under section 117.

450. The effect of new subsection (2D) is to make clear that the duty on a CCG (or the NHS Commissioning Board) is to commission, rather than provide, after-care.

451. The section also includes a number of technical changes to other provisions.

Section 41 - Provision of pocket money for in-patients

452. This section abolishes the power of the Secretary of State in section 122 of the 1983 Act to make payments to in-patients in mental health hospitals in respect of their occasional personal expenses, where they cannot meet those expenses themselves. In England, this power was previously delegated to PCTs by means of regulations. It is primarily used to provide small personal allowances for patients who have been transferred from prison to hospital under section 47 of the 1983 Act and who are therefore not eligible for social security benefits.

453. CCGs and the NHS Commissioning Board would still be able to arrange for such payments to be made to NHS patients under the NHS Act. And the Secretary of State would be able to make regulations requiring such payments to be made, using the power to make "standing rules" introduced in section 20.

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10 *R. v Manchester City Council Ex p.Stennett* [2002] UKHL 34; [2002] 4 All ER 124
11 *R. v Mental Health Tribunal, Ex p. Hall* [1999] 3 All ER 132

454. The section also removes this power entirely in Scotland (where it has no practical significance). This change does not affect the powers of the Scottish Ministers to make pocket-money payments under Scottish mental health legislation. This section does not affect the position in Wales, where the Secretary of State's powers are exercisable by the Welsh Ministers. Indeed, it amends section 122 to confer the power directly on the Welsh Ministers.

Section 42 - Transfers to and from special hospitals

455. This section abolishes the power of the Secretary of State (and the power of Welsh Ministers) under section 123 of the Act to direct that a patient detained in a high secure psychiatric hospital be transferred to another high secure hospital, or to any other hospital. This power was rarely used. This change would not affect the power of the managers of high secure hospitals themselves to arrange the transfer of patients by agreement with the managers of the receiving hospital.

456. The section also removes references to section 123 elsewhere in the 1983 Act and in the Health Act 1999. But it says that the repeal of section 123 does not affect the validity of the detention of anyone who has previously been transferred under section 123, nor prevent the recapture of anyone who escaped from custody while being transferred under that section.

Section 43 - Independent mental health advocates

457. This section transfers from the Secretary of State to local authorities the duty to arrange independent mental health advocate (IMHA) services. IMHAs provide help and support for people subject to the 1983 Act.

458. Previously, section 130A of the 1983 Act placed a duty on the Secretary of State to make arrangements to enable qualifying patients to have access to an IMHA. Qualifying patients are defined in section 130C. They include most of those liable to be detained under the 1983 Act, all patients on supervised community treatment, all patients subject to guardianship and a few others who are being considered for certain specified treatments for a mental disorder.

459. The Secretary of State previously delegated the duty to commission IMHA services to PCTs, by means of directions under section 7 of the NHS Act. This section places the duty on local social services authorities instead. It inserts a new subsection into section 130C of the 1983 Act setting out the rules for deciding which local social services authority is responsible for which qualifying patients.

460. The section also amends Schedule 1 to the Local Authority Social Services Act 1970 to make local social services authorities' new role in respect of IMHAs a social services function for the purposes of that Act. In particular, that allows the Secretary of State to issue directions and statutory guidance to local social services authorities about the exercise of this function.

461. IMHA arrangements in Wales are a devolved matter, and in 2010 the National Assembly for Wales passed legislation amending the provisions in the 1983 Act which deal with IMHA services in Wales. In doing so, the Assembly also made some consequential amendments to the provisions as they apply in England. The changes made by this section are to sections 130A and 130C of the 1983 Act as amended by the Mental Health (Wales) Measure 2010, which received Royal Approval on 15 December 2010.

Section 44 - Patients' correspondence

462. This section amends section 134 of the 1983 Act, which deals with the correspondence of patients detained in hospital under that Act. Section 134(1)(a) allows the managers of a hospital to refuse to put a detained patient's correspondence in the post if the intended

recipient has made a written request not to receive correspondence from the patient in question. It amends that section so that it is no longer possible for such a request to be made to the Secretary of State (or, therefore, to the Welsh Ministers). It continues to be possible for requests to be made to the managers of the hospital in which the patient is detained or to the approved clinician in overall charge of the patient's case.

463. Although the Department of Health cannot recall having received any such request in recent years, the section ensures that any request made to the Secretary of State (or the Welsh Ministers) before this change takes effect remains valid.

Section 45 - Notification of hospitals having arrangements for special cases

464. This section amends section 140 of the 1983 Act, which requires PCTs to notify local social services authorities in their area of the hospitals at which arrangements are in place for mental health patients to be admitted urgently, or for the provision of accommodation designed to be especially suitable for mental health patients under the age of 18.

465. This section transfers that duty from PCTs to CCGs.

Emergency powers

466. Sections 46 and 47 amend the NHS Act to make provision in relation to emergencies affecting the health service. The provisions are in addition to the provisions of the Civil Contingencies Act 2004 relating to emergencies and civil contingency planning by health service and other public bodies.

Section 46 - Role of the Board and clinical commissioning groups in respect of emergencies

467. This section inserts a new section 252A into the NHS Act and sets out the role and responsibilities of the NHS Commissioning Board and CCGs in relation to assuring NHS emergency preparedness, resilience and response. Emergency preparedness enables organisations within the health service and communities to respond to an emergency in a coordinated, proportionate, timely and effective manner.

468. Subsection (1) of section 252A confers duties on the NHS Commissioning Board and each CCG to ensure they are properly prepared for emergencies which might affect them. Similar duties would be imposed on each NHS provider as a term of their contracts with the NHS Commissioning Board or CCGs to provide NHS services.

469. Subsections (2) and (4) of section 252A provide that the NHS Commissioning Board also has duties to take steps to secure that CCGs and providers of NHS services are properly prepared for emergencies.

470. Subsections (3) and (5) of section 252A provide that these duties include a responsibility for monitoring compliance by CCGs and NHS providers with their duties relating to emergency preparedness under this section and, in the case of NHS providers, under the terms of their service contracts with the NHS Commissioning Board or CCGs.

471. Subsection (6) of section 252A allows the NHS Commissioning Board to coordinate the responses between CCGs and service providers to emergencies that might affect those bodies. Subsection (7) of section 252A allows the NHS Commissioning Board to arrange for any other person or body to exercise any of its functions under subsections (2) to (6) of that section in relation to securing the preparedness of CCGs and NHS providers.

472. Subsection (8) of section 252A ensures that if the NHS Commissioning Board makes arrangements under subsection (7) of that section for another body or person to carry out any of its responsibilities for emergency planning, resilience and response, it may also arrange for that other person or body to exercise any functions that the Board has

by virtue of the NHS Commissioning Board being a Category 1 responder under the Civil Contingency Act 2004.

473. Subsection (9) of section 252A requires that all relevant service providers must appoint an individual to be responsible for ensuring that the provider is properly prepared for any relevant emergency, that the provider complies with any requirements relating to emergency preparedness in its service contracts with the NHS Commissioning Board or CCGs and that the NHS Commissioning Board is provided with information that it may require so that it can carry out its duties to secure preparedness and monitor compliance with emergency preparedness obligations. The person appointed would be known as an "accountable emergency officer".

474. Subsection (10) of section 252A is an interpretation provision defining certain terms used in that section. "Relevant emergency" is defined, in relation to the NHS Commissioning Board, a CCG or a service provider respectively, as any emergency which might affect the body in question, whether by increasing the need for services it may arrange or provide, or in any other way. "Relevant service provider" is defined as a body or person providing services in pursuance of service arrangements. "Service arrangements" is defined, in relation to a relevant service provider, as arrangements made by the NHS Commissioning Board or a CCG under or by virtue of section 3, 3A, 3B, 4 or 7A or Schedule 1. The provisions therefore apply in relation to an emergency where the body may be asked to assist other NHS bodies or public authorities responding to that emergency, as well as one which directly affects their local NHS services.

Section 47 - Secretary of State's emergency powers

475. Section 253 of the NHS Act confers on the Secretary of State the power to give directions to any body or person exercising functions under the Act (other than NHS foundation trusts), where he considers it necessary by reason of an emergency to do so in order to ensure that a service under the Act is provided. The amendments extend the Secretary of State's powers and make them consistent with the new framework for the health service provided for by the Act. This is necessary because, under the new framework, the Secretary of State will not have a general power to give directions to NHS bodies about how they exercise their functions.

