The powers and duties of the Secretary of State for Health

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The abbreviations used in this chapter are:

CCG	Clinical Commissioning Group
GP	General Practitioner
NHS Act	National Health Service Act 2006
PbR	Payment by Results under the NHS National Tariff
STP	Sustainability and Transformation Partnership
TDA	Trust Development Authority
NHS England	The National Health Service Commissioning Board
2012 Act	Health and Social Care Act 2012
2012 Regulations	National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

1. **Introduction.**

1.1 The Secretary of State sits at the pinnacle of the NHS with ultimate political responsibility for the performance of NHS. However, the Secretary of State is not a

healthcare professional and may not have any NHS management experience. He or she will be a hugely experienced politician leading a public service where the personal is political. Thus the NHS needs the political skills of an astute Secretary of State just as the Secretary of State needs the technical and professional guidance of all those who advise him and her. In recent years, Secretaries of State have tended to remain in post over a number of years and have learned the complexities of the NHS whilst discharging the complex functions of the office. They have also (in almost all cases and regardless of party) developed a steely commitment to the NHS throughout their time in office, albeit that may not always be apparent to those operating outside the Whitehall machine.

1.2 The Secretary of State for Health has a very wide range of powers and duties as a result of a variety of Acts of Parliament and subordinate legislation. This chapter lists the main functions undertaken by the Secretary of State but it is not a comprehensive list of every function undertaken by the Secretary of State (which would require a separate book). Hence, for example, the Secretary of State has a substantial role in relation to the prices that the NHS pays for medicines under section 260 of the NHS Act (as recently changed by the Health Service Medical Supplies (Costs) Act 2017 which has not yet been implemented). The details of this complex statutory scheme to control drug prices are a specialist area of law and are hence beyond a description of the general powers of the Secretary of State.

1.3 The National Health Service Act 2006 (“**the NHS Act**”), as substantially amended by the Health and Social Care Act 2012 (“**the 2012 Act**”), removed significant parts of the operational duties owed by the Secretary of State and replaced these duties with an overall strategic role for the Ministers. Hence, for example, the duty of the Secretary of State to commission services for patients in section 3 of the NHS Act was replaced with the commissioning duties being owed by a combination of Clinical Commissioning Groups (“**CCGs**”) and the National Health Service Commissioning Board (which operates under the name of “**NHS England**”). This technical legal change attracted considerable (and possibly misguided) criticism but it did not involve any substantial

change in practice. Under previous arrangements, the Secretary of State had delegated performance of his duty to commission services for patients to local NHS commissioners for many years[1] and challenges to the exercise of that decision making functions were made against the local NHS commissioners and not the Secretary of State. However, the political controversy about the perceived abandonment of the Secretary of State's direct responsibility for providing services to patients led to a new section 1(3) of the NHS Act which provides:

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

It follows that the Secretary of State is politically responsible for the NHS to Parliament even though operational responsibility sits with NHS England, the CCGs and the various organisations (both NHS bodies and others) that provide services to patients.

1.4 The primary duty on the Secretary of State lies in section 1 of the NHS Act which provides that the Secretary of State has a duty to "*continue the promotion of*" a comprehensive health service. Section 1 provides:

> "(1) The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—
>
> (a) in the physical and mental health of the people of England, and
>
> (b) in the prevention, diagnosis and treatment of physical and mental illness.

1.5 Section 1H imposes a like duty on the National Health Service Commissioning Board (which operates under the name of "NHS England") as follows:

[1] Prior to the Health and Social Care Act 2012 this delegation was under the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (as amended).

> "(1) There is to be a body corporate known as the National Health Service Commissioning Board ("the Board").
>
> (2) The Board is subject to the duty under section 1(1) concurrently with the Secretary of State except in relation to the part of the health service that is provided in pursuance of the public health functions of the Secretary of State or local authorities.
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> (3) For the purpose of discharging that duty, the Board—
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> (a) has the function of arranging for the provision of services for the purposes of the health service in England in accordance with this Act, and
>
> (b) must exercise the functions conferred on it by this Act in relation to clinical commissioning groups so as to secure that services are provided for those purposes in accordance with this Act"

Thus, the duty to promote a comprehensive health service is imposed on both the Secretary of State and NHS England.

