HOUSE OF LORDS

Select Committee on the Constitution

22nd Report of Session 2010–12

Health and Social Care Bill: Follow-up

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Health and Social Care Bill

1. The Constitution Committee reported on the Health and Social Care Bill in September, in advance of its second reading in the House.[1] In that report we concluded that it was not clear whether the existing structures of political and legal accountability with regard to the NHS would continue to operate as they have done hitherto if the Bill were enacted in its current form. We recommended that the House carefully consider whether the Bill's provisions posed an undue risk either that individual ministerial responsibility to Parliament would be diluted or that legal accountability to the courts would be fragmented, or both. The Government responded on 10 October setting out their views. The correspondence following our earlier report is appended to this report.
2. As the Bill progressed through its committee stage in the House, it became clear that our concerns were shared by a number of Peers on all sides of the House. The Minister, Earl Howe, responding to a number of amendments tabled at committee stage which raised issues similar to those addressed in our report stated:

   > "I believe that ... it would be profitable for me to engage with noble Lords in all parts of the House, both personally and with the help of my officials, between now and Report to try to reach consensus on these important matters ... My concern is only that it is an inclusive process involving Peers from all sides of the House, and that will include listening to the views of the Constitution Committee should it choose to continue its valuable role."[2]
3. This report forms our response to that invitation. Following informal discussions between officials on both sides,[3] the Minister came and spoke to the Committee in private on Wednesday 14 December. We are grateful to the Minister and his officials for giving their time to speak to us.
4. The discussions between our officials and those of the Department of Health were based on five agreed criteria, as follows:

   - The Bill is not intended to reduce the Secretary of State's overall accountability in respect of the NHS in England, even though it will change the way that such accountability works.
   - There is a need for the Bill to be clear, so that the House and the public alike can understand exactly the accountabilities and responsibilities of the Secretary of State.
   - The Bill should support the policy intention that ministers should not be involved in day-to-day operational management.
   - The Bill should reflect the reality of what ministers actually do in practice.
   - The Bill is not intended to weaken the legal protection afforded to individuals in respect of health services.

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1 18th Report (2010–12) (HL Paper 197).

2 HL Deb, 2 November 2011, cols 1248–9.

3 A conference call was held with Department of Health officials, our Legal Advisers and Clerk on Monday 28 November, which was followed by a meeting of those individuals and First Parliamentary Counsel on Tuesday 6 December.

5. Judged against these criteria, **we believe that the amendments to the Bill which we recommend below[4] are a reasonable means to address the concerns raised both in our earlier report and in the Government's response.**[5]

Clause 1

6. Clause 1 of the Bill substitutes for section 1 of the NHS Act 2006 a new section under which the Secretary of State must "secure that services are provided" but which no longer includes a duty on the Secretary of State to provide services. We were concerned that this risked reducing the Secretary of State's accountability to Parliament and asked why the wording contained in the 2006 Act could not be retained. The Government responded that their policy was to avoid "political micro-management" of the health service and that "By explicitly removing the Secretary of State's duty to provide, legislation will better reflect what has been the reality of the NHS for years." That response also argued that this would not "reduce the overall responsibility that the Secretary of State has for the NHS."[6]

7. We acknowledge that the Government's policy is to avoid micro-management, but consider that it should be made clear in the Bill that this policy change will not result in any reduction of the Secretary of State's accountability to Parliament. We note that Lord Mackay of Clashfern tabled an amendment to the Bill at committee stage which stated that "the Secretary of State retains ultimate responsibility to Parliament for the provision of the health service in England".[7] We are firmly of the view that "ministerial responsibility" is the appropriate usage. The concept of ministerial responsibility is well understood, whereas there is no constitutional basis for distinguishing between ultimate and non-ultimate variants of ministerial responsibility to Parliament.[8]

8. **We therefore recommend that the Bill be amended to include a new subsection 1(3) in the 2006 Act as follows:**

Page 2, line 4, at end insert—

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

Clause 4

9. Clause 4 of the Bill inserts a new section 1C into the 2006 Act imposing a new duty on the Secretary of State to promote autonomy. We argued in our earlier report that the provision underscores the extent to which the chain of constitutional responsibility as regards the NHS risks being severed by the Bill. Concerns were also expressed in the House that this autonomy duty would significantly dilute ministerial responsibility to Parliament. The Minister stated in the House that the autonomy duty must be subsidiary to the minister's duties under section 1 and that he welcomed the prospect of

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4 The page and line references given in the recommended amendments reflect those in HL Bill 92 (the Bill as introduced into the House of Lords). These references may need to be updated once the Bill as amended in Committee is published.