476. *Subsection (2)* amends subsection (1) of section 253 to enable the Secretary of State to give a direction under that section where he considers it is appropriate to do so by reason of an emergency. The effect of the amendment is that the power to give directions is not limited to giving directions to ensure that a service is provided. *Subsection (3)* inserts a new subsection (1A) into section 253 which provides that the Secretary of State's power to direct applies to all NHS bodies except Local Health Boards (which are Welsh NHS bodies) – i.e. it covers the NHS Commissioning Board, CCGs, Special Health Authorities, NHS trusts and NHS foundation trusts. The power also applies to the National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre (the Information Centre) and any provider of NHS services.

477. *Subsection (4)* substitutes new subsections (2) and (2A) of section 253 which specify how the direction-making powers may be exercised. A distinction is made between NHS bodies, NICE and the Information Centre, on the one hand, and a provider of NHS services on the other. In relation to NHS bodies, NICE and the Information Centre, the Secretary of State may direct the body: about the exercise of any of its functions; to cease to exercise its functions; to exercise its functions concurrently with another body; or to exercise the functions of another body under the NHS Act. In relation to providers, the power is more limited and the Secretary of State can direct the provider: about the provision of NHS services by the provider; to cease to provide services or to provide additional services. This ensures that the Secretary of State may give directions to both NHS bodies and providers of NHS services not only regarding their own activities but also to ensure coordination between bodies in exercising their activities in times

of emergency. *Subsection (5)* inserts three new subsections into section 253. New subsection (2B) enables the Secretary of State to direct the NHS Commissioning Board to exercise the Secretary of State's functions under section 253. New subsection (2C) enables the Secretary of State to direct the Board about its exercise of any functions that are the subject of a direction under new subsection (2B). New subsection (2C) defines "specified" to mean specified in the direction.

478. *Subsection (6)* omits subsection (4) of section 253 so as to remove the exclusion of NHS foundation trusts from the Secretary of State's emergency powers. *Subsection (7)* amends section 273 of the NHS Act (further provision about orders and directions under the Act) so that directions under section 253 can be given either in writing or by regulations, as is the case with many other directions under the NHS Act.

Section 48 – New Special Health Authorities

479. This section inserts new section 28A after section 28 of the NHS Act. This new section relates to orders under section 28, which pertain to the establishment of Special Health Authorities. Section 28A proposes limitations to section 28, which would allow the Secretary of State to establish a Special Health Authority for a specific function, but only for a time-limited period. The time limit is intended to maintain a stable system architecture by ensuring that when a Special Health Authority is required for a specific purpose, it does not continue to exist once that purpose has been met. This section would only apply to Special Health Authorities established following the coming into force of this section of the Act (as outlined in subsection 28A(1)).

480. Subsection (2)(a) of new section 28A specifies that any order establishing a new Special Health Authority once the Act is in force must include provision for the abolition of that Authority on a specified day. As outlined in subsection 28A(3), this day must be within a period of 3 years from the day the Special Health Authority is established. This means that all new Special Health Authorities established once the Act is in force would be time limited to a maximum of 3 years. The establishment order must also make provision for the transfer of the staff, property and liabilities of the Authority following its abolition.

481. Orders under section 28 could be altered in line with the power to vary orders and directions in section 273(1) of the NHS Act, to change the day on which the Special Health Authority is to be abolished to an earlier or later date (28A(4)(a)). If an order is varied to provide for the abolition of a Special Health Authority on a later date, this must be no more than 3 years from the date on which the Special Health Authority would have been abolished had it not been for the variation, as outlined in 28A(5). Any such order would be subject to the affirmative Parliamentary procedure, in order to discourage the proliferation of Special Health Authorities. Orders under section 28 may also be altered to make different provision as to the transfer of officers, property and liabilities of the Authority (28A(4)(b)).

Section 49 (new sections 98A, 114A, 125A, 168A) - Primary care services: directions as to exercise of functions

482. This section inserts new powers to give directions into the NHS Act. *Subsection (1)* inserts a new section 98A into the NHS Act to provide a power of direction, in respect of those functions of either the Secretary of State or the NHS Commissioning Board that relate to the provision of primary medical services. These would be exercised by the Secretary of State in respect of the NHS Commissioning Board and by the Board in respect of CCGs. This would both permit the delegation of functions by directions and allow for the directions to set out how the functions (including delegated functions) should be exercised by the Board or the CCG.

New section 98A Exercise of functions

483. *Subsection (1)* of new section 98A provides that the Secretary of State may direct the NHS Commissioning Board to exercise on his behalf any of his functions relating to the provision of primary medical services.

484. *Subsection (2)* of new section 98A clarifies that the functions that may be directed do not include the Secretary of State's regulation and order-making powers.

485. *Subsection (3)* of new section 98A provides that the Secretary of State may direct the NHS Commissioning Board as to how it is to exercise any functions that it is directed to exercise under subsection (1). The Secretary of State has retained a number of functions that relate to the setting of the detail that must be included in primary medical services contracts and the various fees and allowances that attach to those contracts. It is envisaged that as the NHS Commissioning Board's role in commissioning primary medical services develops it may be appropriate for the Board to take responsibility for some of the more detailed operational aspects currently set by the Secretary of State. For example, it may be more appropriate for the NHS Commissioning Board to determine the rules under which contractors receive support with the cost of locum cover, a matter currently set out in directions under section 87 of the NHS Act and the Secretary of State may need to give direction to ensure the NHS Commissioning Board exercises its functions correctly.

486. *Subsection (4)* of new section 98A provides that the NHS Commissioning Board may direct a CCG to exercise on its behalf any of the Board's functions relating to the provision of primary medical services.

487. *Subsection (5)* of new section 98A provides that the NHS Commissioning Board may direct CCGs as to how to exercise any functions relating to the provision of primary medical services that it is directed to exercise. The details of the functions to be delegated will be a matter for discussion between the NHS Commissioning Board and the CCGs. It is envisaged that CCGs will play some part in monitoring primary medical service contractors and that they may have a role in commissioning some enhanced primary medical services on behalf of the NHS Commissioning Board.

488. *Subsection (6)* of new section 98A permits regulations to set out functions that the NHS Commissioning Board cannot direct a CCG to exercise on the Board's behalf (for example, it is likely that regulations would prescribe the function of entering into primary medical services contracts as a function that cannot be delegated).

489. *Subsection (7)* of new section 98A permits the NHS Commissioning Board to provide information to the CCG where that information is required by the CCG to exercise any function that the Board has directed it to exercise. The supply of information would be limited to that which the NHS Commissioning Board considers necessary to enable the CCG to perform the function effectively.

490. *Subsections (8), (9)* and *(10)* of new section 98A require the CCG report to the NHS Commissioning Board on matters that come to its attention as a result of undertaking the Board's functions and permit the Board to consider those matters when exercising its primary medical services functions, such as issues relating to a contractor's performance under its contract.

New section 114A Exercise of functions

491. This section inserts a new section 114A into the NHS Act to provide a power of direction in respect of the exercise by the NHS Commissioning Board of any of the Secretary of State's functions relating to the provision of primary dental services. This would both permit the delegation of functions by directions and allow for the directions to set out how any functions (including any functions delegated to it) were to be exercised by the NHS Commissioning Board.

492. Subsection (1) of the new section 114A provides that the Secretary of State may direct the NHS Commissioning Board to exercise on his behalf any of his functions relating to the provision of primary dental services.

493. Subsection (2) of new section 114A clarifies that the functions that may be directed do not include the Secretary of State's regulation and order-making powers.

494. Subsection (3) of new section 114A provides that the Secretary of State may direct the NHS Commissioning Board as to how it is to exercise any functions relating to the provision of primary dental services (including any functions delegated to it).

