*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

### 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 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[1] 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.

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

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**1** 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

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[2]

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 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".

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

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.