5 Letter from Earl Howe to Baroness Jay, 10 October 2011.

6 *Ibid*.

7 Amendment 4.

8 Appendix 1 sets out in detail the meaning and contours of individual ministerial responsibility both generally and as it applies to this Bill.

further discussions as to how to put this matter beyond doubt.[9] We consider that the Bill should explicitly state that new section 1C is "subject to" the relevant provisions of section 1 of the 2006 Act.

10. We further consider that clause 4 should be amended so that it provides for a duty on the Secretary of State to have regard to the desirability of securing that other health bodies exercise their functions as they consider appropriate, rather than a requirement that he act with a view to securing their autonomy. An equivalent amendment would also need to be made to new section 13F, part of clause 20, which imposes a duty to promote autonomy on the NHS Commissioning Board.

11. From a constitutional point of view these amendments would help to ensure that the autonomy duty does not have the effect of reducing ministerial responsibility to Parliament. **We therefore recommend that clauses 4 and 20 of the Bill be amended as follows:**

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

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

Page 17, line 37, leave out "act with a view to" and insert "have regard to the desirability of".

Clause 10

12. Clause 10 removes from the Secretary of State the duty (currently contained in section 3 of the NHS Act 2006) to provide certain health services and places that duty instead on clinical commissioning groups (CCGs). Case law makes it clear that, as the law currently stands, the section 1 duty to promote a comprehensive health service must be read alongside the section 3 duty to provide certain services. Thus, if an individual wishes to challenge a decision to withdraw, relocate or ration a certain health service, a court reviewing the legality or reasonableness of that decision would consider the matter in the light of the overarching duty in section 1 to promote a comprehensive health service; such was the force of the leading Court of Appeal judgment in *Coughlan*.[10] As the Bill de-couples the section 1 and section 3 duties (by placing them on different bodies) it is difficult to see how they could in the future be read alongside one another in the way in which they have in the past. We thus expressed concern in our earlier report that this could have the unintended consequence (contrary to the fifth criterion cited above) of weakening the legal protection afforded to the individual.

13. The Government did not agree with this analysis, stating in their response:

> "Whilst it is true CCGs do not have a duty to promote the comprehensive health service in the Bill, this does not mean they can simply disregard it. It is clear from the Bill that a comprehensive health service must continue to be promoted in England. It is also clear that the key specific duties and powers in the 2006 Act (as amended by the Bill), including section 3, have been imposed or conferred so that such a service can be promoted. This means that CCGs must have regard to

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9 See HL Deb, 9 November, col 270.

10 *R v North and East Devon Health Authority*, ex parte Coughlan [2001] QB 213, cited in our earlier report at paragraphs 9 and 13.

the duty of the Secretary of State to promote a comprehensive health service."[11]

14. We remain unconvinced. If the matter is already implicit in the Bill, why should it not be made explicit (especially considering the clarity criterion noted above)? We note that clause 59 of the Bill (setting out the general duties of Monitor[12]) states that Monitor must exercise its functions "in a manner consistent with the performance by the Secretary of State of the duty under section 1(1)". This wording could be adapted to apply equally to CCGs in exercising their functions under section 3 of the 2006 Act. **We therefore recommend that clause 10 of the Bill be amended as follows:**

Page 6, line 12, at end insert—

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

15. **We believe that these proposed amendments will together address the concerns which we raised in our earlier report about the Secretary of State's political and legal accountability for the health service in England and we commend them to the House.**

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11 Letter from Earl Howe to Baroness Jay, 10 October 2011.

12 The independent regulator of NHS Foundation Trusts.

APPENDIX 1: INDIVIDUAL MINISTERIAL RESPONSIBILITY

1. The *Ministerial Code* provides that "Minsters have a duty to Parliament to account, and be held to account, for the policies, decisions and actions of their departments and agencies".[13]

2. Individual ministerial responsibility means that ministers must take constitutional responsibility, must be accountable and must be answerable to Parliament for their (and their departments' and agencies') policies, decisions and actions. (In this Appendix "constitutional responsibility" means "ministerial responsibility to Parliament".)

3. This does not mean that ministers must always resign whenever anything goes wrong, although in the most serious cases a minister will be expected to offer his resignation to the Prime Minister.