1.6 There is an important distinction in law between the duty on the Secretary of State to promote a comprehensive health service and a duty to provide a comprehensive health service[2]. It follows that whilst the Secretary of State and NHS England must have this duty in mind at all times, neither the Secretary of State not NHS England will be in breach of the duty if the NHS fails to deliver a comprehensive health service. Indeed, as the budget for NHS services is limited and the ability of the NHS to deliver a comprehensive health service is practically infinite, it seems inevitable that, in practice, the Secretary of State will never be in a position to ensure that the NHS provides a comprehensive health service.

2. The Secretary of State's Mandate to NHS England.

[2] Please see Chapter 1 for more detail on the difference between a duty to *promote* a comprehensive healthcare service and a duty to *provide* a comprehensive healthcare service.

2.1 Section 13A of the NHS Act, as introduced by the 2012 Act, formalised the relationship between the Secretary of State and NHS England (which is referred to in legislation as "the Board"). It provides:

"13A Mandate to Board

(1) Before the start of each financial year, the Secretary of State must publish and lay before Parliament a document to be known as "the mandate".

(2) The Secretary of State must specify in the mandate—

(a) the objectives that the Secretary of State considers the Board should seek to achieve in the exercise of its functions during that financial year and such subsequent financial years as the Secretary of State considers appropriate, and

(b) any requirements that the Secretary of State considers it necessary to impose on the Board for the purpose of ensuring that it achieves those objectives.

(3) The Secretary of State must also specify in the mandate the amounts that the Secretary of State has decided to specify in relation to the financial year for the purposes of section 223D(2) and (3) (limits on capital and revenue resource use).

(4) The Secretary of State may specify in the mandate any proposals that the Secretary of State has as to the amounts that the Secretary of State will specify in relation to subsequent financial years for the purposes of section 223D(2) and (3).

(5) The Secretary of State may also specify in the mandate the matters by reference to which the Secretary of State proposes to assess the Board's performance in relation to the first financial year to which the mandate relates.

(6) The Secretary of State may not specify in the mandate an objective or requirement about the exercise of the Board's functions in relation to only one clinical commissioning group.

(7) The Board must—

(a) seek to achieve the objectives specified in the mandate, and

(b) comply with any requirements so specified.

(8) Before specifying any objectives or requirements in the mandate, the Secretary of State must consult—

(a) the Board,

(b) the Healthwatch England committee of the Care Quality Commission, and

(c) such other persons as the Secretary of State considers appropriate.

(9) Requirements included in the mandate have effect only if regulations so provide.

2.2 There are supplemental provisions in section 13B which provide:

"13B The mandate: supplemental provision

(1) The Secretary of State must keep the Board's performance in achieving any objectives or requirements specified in the mandate under review.

(2) If the Secretary of State varies the amount specified for the purposes of section 223D(2) or (3), the Secretary of State must revise the mandate accordingly.

(3) The Secretary of State may make any other revision to the mandate only if—

(a) the Board agrees to the revision,

(b) a parliamentary general election takes place, or

(c) the Secretary of State considers that there are exceptional circumstances that make the revision necessary.

(4) Revisions to the mandate which consist of adding, omitting or modifying requirements have effect only if regulations so provide.

(5) If the Secretary of State revises the mandate, the Secretary of State must—

(a) publish the mandate (as so revised), and

(b) lay it before Parliament, together with an explanation of the reasons for making the revision"

2.3 The requirement on the Secretary of State to issue NHS England with a mandate was introduced by the 2012 Act. It replaced the "NHS Operating Framework" which was a Department of Health framework document which was issued each year in the years prior to the implementation of the 2012 Act. The NHS Operating Framework sought to set out the Secretary of State's broad priorities for the NHS in each financial year, albeit it was issued in the name of the Chief Executive of the NHS (not the Permanent Secretary at the Department of Health). The last NHS Operating Framework was issued by the Department of Health in November 2011 for the financial year 2012/13[3] and was described as follows:

> "This document outlines the business and planning arrangements for the NHS in 2012/13. It describes the national priorities, system levers and enablers needed for NHS organisations to maintain and improve the quality of services provided, while delivering transformational change and maintaining financial stability"

2.4 The Mandate for 2017/18[4] set a number of objectives that the Secretary of State required NHS England to seek to achieve, namely:

- Through better commissioning, improve local and national health outcomes, and reduce health inequalities.
- To help create the safest, highest quality health and care service.
- To balance the NHS budget and improve efficiency and productivity.
- To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.
- To maintain and improve performance against core standards.
- To improve out-of-hospital care.