New section 125A Exercise of functions

495. This section inserts new section 125A into the NHS Act to provide a power of direction in respect of those functions of either the Secretary of State or the NHS Commissioning Board that relate to the provision of primary ophthalmic services. These will be exercised by the Secretary of State in respect of the NHS Commissioning Board and by the NHS Commissioning Board in respect of a CCG, a Special Health Authority or such other body as may be prescribed. This would both permit the delegation of functions by directions and allow for the directions to set out how the functions (including delegated functions) should be exercised by the NHS Commissioning Board, the CCG, the Special Health Authority or any prescribed body.

496. Subsection (1) of new section 125A of the Act provides that the Secretary of State may direct the NHS Commissioning Board to exercise on his behalf any of his functions relating to the provision of primary ophthalmic services.

497. Subsection (2) of new section 125A clarifies that the functions that may be directed do not include the Secretary of State's regulation and order-making powers.

498. Subsection (3) of new section 125A of the Act provides that the Secretary of State may direct the NHS Commissioning Board as to how it exercises any function relating to the provision of primary ophthalmic services (including any functions delegated to it).

499. Subsection (4) of new section 125A of the Act provides that the NHS Commissioning Board may direct a CCG, a Special Health Authority or other prescribed body to exercise on its behalf any of the NHS Commissioning Board's functions relating to the provision of primary ophthalmic services.

500. Subsection (5) of new section 125A of the Act provides that the NHS Commissioning Board may direct a CCG, a Special Health Authority or other prescribed body about the exercise of any functions relating to the provision of primary ophthalmic services (including any function delegated to it).

501. Subsection (6) of new section 125A of the Act permits regulations to set out functions that the NHS Commissioning Board cannot direct a CCG, a Special Health Authority or such other body as may be prescribed to exercise on the Board's behalf.

502. Subsection (7) of new section 125A of the Act permits the NHS Commissioning Board to provide information to the CCG, a Special Health Authority or such other body as may be prescribed where that information is required by the CCG. Special Health Authority or other prescribed body to exercise any function that the NHS Commissioning Board has directed it to exercise. The supply of information would be limited to that which the NHS Commissioning Board considered necessary to allow the function to be performed effectively.

503. Subsections (8), (9) and (10) of new section 125A of the Act require the body directed to report to the NHS Commissioning Board on matters that come to its attention as a result of undertaking the NHS Commissioning Board's functions and permit the NHS Commissioning Board to consider those matters when exercising its primary

ophthalmic services functions, such as issues relating to a contractor's performance under its contract.

New section 168A Exercise of functions

504. This section inserts a new section 168A into the NHS Act to provide a power of direction in respect of the exercise by the NHS Commissioning Board of the Secretary of State's functions relating to the provision of pharmaceutical services or local pharmaceutical services. This would both permit the delegation of functions by directions and allow for the directions to set out how any functions (including any functions delegated to it) are to be exercised by the NHS Commissioning Board.

505. Subsection (1) of new section 168A of the Act enables the Secretary of State to direct the NHS Commissioning Board to undertake certain functions in relation to the provision of pharmaceutical services or local pharmaceutical services, such as maintaining pharmaceutical lists or setting up local pharmaceutical services on his behalf.

506. Subsection (2) of new section 168A clarifies that the functions that may be directed do not include the Secretary of State's regulation and order-making powers.

507. Subsection (3) of new section 168A of the Act enables the Secretary of State to direct the NHS Commissioning Board about the exercise of any functions in relation to the provision of pharmaceutical services or local pharmaceutical services (including any functions delegated to it).

Section 50 - Charges in respect of certain public health functions

508. This section sets out when the Secretary of State or local authorities would be able to charge for steps taken in the exercise of their public health functions – i.e. their functions under new sections 2A and 2B of the NHS Act inserted by sections 11 and 12. The section inserts a new section 186A into the NHS Act. Any service which is provided under section 2A or 2B is a service provided as part of the comprehensive health service and so must be provided free of charge, unless specific provision is made for a charge in legislation (see section 1(3) of the NHS Act).

509. The new section allows the Secretary of State to charge an appropriate amount for any health protection step taken by the Secretary of State under his duty to protect public health (section 2A), including charges for any services or facilities provided. However, this power to charge does not include services or facilities that are provided to an individual in order to protect that individual's health – vaccination or screening, for example (see subsection (2)). These provisions are intended to ensure an approach consistent with the existing position for NHS services, which are generally free of charge to patients.

510. *Subsection (4)* of the new section allows the Secretary of State to make regulations specifying the steps to improve public health taken under section 2B that local authorities would be able to charge for. Subsection (4) also allows the Secretary of State to specify the health protection steps taken under section 2A (by virtue of regulations under section 6C(1)) that local authorities would be able to charge for.

511. The Secretary of State would be able to specify particular services for which a charge may be made, or particular circumstances in which such services could be charged for, and to specify the maximum amount of any charge, or how the charge is calculated. Some existing services for which local authorities charge under current legislation would now fall within the new duty to improve health, and so the new section would enable the Secretary of State to allow local authorities to continue to charge, in appropriate cases, while maintaining the general position that services under the NHS Act are free of charge.

Section 51 - *Pharmaceutical services expenditure*

512. Sections 164 and 165 of the NHS Act set out the general requirements for determining remuneration for NHS pharmaceutical services.

513. This section makes further provision in respect of the arrangement for pharmaceutical services expenditure by inserting a new section 165A and a new Schedule 12A into the NHS Act, which make further provisions to take into account the future NHS architecture.

514. Subsections (1) and (2) of new section 165A provide that the NHS Commissioning Board must give the Secretary of State such information as he or she may require in relation to the pharmaceutical remuneration paid by the NHS Commissioning Board to persons providing pharmaceutical services or local pharmaceutical services in such form or at such time or within such period as the Secretary of State may require. For example, in order for the Secretary of State to be able to discharge his duties in section 164 and 165 of the NHS Act, the Secretary of State may require the NHS Commissioning Board to notify the Secretary of State of:

- both the expenditure for which CCGs are to be liable by virtue of determinations and apportionments under the new Schedule 12A, as inserted by Schedule 3 which makes further provision about pharmaceutical remuneration; and
- the rest of the expenditure by the NHS Commissioning Board on the commissioning of pharmaceutical services under Part 4 of the NHS Act.

515. The word "remuneration" is a specific term about which provision is made by section 165(6) of the NHS Act. It covers the fees and allowances that pharmaceutical contractors (community pharmacies, appliance contractors and dispensing doctors) receive for the services provided. It also covers reimbursement for the costs of the products they supply against prescriptions.

516. Under existing legislation, the Secretary of State determines the reimbursement price paid by the NHS for the products dispensed. The Secretary of State also determines the level of fees and allowances for pharmaceutical services. These are published monthly in the Drug Tariff.

517. The prescriptions dispensed by contractors are processed by the NHS Business Services Authority which then pays the contractors. The costs – for both the services and products – are then charged to PCTs.

518. The NHS Business Services Authority charges these costs to PCTs by deducting the relevant amount from the total sums that PCTs draw down each month – based on their annual unified funding allocation.

519. In future, it is expected that the Secretary of State will continue to determine the reimbursement price paid by the NHS for the products dispensed. This is because wider interests are affected, such as pharmaceutical manufacturers and wholesalers. However, as the NHS Commissioning Board will in future be commissioning pharmaceutical services, it is expected that the NHS Commissioning Board will become responsible for determining the level of fees and allowances paid for pharmaceutical services once PCTs are abolished.

520. This section also introduces Schedule 3.

Schedule 3 – *Pharmaceutical remuneration*

521. This Schedule inserts new Schedule 12A into the NHS Act.

522. Paragraph 1 of the new Schedule makes provision in respect of interpretation. It defines "drugs" by reference to the meaning given in section 126 of the NHS Act so that this term includes listed appliances (such as stoma care products) as well as drugs. It

also defines "pharmaceutical remuneration" so that this term includes both contractors who provide NHS pharmaceutical services and contractors who provide NHS local pharmaceutical services (which would be provided under direct contracts with the NHS Commissioning Board).

523. Paragraph 2 of the new Schedule sets out the arrangements for how pharmaceutical remuneration is to be apportioned amongst CCGs. This largely mirrors current funding flows for NHS pharmaceutical services expenditure.

524. Sub-paragraph (1) of paragraph 2 provides that the NHS Commissioning Board must determine the elements of pharmaceutical remuneration which will be apportioned to CCGs in relation to the relevant financial year in accordance with that sub-paragraph.