4. No distinction is to be drawn between ministerial responsibility, accountability and answerability—they are all aspects of the same thing. Likewise, ministerial responsibility to Parliament is not to be qualified. No distinction is to be drawn between ultimate and non-ultimate responsibility, or between direct and indirect responsibility. Further, no distinction is to be drawn between responsibility for policy on the one hand and responsibility for operational decisions on the other.[14]

5. It is essential to bear in mind that (i) what ministers are constitutionally responsible to Parliament for and (ii) what ministers themselves do may not be the same. The distinction matters in the context of the Health and Social Care Bill for the following reason: removing from the Secretary of State the duty to provide health services[15] does not mean that the Secretary of State no longer remains constitutionally responsible to Parliament for the provision of health services. Likewise, a provision to the effect that the Secretary of State remains constitutionally responsible to Parliament for the provision of health services does not mean that the Secretary of State must himself provide the services. It is because of a failure to bear this distinction in mind that much of the confusion about this matter has arisen. It is the Government's policy to legislate for the reality of the fact that the Secretary of State does not himself provide health services. But, as the Government recognise, this needs to be done in a way that does not suggest that the Secretary of State's constitutional responsibility to Parliament for the provision of health services is reduced.

6. All of this said, however, and as has been amply recognised in debates on the Bill, there is no point in legislating for the Secretary of State's ongoing ministerial responsibility to Parliament in respect of health services in England if those services are in fact to be provided by arms-length bodies over which the Secretary of State has no powers. But, as the extensive debates on the scope of the Secretary of State's various intervention and other powers have made plain, ministers will retain considerable powers over both the NHS Commissioning Board and over CCGs (the critical clauses are 17, 20, 44 and 49), albeit that political argument will no doubt continue over whether these powers are adequate or appropriate.

7. Two further points should be noted. First, there is a constitutionally significant difference between ministerial responsibility to Parliament and the accountability of a public body (such as the NHS Commissioning Board) to a minister. In

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13 *Ministerial Code* (2010), para 1.2 (b).

14 There was extensive argument about these matters during Sir John Major's premiership; they were resolved in 1997: see especially HC Deb, 19 March 1997, cols 1046–7 and HL Deb, 20 March 1997, cols 1055–62.

15 NHS Act 2006, section 1(2).

constitutional terms the latter can never be a substitute for the former because, in the latter case, Parliament is not involved. As the Minister correctly stated in his opening speech in the second reading debate, "We in Parliament can only turn to the Secretary of State".[16] Parliament cannot call or hold the Chair of the Commissioning Board, for example, to constitutional account. A select committee can of course call him as a witness, but giving evidence as a witness to a committee and being liable to be held to account by Parliament are not the same thing.

8. Lastly, and for the avoidance of doubt, no-one suggests that the Secretary of State is responsible to Parliament for individual clinical decisions: he plainly is not, and the Bill makes no change to this.

16 HL Deb, 11 Oct, col 1470 (Earl Howe).

APPENDIX 2: CORRESPONDENCE

Letter from Earl Howe, Parliamentary Under Secretary of State for Quality, Department of Health, 10 October 2011

1. I would like to thank you for the Committee's report on the Health and Social Care Bill. I am grateful for the consideration paid to the Bill and welcome the opportunity to address the issues raised in this report. I trust that the House will give the findings of this report and the Government's response the due consideration these matters deserve.

2. The Committee raised four substantive points in relation to the Bill, which the Government has considered carefully and which I will attempt to answer in turn. You conclude "that it may well be necessary to amend the Bill in order to put this matter 'beyond legal doubt'."[17]

The Bill's impact on ministerial responsibility and accountability for the NHS

3. Your report raises concerns about ministerial responsibility and accountability for the NHS. We consider ministerial responsibility and accountability to be of the utmost importance and thank the Committee for its deliberations on this subject. However, we do not agree that the Bill places undue risk on the Government's accountability for the NHS to Parliament or the courts. The report says:

> "We are concerned that the Bill, if enacted in its current form, may risk diluting the Government's constitutional responsibilities with regard to the NHS."[18]

And:

> "It is not clear whether the existing structures of political and legal accountability with regard to the NHS will continue to operate as they have done hitherto if the Bill is passed in its current form. As such, the House will wish carefully to consider whether these changes pose an undue risk either that individual ministerial responsibility to Parliament will be diluted or that legal accountability to the courts will be fragmented."[19]