[3] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216590/dh_131428.pdf
[4] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/601188/NHS_Mandate_2017-18_A.pdf

- To support research, innovation and growth.

2.5 Section 13A(7) of the NHS Act requires NHS England to “*seek to achieve*” these objectives. However, as is a target duty, NHS England will not necessarily act unlawfully if the objectives are not achieved or are only partly achieved provided NHS England is striving to achieve the objectives set out in the Mandate. Hence, as seems entirely predictable, there will probably be no breach of the legal duties created by the Mandate if NHS England fails to live within its budget, provided it can shows that it “seeks” to do so. Nonetheless, the Mandate does create a substantial level of expectation and thus NHS England would be acting unlawfully if it did not allocate resources appropriately with a view to seeking to achieve the terms of the Mandate.

3. **The general duties on the Secretary of State in Part 1 of the NHS Act.**

3.1 There are a large number of procedural duties imposed on the Secretary of State in Part 1 of the NHS Act, which were largely introduced as a result of the 2012 Act. The precise meaning and effect of these duties is unclear because their meaning has not been explored in High Court judgments. However, these procedural duties are likely to become increasingly important as the Secretary of State is called upon to make contentious decisions.

3.2 The first duty imposed on the Secretary of State by section 1A is to discharge his functions with a view to securing continuous improvement in the quality of NHS services and, in particular, the outcomes for NHS patients. It provides as follows:

> “(1) The Secretary of State must exercise the functions of the Secretary of State in relation to the health service with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with—
>
> (a) the prevention, diagnosis or treatment of illness, or
>
> (b) the protection or improvement of public health.

(2) In discharging the duty under subsection (1) the Secretary of State must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services.

(3) The outcomes relevant for the purposes of subsection (2) include, in particular, outcomes which show—

(a) the effectiveness of the services,

(b) the safety of the services, and

(c) the quality of the experience undergone by patients.

(4) In discharging the duty under subsection (1), the Secretary of State must have regard to the quality standards prepared by NICE under section 234 of the Health and Social Care Act 2012"

3.3 This is a duty to "*act with a view to*" achieving continuous improvements in services and outcomes. That formulation probably gives the Secretary of State a wide area of discretionary decision-making, provided he or she remains focused on the objective of improving services and outcomes for NHS patients. The question as to whether the Secretary of State has acted in breach of this duty when making a particular decision or issuing a specific direction would depend upon a precise analysis of the decision-making process. However, at a minimum, officials advising the Secretary of State would be required to draw this legal duty to the attention of the Secretary of State and to explain the basis upon which he could make the decision in compliance with the duty. If there is no reference to the duty in the documents showing the decision-making process, there may be a case that the decision is unlawful because the Secretary of State has not exercised his functions in order to achieve the statutory objective.

3.4 The importance of the duty on the Secretary of State to "*act with a view to*" achieving continuous improvements in services and outcomes is reflected in Section 247D of the NHS Act which provides that the Secretary of State must publish an Annual Report

about the NHS which contains the Secretary of State's assessment of the effectiveness of his or her discharge of the duties under section 1A. It provides:

> "(1) The Secretary of State must publish an annual report on the performance of the health service in England.
>
> (2) The report must include the Secretary of State's assessment of the effectiveness of the discharge of the duties under sections 1A and 1C.
>
> (3) The Secretary of State must lay any report prepared under this section before Parliament.

Thus the Secretary of State's Annual Report (which in practice is included as part of the Department's Annual Report and Accounts) needs to report specifically on compliance with the section 1A duty.