525. Sub-paragraph (2) of paragraph 2 provides that the elements of pharmaceutical expenditure to be apportioned each financial year, which the NHS Commissioning Board has determined in accordance with sub-paragraph (1), are to be referred to as "designated elements".

526. Sub-paragraph (3) of paragraph 2 requires the NHS Commissioning Board to notify each CCG of its determination of the designated elements of pharmaceutical remuneration on which the apportionment to CCGs during the financial year is based.

527. Sub-paragraph (4) of paragraph 2 provides that the NHS Commissioning Board must apportion among all CCGs the sums paid by it for each designated element as the Board thinks appropriate. For example, the NHS Commissioning Board could determine that the drug costs for prescriptions written in Scotland but dispensed in England are to be shared across all CCGs in an equitable way. This would reflect existing arrangements whereby such costs are shared equitably across all PCTs (since such costs cannot be attributed to an individual PCT and will not be capable in future of being attributed to an individual CCG).

528. Sub-paragraph (5) of paragraph 2 provides that when the NHS Commissioning Board is apportioning the sums paid by it to CCGs under sub-paragraph (4), the NHS Commissioning Board may, in particular, take into account the financial consequences of the prescriptions issued by GP practices in the CCG in the same way that they will be responsible for the financial consequences of referral decisions. It is intended that this will provide incentives for CCGs to work with practices in the CCG to look in the round at how to achieve the best overall health outcomes from the resources available.

529. Sub-paragraph (6) of paragraph 2 provides that the NHS Commissioning Board may deduct the amount of pharmaceutical remuneration it has apportioned to a CCG from the sums it would otherwise pay to the CCG under section 223H and where it does so it must notify the CCG.

530. Sub-paragraph (7) of paragraph 2 provides that the Secretary of State may direct the NHS Commissioning Board that a particular element (or elements) of pharmaceutical remuneration should not to be included in a determination the NHS Commissioning Board makes under sub-paragraph (1). For example, the Secretary of State might direct the NHS Commissioning Board that the cost of dental prescriptions is not to be included in a determination by the Board under sub-paragraph(1).

531. Sub-paragraph (8) of paragraph 2 provides that the NHS Commissioning Board, when determining the overall allocation to a CCG under section 223H of the NHS Act, must take account of the effect of the new Schedule 12A. The NHS Commissioning Board must therefore take account of pharmaceutical needs, alongside other relevant healthcare needs, when determining the overall allocation.

532. Sub-paragraph (9) of paragraph 2 provides that, for the purposes of sections 223H, 223I(3), and paragraph (16) of Schedule 1A, any amount of pharmaceutical remuneration apportioned by the NHS Commissioning Board for a given financial year

which is notified to CCGs under sub-paragraph (6) is to be treated as expenditure of the CCG which is attributable to the performance of its functions in the relevant year.

533. Paragraph 3 of the new Schedule makes provision for the reimbursement by the NHS Commissioning Board of other pharmaceutical remuneration. Sub-paragraph (1) makes clear that paragraph 3 does not apply to elements of pharmaceutical remuneration which are designated elements under paragraph 2(2) or other remuneration of a prescribed description. Sub-paragraph (2) makes provision for the NHS Commissioning Board to require a person to reimburse it for any pharmaceutical remuneration to which paragraph 3 applies if the drugs or appliances in question were ordered by that person or ordered in the course of the delivery of a service arranged by that person. This paragraph does not relate to the pharmaceutical remuneration attributable to CCGs. Rather, it enables the NHS Commissioning Board to require providers who deliver services that give rise to pharmaceutical expenditure to cover the costs that may arise. The NHS Commissioning Board would, for example, under sub-paragraph (2), be able to require reimbursement from an NHS foundation trust for the costs of the drugs prescribed by one of its employees (or any such costs incurred in the course of the delivery of services arranged by that person) which are dispensed in the community by a pharmaceutical contractor. Sub-paragraph (3) provides that any such sums due can be recovered summarily as a civil debt.

534. Paragraph 4 provides that the NHS Commissioning Board may, with the express consent of the Secretary of State, delegate any of its functions under Schedule 12A to a Special Health Authority or arrange for its functions to be exercised by any other person. This would, for example, enable existing arrangements to continue if so desired whereby the NHS Business Services Authority makes payments to contractors for the provision of pharmaceutical services on behalf of PCTs.

Section 52 - Secretary of State's duty to keep health service functions under review

535. This section inserts new section 247C into the NHS Act. This gives the Secretary of State a duty to keep health service functions under review. The purpose of this is to make clear on the face of legislation that Secretary of State is ultimately accountable for ensuring that the national level arm's length bodies, such as the NHS Commissioning Board, Monitor and the Care Quality Commission (including the Healthwatch England Committee of CQC), are performing their functions effectively. This duty is backed by powers of intervention in the event of significant failure (see new section 13Z2 of the NHS Act and sections 71, 245, 272 and 294 of this Act). This section was added to the Act following the Department's response to the NHS Future Forum, as a way of emphasising the Government's continuing responsibility for the NHS.

536. Section 247C also makes it explicit that the Secretary of State may report on how the national level organisations have discharged their functions, as part of his annual report on the performance of the health service (see section 53).

Section 53 - Secretary of State's annual report

537. This section inserts new section 247D into the NHS Act. This section would require the Secretary of State to publish an annual report relating to the performance of the comprehensive health service in England, which is to be laid before Parliament. This is the first time that there has been a specific requirement for an annual report of this kind, and it is intended to ensure that the performance of the comprehensive health service is subject to the appropriate Parliamentary scrutiny.

538. This report would cover both those aspects of the health service commissioned by the NHS Commissioning Board and CCGs, as well as those public health services for which the Secretary of State and local authorities are responsible. Subsection (2) requires the Secretary of State to include in the report his assessment of how effectively he has discharged his duties under sections 1A (Duty as to improvement in quality of services) and 1C (Duty as to reducing inequalities). In addition to these requirements,

the report may, for example, include an assessment as to the extent to which the comprehensive health service had achieved progress in the outcomes set out in the Outcomes Framework.

Section 54 – Certification of death

539. This section makes amendments to the Coroners and Justice Act 2009 placing responsibility for the appointment of medical examiners and related activities on local authorities (in England) instead of PCTs.

Section 55 - Amendments related to Part 1 and transitional provision

540. This section gives effect to Schedules 4, 5 and 6.

Schedule 4 – Amendments of the National Health Service Act 2006

541. This Schedule makes a number of amendments to the NHS Act as a result of the changes made to the health service architecture elsewhere in Part 1 of this Act.

542. **Part 1 of Schedule 4 (the health service in England)** makes amendments to Part 1 of the NHS Act primarily as a result of the abolition of SHAs and PCTs, the establishment of the NHS Commissioning Board and CCGs and changes to the Secretary of State's role as provided for in Part 1 of this Act.

543. Paragraph 1 substitutes section 2 of the NHS Act. Previously, section 2 of the NHS Act empowered the Secretary of State to provide such services as the Secretary of State considers appropriate for the purpose of discharging his duties under the Act (section 2(1)(a)), and to do anything which is calculated to facilitate, or is conducive or incidental to the discharge of such duties (section 2(1)(b)). Section 2(1)(a) is no longer necessary because the Secretary of State will no longer be under a duty to provide services. CCGs will however have a power to arrange such services as they consider appropriate for the purposes of the health service under new section 3A (section 14). In relation to what was section 2(1)(b), the new section 2 substituted by paragraph 1 of Schedule 4 to this Act confers powers on the Secretary of State, the NHS Commissioning Board and CCGs to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of their functions.

544. Paragraph 2 amends section 6 of the NHS Act so that instead of applying only to the Secretary of State, it applies in addition to the NHS Commissioning Board and CCGs. Section 6 allows for health services to be procured outside of England, and also for functions to be performed outside England in certain circumstances, such as transfers of patients across borders.

545. Paragraphs 3 and 4 amend sections 6A and 6B of the NHS Act. These sections deal with reimbursement of the cost of services provided in another EEA state and prior authorisation for the purpose of seeking treatment in another EEA state. The changes reflect the fact that services will in future be commissioned by the NHS Commissioning Board and CCGs, or in relation to public health, provided by the Secretary of State and local authorities.