4. As the Committee highlights, the Bill proposes to amend the NHS Act 2006, which currently places a duty on the Secretary of State to 'provide or secure the provision of services' in accordance with the Act.[20]

5. The Government's proposed amendment will place a duty on the Secretary of State to 'exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act'.[21]

6. The Government accepts that replacing the Secretary of State's duty to 'provide or secure the provision of services' with a duty 'to secure that services are provided' does alter the Secretary of State's political accountability in so much as he will no longer have a statutory duty to provide or commission services which is at present delegated to NHS bodies. This does not reduce the overall responsibility that the Secretary of State has for the NHS. The Secretary of State

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17 Paragraph 5, *18th Report of Session 2010–2012, Health and Social Care Bill;* House of Lords Select Committee on the Constitution (30/9/11)

18 Paragraph 4, ibid.

19 Paragraph 18, ibid.

20 NHS Act 2006, Section 1(2).

21 Health and Social Care Bill 2011, Section 1(2).

retains political accountability for the NHS and legal accountability for the statutory functions placed on him.

7. The Bill also proposes to remove the duty on the Secretary of State to 'provide throughout England, to such extent as he considers necessary to meet all reasonable requirements'[22]. This duty will now be placed on clinical commissioning groups ("CCGs") which 'must arrange for the provision … to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility'[23].

8. The purpose here of removing the Secretary of State's duty to provide particular services and instead giving the function of commissioning those services to the NHS Commissioning Board ("the Board") and CCGs is simply to make clear that it should not be the responsibility of ministers to provide or commission services directly. Currently the Secretary of State uses directions to delegate the duty in section 3 to Primary Care Trusts ("PCTs"), and to direct them about its exercise. The Government's policy is that the Board and CCGs should not be subject to a general power of direction and should instead use their professional expertise to act in the best interests of patients, free from political micromanagement. In practice, the Bill will change little; there will continue to be no involvement in the commissioning process for Whitehall or the Secretary of State.

9. Furthermore, this Bill will not change the long shared policy aim of all the main parties in England to secure a commissioner/provider split in NHS services in order to avoid conflicts of interest and maximise value for money for patients and taxpayers. By explicitly removing the Secretary of State's duty to provide, legislation will better reflect what has been the reality of the NHS for years.

10. Currently, PCTs commission rather than provide the majority of their services, and once PCTs complete the process of transferring their community health services provider arms, the separation will be complete. In these circumstances, the Secretary of State's duty to provide under section 1(2) of the 2006 Act would no longer be necessary or appropriate, in the light of the policy that neither the Secretary of State nor NHS commissioners would be providing NHS services. Even without the rest of the Government's modernisation programme, there would be a case for removing the duty to provide, so that the legal framework accurately reflects the practical realities.

11. Removing the duty to provide and giving CCGs the function of commissioning does not mean that the Secretary of State no longer has any control or influence over the NHS. In addition to the overarching duty to promote a comprehensive health service[24] and his duty—for that purpose—to exercise his other functions so as to secure that services are provided, the Bill gives the Secretary of State extensive powers of oversight and stewardship of the NHS.

12. For example, the Secretary of State will have a wide range of functions to set national objectives, requirements and parameters for the health service, including:

- the duty to issue a mandate setting objectives and requirements for the NHS Commissioning Board (new section 13A in clause 20);
- "standing rules" regulations imposing requirements on the Board and CCGs (clause 17);

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22 NHS Act 2006, Section 3(1).

23 Health and Social Care Bill 2011, Section 10(1).

24 Health and Social Care Bill 2011, Section 1(1)

- regulations determining how the Board authorises or intervenes in CCGs (new sections 14C and 14Z20 in clause 22);
- regulations setting procurement rules for commissioners to follow (clause 71);
- a power of veto over Monitor's first proposed set of general licence conditions for providers; and
- regulations defining which health or social care services should be subject to regulation by the Care Quality Commission and defining the safety and quality requirements that those services should be regulated against (sections 8 and 20 of the Health and Social Care Act 2008).

13. The Bill also places overarching duties on the Secretary of State in relation to the health service, such as duties about improving the quality of care and reducing inequalities (clauses 2 and 3), and a duty to report annually on the performance of the health service (clause 50).