3.5 Section 1B of the NHS Act imposes a duty on the Secretary of State to have regard to the NHS Constitution. It provides:

> "(1) In exercising functions in relation to the health service, the Secretary of State must have regard to the NHS Constitution.
>
> (2) In this Act, "NHS Constitution" has the same meaning as in Chapter 1 of Part 1 of the Health Act 2009 (see section 1 of that Act)"

3.6 The meaning and legal effect of the NHS Constitution is explored in a separte chapter. It is only necessary for present purposes to note that the Secretary of State was originally omitted from the list of NHS bodies that were obliged to have regard to the constitution in the Health Act 1999. However, this omission was remedied by section 3 of the Health and Social Care Act 2012 which introduced section 1B into the NHS Act.

3.7 Section 1C contains a duty on the Secretary of State to exercise his or her functions so as to reduce health inequalities. It provides:

> "In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service"

3.8 This is a deceptively simple but potentially far-reaching provision. The duty is concerned with inequalities between people "*with respect to the benefits that they can obtain from the health service*". The background is that the NHS provides universal services which can be accessed by anybody but the decision to access an NHS service is a decision by the patient alone. Aside from very special cases such as mental health or infectious diseases, there is no duty on any NHS body to provide medical care to anyone. The NHS has a duty to offer medical services. The patient decides whether, how and when to access services. So a patient who suffers pain or symptoms of the condition has the ability to go to the pharmacist or the GP to seek treatment, or could decide not to do so.

3.9 There is a wealth of evidence of persistent inequality in the health of people in the UK, and this is partly related to the way in which NHS services are accessed. This was summarised in the Acheson Report[5] published back in 1998. The conclusion is that universal services open to all do not, of themselves, deliver equal benefits. Hence the assumption behind the wording of section 1C appears to be that making services available on a universal basis – of itself - does not deliver equal benefits to people.

3.10 Thus, when determining whether the duty has been complied with, the statutory starting point must be to see whether the decision maker has understood that there is existing unequal access to the benefits of NHS services, and has then asked himself what steps could be taken to reduce that inequality of benefit. The wording of section 1C refers to the "*need*" to "*reduce*" the inequalities that presently exist with respect to the benefits that people can obtain from the health service (i.e. the NHS). "*Need*" and "*reduce*" are both strong words, implying an added level of urgency to achieving the objective (but probably falling short of an absolute requirement to do so).

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[5] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265503/ih.pdf

Accordingly, a duty to have regard to the "need to reduce" X is a stronger duty than a duty just to have regard to X. By way of contrast, the Secretary of State must have regard to the NHS Constitution under section 1B but not the "need to ensure compliance with the NHS Constitution" which would be a stronger form of duty.

3.11 These duties were the subject of a decision by the High Court *in R (The Pharmaceutical Services Negotiating Committee & Anor) v Secretary of State for Health* [2017] EWHC 1147. The Secretary of State had argued that a "have regard" duty was a lesser form of duty to the "have due regard" duty under Secretary of State 149 of the Equality Act 2010 (about which there has been considerable litigation[6]). The submission was rejected by the Judge who said:

> "But I am equally wholly unpersauded that there is in reality any material difference between the obligations to have regard and to have due regard. Merely to have regard in the sense that the existence of the statutory requirements is recognised is never likely to suffice, albeit much will turn on the nature of the matters to which regard must be had. In s.1C it is a specific need to reduce inequalities so that the defendant is obliged to show that that need is recognised and that what is proposed does not in his view at the very least cause an increase in such inequalities. All that 'due' adds in my view is a specific recognition that the effect of the decision on the specified matters must be properly taken into account. It could indeed be argued that 'due' does not strengthen but rather weakens in that it recognises that there may be circumstances in which regard is not needed. But it seems to me in any event that the argument was a barren one having regard to the nature of the obligation in s.1C"

3.12 The Judge did not accept that there was a breach of the section 1C duty. He said:

> "Cuts of the nature required will inevitably produce some hardships for individual pharmacies and for some who make use of them. But that cannot mean that in times of the need for some retrenchment no cuts can be made. The Department has, as the material now disclosed shows, given detailed and careful consideration to the way in which the cuts can be made. I do not doubt that some criticism is properly made in that it is possible to think that different means might have been better. But that is not for this court, since it is only if unreasonableness is established that it is proper to intervene"

[6] See part 4 below.