546. References to SHAs and PCTs are removed from sections 8 (Secretary of State's directions to health service bodies), 9 (NHS contracts) and 11 (Arrangements to be treated as NHS contracts) of the NHS Act by paragraphs 5, 6 and 7 respectively. Paragraph 6 adds the NHS Commissioning Board and CCGs into the definition of "health service body" in section 9 of the NHS Act, meaning that contracts entered into by those bodies with other health service bodies will be treated as NHS contracts for the purposes of the NHS Act. Paragraph 7 adds the NHS Commissioning Board into the list of persons in section 11(1) of the NHS Act. This means that certain arrangements which it enters into in relation to ophthalmic and pharmaceutical services will be treated as NHS contracts.

547. Paragraph 8 amends section 12 of the NHS Act to reflect the fact that the Secretary of State will no longer be a provider of NHS services, but may be providing services in the exercise of public health functions. Section 12 allows the Secretary of State to make arrangements with any person or body to secure or assist in the securing of any of the services he or she is under a duty to provide. This includes arrangements with voluntary organisations, and will in future include the NHS Commissioning Board and CCGs.

548. Paragraph 9 inserts new section 12ZA into the NHS Act, which makes special provision about commissioning arrangements made by the NHS Commissioning Board and CCGs. For example, it allows those bodies to make their facilities and employees available to service providers.

549. Paragraphs 10 to 12 amend sections 12A, 12B and 12D of the NHS Act (inserted by the Health Act 2009) to allow the NHS Commissioning Board, CCGs and local authorities rather than the Secretary of State to make monetary payments to patients in lieu of providing them with health care services. These are known as 'direct payments' or 'personal health budgets'. The amendment to section 12B allows the regulations governing the rules around administration of such payments to apply to the NHS Commissioning Board, CCGs and local authorities instead of PCTs.

550. **Part 2 of Schedule 4 (NHS bodies)**, consisting of paragraphs 13 to 23 of Schedule 4 to this Act, makes a series of amendments to Part 2 of the NHS Act (which deals with NHS bodies). Paragraph 13 amends section 28 (special health authorities). Subsection (5) of that section provides that on dissolution of a Special Health Authority, criminal liabilities may be transferred to an "NHS body"; subsection (6) defines "NHS body", but is omitted by paragraph 13. The provision is omitted as a new definition of "NHS body", which does not include SHAs and PCTs, but includes the NHS Commissioning Board and CCGs, is inserted into section 275 of the Act by paragraph 138 of Schedule 4.

551. Paragraph 14 amends section 29, which relates to the exercise of functions by Special Health Authorities, to remove references to section 14 and 19 which relate to the exercise of SHA and PCT functions

552. Paragraph 15 makes provision for the omission of Chapter 5B of Part 2 of the NHS Act, 'trust special administrators: PCTs.' This is consequential on the abolition of PCTs elsewhere in this Act.

553. Paragraph 16 amends section 67 (effect of intervention orders) which makes provision regarding the effect of an order made under section 66. Section 66 enables the Secretary of State to make an intervention order where an NHS body (other than a foundation trust) is not performing its functions adequately or at all, or where there are significant failings in the way it is being run. Section 66 is amended in Schedule 21 to this Act (relations between health services), so that it applies only to NHS trusts and Special Health Authorities. Section 67 is amended to remove the references to SHAs and PCTs. References to the NHS Commissioning Board and CCGs are not inserted, as they are subject to separate powers provided for in Part 1 of this Act.

554. Paragraph 17 amends section 70 (transfer of residual liabilities), which provides that on dissolution of certain bodies, the Secretary of State must ensure that all their liabilities are dealt with by being transferred to the Secretary of State or an NHS body.

555. Paragraph 18 amends section 71 (schemes for meeting losses and liabilities in respect of certain health service bodies) so as to remove references to SHAs and PCTs and insert references to the NHS Commissioning Board and CCGs. This enables the Secretary of State to provide in regulations that the NHS Commissioning Board and CCGs are eligible to participate in such schemes or may administer such schemes.

556. Section 73 (directions and regulations) of the NHS Act makes provision relating to directions and regulations made under the provisions specified in subsection (1). Paragraph 19 of Schedule 4 to this Act removes sections 14, 15, 19 and 20 from the list in subsection (1), as those sections relate only to SHAs and PCTs.

557. Paragraphs 20 and 21 omit Schedules 2 and 3 to the NHS Act, as they deal with the constitution of SHAs and PCTs.

558. Paragraph 22 amends Schedule 4 to the NHS Act, which deals with NHS trusts. Sub-paragraphs (2) and (3) of paragraph 15, omitted by sub-paragraph 7, provide that an NHS trust may provide high security psychiatric services only where approved by the Secretary of State. Those provisions are omitted, as this Act makes new provision requiring any provider of such services to have approval – see section 16 of this Act.

559. Schedule 6 to the NHS Act provides for the Secretary of State to make regulations or give directions about Special Health Authorities transferring staff to, making staff available to, and furnishing information to, various bodies. Paragraph 23 of Schedule 4 removes SHAs from the list of bodies to which those provisions apply.

560. **Part 3 of Schedule 4 (local authorities)** amends Part 3 of the NHS Act (local authorities and the NHS).

561. Paragraph 24 amends section 74 by removing references to a SHA and a PCT and inserting references to the NHS Commissioning Board and CCGs so that the expression 'public body' in the Local Authorities (Goods and Services) Act 1970 (c.39) includes the Board and CCGs.

562. Paragraph 25 amends section 76 by removing references to a SHA and a PCT and inserting references to the NHS Commissioning Board and a CCG so that a local authority can make payments to those bodies towards expenditure incurred or to be incurred by the body in connection with its performance of prescribed functions.

563. Paragraph 26 amends section 77 by removing the references to PCTs.

564. Paragraph 27 amends section 78(3) to remove the references to PCTs and SHAs. Section 78 provides a power for the Secretary of State to direct certain bodies to enter into partnership arrangements in the event that they fail to exercise their functions adequately. This section will eventually be entirely repealed by this Act, when section 179 (abolition of NHS trusts) is brought into force.

565. Paragraphs 28 and 29 amend sections 80 and 81 by removing references to SHAs and PCTs and inserting references to the NHS Commissioning Board and CCGs. The amendment of section 80 gives the NHS Commissioning Board and CCGs powers to supply goods and services to local authorities and such public bodies as the Secretary of State may determine. The amendment also requires the NHS Commissioning Board and CCGs to make certain services available to local authorities so far as is reasonable necessary and practicable to enable local authorities to discharge their functions relating to social services, education and public health. Section 81 is amended so that the conditions of supply under section 80 apply to the NHS Commissioning Board and CCGs.

566. **Part 4 of Schedule 4 (medical services)** makes consequential amendments to Part 4 of the NHS Act. In particular, the NHS Commissioning Board is placed under a duty to secure the provision of primary medical services in England under section 83 of the NHS Act and may make such arrangements as it considers appropriate to meet all reasonable requirements in this area including arrangements for the performance of a service outside England. The NHS Commissioning Board will be unable to provide primary medical services itself but will make arrangements for the provision of services with general practitioners and other providers.

567. Sections 89 and 94 are amended to clarify that any consequential changes made to a General Medical Services contract or a Personal Medical Services agreement as the result of the establishment of CCGs may be imposed by virtue of existing provision in section 89(2)(d) and section 94(3)(f) of the NHS Act. Provision is also included to clarify that transitional provision may be made in connection with the commencement of the amendments to section 92 of the NHS Act, for the NHS Commissioning Board

to direct a PCT to exercise its functions under section 92 (personal medical services) arrangements during the interim period between the abolition of SHAs and the abolition of PCTs. A new subsection (3)(ca) is inserted into section 94 of the NHS Act which clarifies, for consistency with section 84(4)(b), that section 92 arrangements can include services performed outside England. Section 95 is omitted. Provision is also made in section 97 for the NHS Commissioning Board to recognise Local Medical Committees for an area.