14. These powers and duties together make the Secretary of State's responsibility for the NHS clearer than ever before.

15. To make clear that Ministers are responsible for overseeing the NHS and holding it to account, the Bill creates an explicit duty to keep under review how effectively all the national NHS bodies are performing their functions (clause 49). The Secretary of State will have extensive powers of intervention in the event of a significant failure by any of those bodies.

16. The Committee's report argues that the Bill would break the link between the Secretary of State's duty to promote a comprehensive health service[25] and the duty to provide or arrange services[26] in the NHS Act, 2006. Whilst it is true CCGs do not have a duty to promote the comprehensive health service in the Bill, this does not mean they can simply disregard it. It is clear from the Bill that a comprehensive health service must continue to be promoted in England. It is also clear that the key specific duties and powers in the 2006 Act (as amended by the Bill), including section 3, have been imposed or conferred so that such a service can be promoted. This means that CCGs must have regard to the duty of the Secretary of State to promote a comprehensive health service

17. As stated in earlier paragraphs, the Secretary of State and the Board will have powers and duties in place to ensure that if the level of services that are being commissioned by CCGs mean that there is a risk to the provision of a comprehensive health service, they will step in to rectify this. For example, the Board will be subject to the duty[27] to promote the comprehensive health service and will set the commissioning outcomes framework and maintain a national oversight of CCGs to this end. And, if there was any risk that CCGs might fail to commission an important service, the Secretary of State would have power to make "standing rules" regulations to require this service to be commissioned.

18. In relation to the accusation that the Bill poses a risk of fragmentation of legal accountability to the courts, whilst CCGs would be the target of any legal challenges to decisions about the commissioning/provision of health services, this largely reflects the current situation. Under the current system, PCTs and not the Secretary of State are the proper target of such legal challenges, even though PCTs are exercising the Secretary of State's functions. The PCTs are the bodies making

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25 NHS Act 2006, Section 1(1)

26 NHS Act 2006, Section 3(1)

27 Health and Social Care Bill 2011, Section 1E (2).

decisions about local services and are therefore liable to judicial review. Paragraph 16 of Schedule 3 to the 2006 Act means that, even when exercising the Secretary of State's functions, any liabilities incurred are enforceable against the PCTs and not the Secretary of State.

19. Similarly, in future it will be CCGs which are subject to legal challenge about local decisions. The Secretary of State could also be challenged by way of judicial review in relation to his statutory duty to secure that services are provided, as could the Board in relation to its corresponding duty in new section 1E(3)(b) to exercise its functions in relation to CCGs in that way. This mirrors the current system, whereby the Secretary of State and Strategic Health Authorities ("SHAs") could also be subject to judicial review. As such, we reject the notion that fragmentation of legal accountability will occur under the new Bill.

The Bill's specific provisions for ensuring ministerial accountability

20. The Committee's report questions whether the measures set out in the Bill will do enough to achieve proper ministerial accountability for the NHS. The Government firmly believes that it does. The Committee's report says:

> "Under clause 49 the Secretary of State must 'keep under review the effectiveness' of a range of NHS bodies. These include the NHS Commissioning Board but do not include CCGs. Under Clause 50 the Secretary of State must publish an annual report on the performance of the health service in England. While these clauses will make a modest contribution towards accountability, the House will wish carefully to consider whether they are sufficient."[28]

21. As explained above, clauses 49 and 50 are only a part of the package of ways in which accountability will be assured in the new system. The fundamental provisions which mean that the Secretary of State will continue to be politically and legally accountable for the NHS are his duties to promote a comprehensive health service and to exercise his functions so as to secure that services are provided.

22. The Bill will improve Ministerial accountability to Parliament and the public. For the first time the Secretary of State will have to report to Parliament on the performance of national NHS bodies and the state of the NHS as a whole.

23. Currently, the Secretary of State has sweeping powers to decide how large parts of the NHS operate, through wide powers of delegation and direction over PCTs and SHAs. For example, the way in which NHS services are commissioned, the way that providers are paid, and the way that competition works in the NHS are largely decided by the Minister of the day, with little or no direct accountability to Parliament. Yet, as the debate around this Bill has illustrated, these are all fundamental issues where Parliament has a strong view and a legitimate interest. Under our proposals, it will be Parliament that decides, through the Bill, the key parameters of how NHS care is commissioned and regulated. Detailed requirements will be set out in regulations (which are subject to Parliamentary scrutiny) rather than in directions (which are not).

The need to amend the current Act

24. The Committee asks whether it is necessary to amend the relevant sections of the NHS Act 2006 at all. The Committee's report says:

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[28] Paragraph 17, *18th Report of Session 2010–2012, Health and Social Care Bill;* House of Lords Select Committee on the Constitution (30/9/11).

> "It is not self-evident that the proposed changes are a necessary component of the Government's reform package. Given the uncertainty as to the interpretation of the provisions proposed in the Bill, could not the relevant wording contained in the 2006 Act be retained?"[29]

25. The Government considers that changing the 2006 Act is vital. Section 1(2) of the 2006 Act needs to be amended to remove the Secretary of State's duty to provide services in accordance with the Act, in order to reflect the changes to the legal framework for the NHS made by the Bill. This is particularly true because:

(a) The functions relating to commissioning services are to be conferred directly on the NHS Commissioning Board and CCGs, rather than relying on the current system of directions to PCTs to perform the Secretary of State's functions.

(b) The Secretary of State, the Board and CCGs will not have the function of providing NHS services. The Board and CCGs are to be responsible for the commissioning of services but not provision.

(c) The Secretary of State will secure the provision of services by exercising his functions in relation to other bodies, for example through the mandate, rather than as in the 2006 Act where the function of providing or commissioning services is placed on the Secretary of State who in turn delegates it to NHS bodies by directions.

26. The Government's policy is that responsibility for commissioning NHS services should be imposed clearly in primary legislation on the bodies who will actually carry out that function, not on the Secretary of State, who does not in practice commission or provide services under the current system. In the Government's view, outside of the cases of significant failure or emergencies which are catered for in the Bill, the Secretary of State should not have direct responsibility for commissioning when these functions have been conferred upon CCGs and the Board by Parliament. This provides greater clarity and accountability for the NHS.

27. In addition, as discussed in paragraphs 9 and 10 of this letter, the Government's policy is that neither the Secretary of State, nor the NHS bodies responsible for securing local services, should be providing NHS services. This means the Department, the Board and CCGs should not be directly managing NHS hospitals or other facilities, nor employing the staff providing NHS services[30].

28. It is for these reasons that the proposed changes to sections 1 and 3 of the 2006 Act do represent a necessary component of the proposed reform package.

The Secretary of State's duty to promote autonomy

29. The report points to the new duty to promote autonomy in the health service placed on the Secretary of State as a further indicator that constitutional accountability for the NHS will be severed. The Government believes that devolving day-to-day decision-making to front-line organisations is essential to improving the quality of the NHS and making services more responsive to patients. The duty in clause 4 around promoting autonomy is important to

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[29] Paragraph 19, *18th Report of Session 2010–2012, Health and Social Care Bill;* House of Lords Select Committee on the Constitution (30/9/11).

[30] The Secretary of State will be able to secure public health services by providing or commissioning them himself, under new sections 2A and 2B—see clauses 8 and 9.

support and reinforce this. But it will in no way remove overall responsibility from Ministers, and the duty will always be subservient to the greater interests of the health service.

30. The Committee's report says of the duty to promote autonomy (Section 4):

> "This provision underscores the extent to which the chain of constitutional responsibility as regard to the NHS is severed."[31]

31. The duty on the Secretary of State to act with a view to securing autonomy is subject to the words "so far as is consistent with the interests of the health service". This means that the interests of the health service must always take priority. That wording must also be seen in the overall context of the Bill, in particular the duty to promote the comprehensive health service and the new duty to the improve the quality of services. The effective discharge of these core duties is plainly in the interests of the health service and takes precedence over the promotion of autonomy. The duty of autonomy will never prevent the Secretary of State intervening in the interests of the health service.

32. The specific purpose of the autonomy duty is to free frontline professionals to focus on improving outcomes for patients rather than looking up to Whitehall. It requires the Secretary of State to always consider the impact of his actions on health service organisations and ensure that he is acting proportionately. It does not undermine his overarching duty to promote a comprehensive health service nor does it enable ministers to abdicate responsibility for the NHS.

Conclusion

33. I would once again like to thank the Committee for examining the constitutional implications of the current Bill. Whilst we accept that specific responsibilities will change as new NHS bodies are set up, the Government does not believe that this in any way diminishes ultimate ministerial accountability or responsibility for the NHS. Indeed we believe the measures set out in it strengthen and make accountability and responsibility clearer than it has ever been. We do not consider any amendments necessary to put this matter 'beyond legal doubt'.