568. **Part 5 of Schedule 4 (dental services)** makes consequential amendments to Part 5 of the NHS Act. In particular, the NHS Commissioning Board is placed under a duty to secure the provision of primary dental services in England under section 99 of the NHS Act and may make such arrangements as it considers appropriate to meet all reasonable requirements in this area including arrangements for the performance of primary dental services outside England. The NHS Commissioning Board will be unable to provide primary dental services itself but will make arrangements for the provisions of services with dentists and other providers.

569. Section 107 of the Act is amended to enable the NHS Commissioning Board to enter into arrangements for the provision of primary dental services instead of SHAs. Provision is also included to clarify that transitional provision in connection with the commencement of the amendments to section 107 of the NHS Act may be made for the NHS Commissioning Board to direct a PCT to exercise its functions under that section (personal dental services) arrangements during the interim period between the abolition of SHAs and the abolition of PCTs. A new subsection (3)(ca) is inserted into section 109 of the NHS Act which clarifies, for consistency with the new section 99(1A) of the Act, that section 107 arrangements can include services performed outside England. Section 110 is omitted. Provision is also made for the NHS Commissioning Board to recognise Local Dental Committees for an area.

570. **Part 6 of Schedule 4 (ophthalmic services)** makes consequential amendments to Part 6 of the NHS Act. In particular, the NHS Commissioning Board is placed under a duty to provide a sight testing service and other ophthalmic services and may make such arrangements as it considers appropriate to meet all reasonable requirements in this area including arrangements for the performance of ophthalmic services outside England. The NHS Commissioning Board will be unable to provide primary ophthalmic services itself. Provision is also made for the Board to recognise Local Optical Committees formed for an area.

571. **Part 7 of Schedule 4 (pharmaceutical services)** makes consequential amendments to provisions in Part 7 of the NHS Act in respect of pharmaceutical services. In particular, provision is made for the NHS Commissioning Board to commission pharmaceutical services for England. The NHS Commissioning Board cannot provide pharmaceutical services itself but will make arrangements for the provision of services with other persons and bodies. Further amendments are made to section 129 of the Act regarding the preparation and publication of pharmaceutical lists of NHS contractors. The NHS Commissioning Board will be required to prepare such lists by reference to the area in which the premises from which the services are provided are situated. Under section 150A of the NHS Act, the NHS Commissioning Board may remove a pharmaceutical services contractor from a list if they breach their terms of service by, for example, a repeated failure to open in accordance with contracted hours. Section 132 of the NHS Act is amended to require the NHS Commissioning Board to prepare lists of medical and dental practitioners who are authorised by it to provide pharmaceutical services by reference to an area of a prescribed description. The disqualification provisions in sections 151 to 162 of the NHS Act are also amended to enable the NHS Commissioning Board to make decisions and take action (such as suspension or removal from a list) in fitness to practise matters. Provision is also made for such matters to be referred to the First Tier Tribunal for national disqualification. Provision is made for the NHS Commissioning Board to recognise Local Pharmaceutical Services Committees for an area. Transitional provision is

included in Schedule 11 to the NHS Act for the continuation of pilot schemes and in Schedule 12 to that Act for the continuation of Local Pharmaceutical Services (LPS) schemes and for such schemes to be treated as if they had been established by the NHS Commissioning Board. The Secretary of State may continue to establish LPS schemes and, in prescribed circumstances, the NHS Commissioning Board will be able to provide local pharmaceutical services itself.

572. **Part 8 of Schedule 4 (charging)** makes amendments to Part 9 of the NHS Act by removing references to PCTs and SHAs.

573. Paragraph 94 amends section 176 by inserting a reference to the NHS Commissioning Board to ensure that regulations under subsection (1), which provide for the making and recovery of charges for relevant dental services, may provide for sums otherwise payable by the Board to persons providing relevant dental services to be reduced by the amount of the charges.

574. Paragraph 96 amends section 180 by inserting references to the NHS Commissioning Board so that the Secretary of State must provide by regulations for payments to be made by the NHS Commissioning Board to meet or contribute to the costs incurred in respect of optical appliances and sight tests. The amendment also inserts new subsection (6A) into section 180 to enable the NHS Commissioning Board to direct a Special Health Authority, or such other body as may be prescribed, to exercise any of the NHS Commissioning Board's functions under regulations under section 180. Section 180 of the Act is also amended to include new provision for the NHS Commissioning Board to direct a Special Health Authority or such other body as may be prescribed to exercise the Board's functions under that section and to omit subsection (10) of that section which is not consistent with the funding arrangements for the Board. The title of section 180 is also amended to reflect that this section now relates to payments for both the cost of optical appliances and sight tests.

575. Paragraph 98 amends section 183 by removing references to PCTs and inserting references to the NHS Commissioning Board and a CCG so that regulations may provide for the payment by those bodies of travelling expenses to prescribed descriptions of persons.

576. Paragraphs 99 and 100 amend sections 185 and 186 by removing references to PCTs and inserting references to the NHS Commissioning Board, CCGs and local authorities so that regulations may provide for the making and recovery of charges by those bodies in respect of more expensive supplies and repairs and replacements of appliances or vehicles in certain cases.

577. Paragraph 101 amends section 187, which enables the Secretary of State to make regulations to provide for charges in respect of services or facilities for the care of pregnant women, women who are breastfeeding and young children, or 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. This covers certain "community health services" arranged at present by PCTs under section 3(1) of the NHS Act. The amendment ensures that the Secretary of State may continue to make provision for charges for these kinds of services, whether arranged by CCGs under section 3(1) (as amended by section 13 of this Act), or by local authorities under their new health improvement powers (new section 2B inserted by section 12 of this Act).

578. **Part 9 of Schedule 4 (fraud etc.).** Paragraph 103 amends section 195 as a result of changes made to section 2 of the NHS Act. Paragraph 104 amends section 196 by removing references to SHA and PCT and inserting references to the NHS Commissioning Board and CCGs in the definition of 'NHS body' and 'public health service contractor' for the purposes of sections 195(3) and 197(1). Paragraph 106 amends section 201 by enabling the disclosure of certain information if it is in connection with any of the functions of the NHS Commissioning Board, a CCG or a local authority as well as those of the Secretary of State. Paragraphs 105 and 107 amend

sections 197 and 210 by substituting the references to 'NHS contractor' with references to 'public health service contractor'.

579. **Part 10 of Schedule 4 (property and finance).** Paragraph 108 amends section 211 by replacing the reference to a 'local social services authority' with a reference to a 'local authority' in order to accurately reflect the definition and functions of a local authority under this Act. Paragraph 109 amends section 213 by removing the reference to a PCT as a 'relevant health service body' and providing that CCGs and the NHS Commissioning Board are 'relevant health service bodies' who the Secretary of State may provide for the transfer of trust property to and from.

580. Paragraph 110 amends section 214 which contains a power for the Secretary of State to transfer all trust property by order from any special trustees to certain health service bodies. The amendment makes provision for the NHS Commissioning Board and CCGs to be included as bodies to who all trust property can be transferred and removes the references to PCTs.

581. Paragraph 111 amends section 215 consequently upon the amendments to section 214. Paragraph 113 amends section 217 by removing references to Schedules 2 and 3 to the NHS Act (which relate to PCTs and SHAs). Paragraph 114 amends section 218 by removing references to PCTs and SHAs.

582. Paragraphs 112 and 115 amend sections 216 and 220 of the NHS Act 2006 to add a reference to this Act's provisions on transfer schemes (in sections 300 and 302). The amendments would ensure that existing provisions on property held on trust by the NHS (e.g. charitable property) continue to apply where such property is transferred by transfer schemes under this Act.

583. Paragraph 116 amends section 222 which contains a power for the Secretary of State to exclude, by way of directions, specified descriptions of activities from the list of activities that NHS bodies (other than Local Health Boards) may undertake in order to raise money. This power has been amended to enable (a) the NHS Commissioning Board to make directions excluding specified descriptions of activities in relation to CCGs and (b) the Secretary of State to make directions excluding specified descriptions of activities in relation to any other NHS body (other than Local Health Boards).

584. Paragraph 117 amends section 223 by inserting a reference to the NHS Commissioning Board so that the Board also has powers to form and invest in companies. Paragraph 117(2) also inserts new section 223A to apply section 223 to CCGs.

585. Paragraph 118 omits section 224 which concerns the funding of SHAs. Paragraphs 119 and 120 amend sections 226 and 227 to remove the references to SHAs so that the sections only apply to Special Health Authorities. Paragraph 121 omits sections 228 to 231 which concern the funding of PCTs.

586. Paragraph 122 provides for the omission of subsection 4 of section 234 to reflect the fact that PCTs are being abolished

587. Paragraph 123 amends section 236 replacing the reference to the Secretary of State with a reference to the 'prescribed CCG' so that a CCG must pay remuneration and reasonable expenses under section 236 rather than the Secretary of State. The amendment also omits the reference in section 236(2)(b), which sets out when payments may not be made to a medical practitioner, to a PCT and inserts a reference to arrangements made by the NHS Commissioning Board or a CCG which sets out when payments may not be made to a medical practitioner.

588. Paragraph 124 omits Schedule 14. Paragraph 125 amends Schedule 15 by removing references to PCTs and SHAs and by removing the requirement for the Secretary of State to prepare summarised accounts.

589. **Part 11 of Schedule 4 (public involvement and scrutiny).** Paragraph 126 removes SHAs and PCTs from the list of bodies to whom duties on public involvement and consultation in section 242 apply. Paragraph 126 omits sections 242A and 242B which provide for regulations to require SHAs to involve health service users in prescribed matters.

590. **Part 12 of Schedule 4 (miscellaneous).** Paragraph 128 inserts new section 254A into the NHS Act. This enables the Secretary of State to continue to be able to provide support services to persons providing services or exercising functions in relation to the health service (subject to subsection 5) where it makes sense to coordinate activity centrally. This function was previously carried out in reliance of the Secretary of State's general power in section 2 of the NHS Act.

591. Support provided under this new section might include providing advice and assistance to NHS trusts and NHS foundation trusts when they procure medicines or other goods to help them get best value for money, and managing central contracts with section 223 companies which provide services to the NHS (e.g. NHS Professionals, which provides recruitment and temporary staff agency services to NHS trusts and NHS foundation trusts).

592. The power does not allow the Secretary of State to commission or provide health services. Nor does it allow him or her to give financial assistance to the private sector.

593. Paragraph 129(4) amends section 256 by substituting references to PCTs with references to the NHS Commissioning Board or CCGs so that those bodies they have power to make payments towards expenditure on community services.

594. Paragraph 129(4) confers additional powers for the Secretary of State to specify minimum sums that the NHS Commissioning Board must pay to local authorities (or certain other bodies exercising functions in relation to housing) towards expenditure on local authority social care or other community services. This would not affect the powers off the NHS Commissioning Board to make payments to local authorities under these powers in addition to those sums, or the powers of CCGs.

595. The Secretary of State may specify in directions the bodies to which those payments must be made and the functions in respect of which the payments must be made. The Secretary of State may also specify the minimum amount to be paid to each local authority (or other body) specified in the direction. Although a direction would relate to a particular financial year, the Secretary of State would be able to amend the direction at any time during the year, in order to change the minimum amount payable (either in total or to a particular body).

596. The existing powers in section 256 for the Secretary of State to give directions as to the conditions that should apply to such payments continue to apply. These directions could, for example, include a requirement on a local authority to obtain the agreement of their health and wellbeing board as to how the funds are spent.

597. Paragraph 130 amends section 257 by substituting the reference to a PCT with reference to the NHS Commissioning Board and a CCG as a result of amendments made to section 256.

598. Paragraph 131 amends section 258 to provide that the Secretary of State, the NHS Commissioning Board and CCGs must exercise their functions to secure that such facilities, as they consider to be reasonably required, are made available in connection with clinical teaching and research. The amendment to this section also removes the references to PCTs and SHAs

599. Paragraph 132 amends section 259 as a result of amendments made to the provisions relating to primary medical services (Part 4 of the NHS Act). Paragraph 133 omits section 268.

600. Paragraph 135 inserts a new section 271A of the NHS Act so as to provide that services commissioned by the NHS Commissioning Board or a CCG, or provided or commissioned by a local authority in the exercise of its public health functions, are to be treated as "services of the Crown" for the purposes of Schedule 1 to the Registered Designs Act 1949 and sections 55 to 59 of the Patents Act 1977.

601. Paragraph 136 amends section 272 to remove any references to provisions that concern PCTs and SHAs.

602. Paragraph 137 inserts a reference to the NHS Commissioning Board in section 273 to ensure that a direction under the NHS Act by the NHS Commissioning Board must be given by an instrument in writing.

603. Paragraph 138 inserts a new definition of "NHS body" into section 275 and makes transitional provision to ensure the definition includes a reference to PCTs until they are abolished.

604. Paragraph 139 amends section 276, which lists various expressions defined by other provisions of the Act. The amendment removes the references to 'NHS Body' and 'PCT order' from the index of defined expressions and inserts references to the definitions in the NHS Act of "public health functions of the Secretary of State" and "public health functions of local authorities", and the NHS Constitution.

Schedule 5 – Part 1: amendments of other enactments

605. This Schedule makes a number of consequential amendments to other Acts. Most of the consequential amendments in this Schedule address references to 'PCTs' and 'SHAs', removing references to those bodies and inserting references to CCGs, the NHS Commissioning Board and local authorities as necessary.

606. The following amendments make more substantive changes to other Acts:

Act	***Amendment***
National Assistance Act 1948 (c.29), section 24.	This amends the definition of "NHS accommodation" in light of amendments to section 117 of the Mental Health Act 1983, removing references to PCTs.
Local Government Act 1974 (c.7), section 26.	This extends the matters subject to investigation by the local government ombudsman to cover services provided, or to be provided, by local authorities pursuant to arrangements under section 7A of the NHS Act to exercise Secretary of State's public health functions.
Mental Health Act 1983 (c.20), sections 39 and 145.	The amendment to section 39 removes references to PCTs and inserts references to CCGs and the NHS Commissioning Board for the purposes of requiring them to provide information under section 39. The NHS Commissioning Board will only be required to provide information in relation to services or facilities the provision of which the Board arranges.
	The amendment to section 145 makes provision for circumstances in which Secretary of State may manage a hospital in exercise of public health functions.
Disabled Persons (Services, Consultation and Representation) Act 1986 (c.33), section 11.	The amendment to section 11 removes the duty on the Secretary of State to lay reports before Parliament on the development of health and social care services for persons with mental illness and for persons with learning disabilities.

Act	***Amendment***
Local Government and Housing Act 1989 (c.42), section 2.	The amendment to section 2 of the Local Government and Housing Act 1989 (politically restricted posts) adds the director of public health to the list of statutory chief officers in section 2(6). As a statutory chief officer, a person appointed as a director of public health would hold a "politically restricted post", prevented by the 1989 Act from being a member of a local authority and subject to other restrictions on political activity. This puts directors of public health in the same position as other statutory chief officers such as directors of adult social services.
Freedom of Information Act 2000 (c.36,) Part 3 of schedule 1.	The amendment inserts references to CCGs and the NHS Commissioning Board as 'public authorities' for the purposes of the Act.
Health and Social Care (Community Health and Standards) Act 2003 (c.43,)section 45.	The amendment removes the reference to regulations under section 12A(4) of the NHS Act, reflecting the changes to section 117 of the Mental Health Act 1983.
Licensing Act 2003 (c.17), sections 5, 13, 16, 69 and 172B.	The Police Reform and Social Responsibility Act 2011 amends the Licensing Act 2003 to add PCTs to the list of existing responsible authorities that are entitled to make representations to a licensing authority in relation to the application for the grant, variation or review of a licence to use premises for the supply of alcohol or to undertake certain entertainment activities. The 2011 Act also adds PCTs to the list of bodies which a licensing authority must consult before determining or revising its statement of licensing policy, and makes provision for representations by responsible authorities, including PCTs, in relation to the new "early morning alcohol restriction orders".
	The amendments to sections 5(3), 13 (4), 69(4) and 172B(4) of the Licensing Act 2003 omit references to PCTs in the definitions of "relevant authority" and insert references to "the local authority in England whose public health functions are within the meaning of the NHS Act 2006 and are exercisable in respect of an area any part of which is in the licensing authority's area".
	The effect is that local authorities with responsibility for health improvement under section 2B of the NHS Act (as inserted by section 11 of this Act) would be responsible authorities able to make representations in relation to licence applications and early morning alcohol restriction orders affecting their area.
Civil Contingencies Act 2004 (c.44), Schedule 1.	The amendment removes references to SHAs and PCTs, and provides that the NHS Commissioning Board is a "category one responder" and CCGs are "category two responders" for the purposes of Part 1 of the Act. Category one responses have specific responsibilities to plan and respond to emergencies, while category two responders have responsibilities to co-operate with such arrangements.
Mental Capacity Act 2005 (c.9), sections 35, 64 and Schedule A1.	The amendment to section 35 makes local authorities, instead of the Secretary of State, responsible for making