34. In order to ensure that the House can consider our response to the Committee's report in advance of the Bill's second reading, I am copying in all members of the Committee and providing copies for interested Peers in for the Printed Papers Office. I am also placing a copy in the library of the House.

Letter to Earl Howe from the Chairman, 26 October 2011

The Constitution Committee, at its meeting today, discussed the question of a possible amendment to the Health and Social Care Bill concerning the issue of the Bill's potential impact on ministerial responsibility and accountability for the NHS. The discussion centred on a suggested revised wording for the Bill which I mentioned to you yesterday evening, the wording of which was:

> "This Act does not adversely affect the existing constitutional responsibility of the Secretary of State for the health service in England."

In discussion, the Committee considered that this alternative form of words was preferable:

> "This Act does not diminish in any way the existing constitutional responsibility of the Secretary of State for the health service in England."

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[31] Paragraph 14, *18th Report of Session 2010–2012, Health and Social Care Bill;* House of Lords Select Committee on the Constitution (30/9/11).

Please let either myself or the Clerk to the Committee know if it would be useful to take this forward as an amendment before the next day of Committee proceedings on the Bill.

Incidentally, the Committee also noted that the relevant words in the 2006 Act which we originally thought suitable for this Bill are still extant in current legislation in, for example, Wales.

Response from Earl Howe, 31 October 2011

Thank you for your letter of 26 October 2011 setting out a possible amendment to the Health and Social Care Bill.

I was very interested to read the amendment proposed by the Select Committee on the Constitution, particularly in the light of the useful discussions we had on the accountability of the Secretary of State during the latter stages of Committee on Tuesday.

I have been giving careful thought to your suggestion, alongside the other amendments on the same theme. I appreciate your letter and input on this important issue, and we share the aim of ensuring that the Secretary of State's responsibility to parliament is placed beyond legal doubt. We are keen to engage on this point further and I know we are meeting to discuss SofS powers later this afternoon.

My reading of the Committee's proposed amendment is that, like the amendment tabled by Lord Mackay, it seeks to clarify the Secretary of State's continued responsibility to Parliament for the health service. While it has always been our intention that the Secretary of State should retain ultimate responsibility to Parliament for the provision of the health service, I recognise that there have been some concerns on this point. However, having taken advice, my view is that we would be unable to accept this amendment were you to table it. The words "constitutional responsibility" have no clear meaning in this context and therefore make the precise responsibilities of the Secretary of State uncertain. I am not aware of this term having been used in primary legislation before, either in relation to the NHS or in other areas.

My understanding of the constitutional position is that Parliament has provided for the establishment and operation of a comprehensive health service in statute since 1946. That legislation has imposed legal responsibilities on the Secretary of State in relation to that service, including the core duty to promote. In accordance with ordinary constitutional principles and structures of political accountability, Ministers are responsible and accountable to Parliament for the health service. It is unclear whether "constitutional responsibility" is simply intended to refer to Secretary of State's responsibility to Parliament, or any other responsibilities, such as the duties to promote or secure the provision of services. These latter duties cannot in themselves be defined as "constitutional responsibilities", other than in the sense that Ministers have a general obligation to comply with the law.

I should also let you know that, although I am still considering the amendments we have received on this issue, the advice I have received suggests that the amendment from Lord Mackay is more acceptable. It is consistent with our policy of conferring powers directly on NHS commissioners and providers, with the Secretary of State retaining responsibility, both to Parliament to account for the health service, and to the courts for performing his duties to promote a comprehensive health service and to secure the provision of services for that purpose.

At the end of your letter you mention that the Committee has noted that the duty to provide remains in current NHS legislation such as the National Health Service (Wales) Act 2006. You are indeed correct on this point. The words remain appropriate in that Act, as Welsh Ministers continue to have duties and powers to provide NHS services. In relation to England, however, the Bill modifies the Secretary of State's functions so that he no longer has specific duties or powers to provide NHS services, but does retain duties to ensure that a service is provided.

You will be well aware of the Government's reasons for updating the wording of the 2006 Act with regard to the Secretary of State's duty to provide, so I will not rehearse them here. However, I would refer you to my response to the Constitution Committee (10 October) which explains the Government's position in detail.

While I am unable to accept your suggestion, I would like to thank you and the members of the Select Committee on the Constitution for your continuing and constructive interest in this important matter and look forward to engaging with you further at the next session of Committee. I look forward to discussing these points with you later.