Act	*Amendment*
	arrangements to enable independent mental capacity advocates to represent and support specified persons.
	The amendment to Schedule A1 removes references to PCTs and SHAs and inserts references to a local authority as the supervisory body if the relevant person is ordinarily resident in England. There are also minor changes to the situation in Wales as regards the determination of who is a supervisory body. The reference to the Welsh Ministers, in contrast to the references in the Act to the National Assembly for Wales, is necessitated by devolution. The amendment also makes provision for circumstances in which Secretary of State may manage a hospital in exercise of public health functions.
Safeguarding Vulnerable Groups Act 2006 (c.47), sections 6, 17, 21 and 59.	The amendment removes references to SHAs and PCTs and inserts references to CCGs and the NHS Commissioning Board in section 17.
	The amendment also removes references to section 12A(4) of the NHS Act, reflecting the changes to section 117 of the Mental Health Act 1983.
Health and Social Care Act 2008 (c.14), sections 30, 39, 46, 48, 49, 54, 59, 64, 70, 72 and 81.	The amendment removes references to SHAs and PCTs and where appropriate, inserts references to CCGs and the NHS Commissioning Board.
	The amendment to sections 30 and 39 requires the Care Quality Commission to give notice to certain NHS bodies (when required by regulations) if it takes action against a registered provider.
	The amendment to section 46 removes the requirement on the Care Quality Commission to conduct periodic reviews of health care provided or commissioned by NHS bodies. The amendments to sections 48, 49, 70 and 72 also reflect this change.
	The amendment to section 54 inserts a reference to the NHS Commissioning Board and CCGs so that they are not included in the definition of 'English NHS Body' for the purpose of section 54(1) which relates to the Care Quality Commission's power to undertake studies designed to enable it to make recommendations for improving the management of an English NHS body.
	The amendment to section 59 means that the Secretary of State will not have the power to confer additional functions on the Care Quality Commission relating to improving the economy, efficiency and effectiveness and the financial or other management or operations of certain NHS bodies.
	The amendment to section 81 requires that the Care Quality Commission consults the NHS Commissioning Board on their proposals for the topics of their reviews, studies and investigations.

Schedule 6 – Part 1: transitional provision

607. This Schedule is concerned with the transitional arrangements for the establishment of CCGs, the exercise of functions by CCGs during the 'initial period' and for arrangements prior to the abolition of SHAs and PCTs. The initial period is defined in paragraph 1(2) as the period beginning with the commencement of section 25 and ending on a day specified by the Secretary of State for the purposes of new section 14A (the date from which the NHS Commissioning Board must ensure every provider of primary medical services is a member of a CCG and that the areas specified in the constitutions of CCGs cover the whole of England and do not coincide or overlap). It is envisaged that this 'initial period' will run from 1 October 2012 (at the latest) to 31 March 2013. Initial applications are applications made during the initial period. It is proposed that SHAs and PCTs will be abolished at the end of the initial period.

608. Paragraph 2 of Schedule 6 allows the Secretary of State to consult a Special Health Authority on proposals for the annual mandate for the Board under new section 13A of the NHS Act and on regulations requiring the NHS Commissioning Board to commission services under section 3B of the NHS Act, before the NHS Commissioning Board is established. A Special Health Authority known as the NHS Commissioning Board Authority was established on 31 October 2011 to make preparations for the establishment and operation of the NHS Commissioning Board

609. Paragraphs 3 and 4 of Schedule 6 make provision so that the directions given to SHAs and PCTs under section 7 of the NHS Act continue to have effect, and the Secretary of State can issue new directions to those bodies under that section, until those bodies are abolished.

610. Paragraph 5 of Schedule 6 allows existing directions from the Secretary of State to Special Health Authorities to continue once section 21 has been commenced. This means that for existing Special Health Authorities - NHS Blood and Transplant, NHS Business Services Authority and the NHS Litigation Authority - there would be no need to re-issue the current directions specifying their functions and they would continue in force as if given under the new power.

611. Paragraph 7 provides that, during the initial period, the Secretary of State may direct the Board to exercise any of the functions of the Secretary of State that relate to SHAs or PCTs, but not including the Secretary of State's powers or duties to make orders or regulations. This will, for instance, enable the Secretary of State to arrange for the Board to hold PCTs to account for their performance during 2012/13.

612. Paragraph 8 of the Schedule makes provision for the conditional establishment of CCGs during the initial period in any cases where the Board is not fully satisfied as to the matters, as to which it would have to satisfy itself before granting an application for establishment, set out in new section 14C. Regulations may be made authorising the NHS Commissioning Board in these circumstances to grant initial applications, but allowing the NHS Commissioning Board to impose conditions or to give a direction that the CCG exercise some of its functions in a certain way or not to exercise specified functions. If the regulations authorise the NHS Commissioning Board to give such a direction, they may also authorise or require the NHS Commissioning Board to exercise any functions specified on behalf of the CCG, or arrange for another CCG to exercise those functions. Regulations may also make provision requiring the NHS Commissioning Board to keep any conditions or directions under review and make provision about how the NHS Commissioning Board varies or removes any conditions or directions imposed.

613. Paragraph 8(6) enables regulations to be made making modifications to the NHS Act as far as it applies to CCGs established on the grant of an initial application. These regulations may provide that the Board's power to dissolve a CCG (in new section 14Z21) applies where a CCG established with conditions fails to comply with those conditions. The regulations may also make provision about the factors that the

Board must or may take into account when exercising these powers, and the procedures to be followed. Paragraph 5(12) provides that, where a conditionally established CCG ceases to be subject to any conditions or directions, it is deemed to have been established on an application granted under new section14C.

614. Paragraph 9 of the Schedule provides that, where an application for the establishment of a CCG is granted under section 14C during the initial period, the Board may direct it to exercise only some of its functions during this initial period. This power of direction is necessary to avoid CCGs having concurrent statutory responsibility for commissioning functions that remain with PCTs during the initial period. It is intended that PCTs will retain legal responsibility for commissioning until 1st April 2013. This means that, where CCGs commission services for patients during the initial period, they will be doing so on behalf of PCTs (see paragraph 11 of the Schedule) rather than through exercising the CCG's own statutory functions

615. Paragraph 10 of the Schedule provides that a CCG may, in the initial period, while it is carrying out limited functions, undertake preparatory work to help it prepare to exercise its functions after the end of the initial period (even if that CCG has had conditions imposed on it by a direction from the NHS Commissioning Board).

616. Paragraph 11 provides that, during the initial period, a PCT can make arrangements with a CCG under which the CCG carries out functions of the PCT on the PCT's behalf. This will allow CCGs to carry out, on behalf of PCTs, commissioning functions very similar to those for which they are proposed to be responsible for in their own right from April 2013 onwards. These arrangements are intended to support a smooth transition from PCT commissioning to CCGs commissioning. However the legal responsibility for the commissioning will remain with the PCT.

617. Paragraph 11(2) ensures that references in the listed provisions of the NHS Act to the functions of a CCG include any function of a PCT the group is exercising on the PCT's behalf, under arrangements made under paragraph 11(1) during the initial period.

618. Paragraph 12 enables the Secretary of State to make payments to the NHS Commissioning Board towards meeting the expenditure that the NHS Commissioning Board incurs in exercising its functions during the initial period. Such payments may be made at such times and on such terms and conditions that the Secretary of State considers appropriate.

619. Paragraph 13 confers powers on PCTs to provide assistance or support to a CCG during the initial period, including financial assistance, or make available the employees or other resources of the PCT, to such a group. The support may be provided on such terms and conditions, including restrictions on the use of financial support, as the PCT considers appropriate