3.13 The criticism can be made that the Judge did not grapple with the nature and effect of the duty, and applied a *Wednesbury* test when this was not the relevant test to determine compliance with the statutory scheme[7]. The case has been granted permission to go to the Court of Appeal.

3.14 The wording of the duty suggests that the key factor to which the Secretary of State is obliged to have regard is the need to reduce inequalities with respect to the benefits that different people can obtain from health services. This appears to involve:

a) A recognition that it is inevitable that a service which is provided generally to the population, as part of the health service, will be accessed by people in an unequal way; and

b) A recognition that there is a need to reduce the inequality of benefits between different groups of people notwithstanding the provision of of universally available NHS services.

3.15 Hence, it appears that the Secretary of State has a duty must consider how his functions could be exercised with the aim of reducing this inequality of benefit. It is clear that there are groups of people who get less benefit from universally provided services than those who are more comfortable about accessing health services. These groups include:

- those whose first language is not English;
- the learning disabled who have physical health problems;
- those with poor education;
- other identifiable groups, such as travellers.

[7] The author is leading counsel for the NPA, so his views may reflect submissions made in this case and to be made on appeal rather than the decision of the Judge.

All of these groups may well not get equal benefit from NHS services for a variety of reasons. There are a myriad of such groups but a common theme is that they are disproportionately represented in deprived communities.

3.16 The section 1C duty is not just about ensuring that deprived communities have adequate health services, although that would be an essential part of delivering on the duty. It is primarily a duty to have regard to the need to design health services in a way that tackles the existing inequality benefit that a variety of groups of people - in practice - get from services that are available to all.

3.17 The section 1C duty must be part of the Secretary of State's Annual Report. The 2015/16 Annual Report contained the following assessment:

> "236. The government's vision is for measurable and sustained reductions in health inequalities where more people can enjoy good health throughout life, wherever they live or whatever their social position. The need to reduce health inequalities across society has been highlighted as part of delivering the Shared Delivery Plan. This aim is also reflected in the NHS Constitution, the 2016-17 mandate to NHS England and is a key part of Public Health England's remit for 2016-17.
>
> ….
> 239. Across the set of indicators, the data show a mixed picture on inequalities. For the overarching inequalities indicator in the PHOF in 2012-14 the gap in life expectancy at birth between the most and least deprived areas, as measured by the Slope Index of Inequality38, was 9.2 years for males and 7.0 years for females. The gaps in healthy life expectancy at birth were wider: 19.0 years for males and 20.2 years for females. There has been little change in the life expectancy gaps since 2002-04, or in the healthy life expectancy gaps since 2009-11 (the earliest data available).
>
> 240. For the NHSOF [*the National Health Service Outcomes Framework*] health inequalities assessed indicators, inequalities by deprivation continued to narrow between 2013 and 2014 for cardiovascular disease (CVD) mortality and infant mortality. The gap in CVD death rates (ages under 75) between the most and least deprived areas narrowed by 3% between 2013 and 2014. The infant mortality inequalities gap has more than halved since 2003. Inequalities by ethnicity also

narrowed in 2014 for health-related quality of life for people with long term conditions.

241. However, inequalities by deprivation widened in 2014 for emergency admissions for acute conditions not usually requiring an admission, continuing a longer term widening trend. Inequalities also widened in 2014 for satisfaction with GP services and making a GP appointment, a worsening in the trend which had been flat over recent years. Satisfaction decreased across all deprivation deciles, but decreases were larger in more deprived areas, and inequalities by ethnicity and sexual orientation also widened. Inequalities by deprivation in life expectancy at 75 have also been widening (but data is not yet available to assess progress since 2013).

242. Other NHSOF inequalities indicators show little change in inequalities over recent years (for example cancer mortality and adult potential years of life lost due to causes considered amenable to healthcare).

243. The Government is keenly aware that reducing health inequalities is very challenging with complex drivers, many of which are outside health system control. The Secretary of State's assessment of how well his duty to have regard to the need to reduce health inequalities between the people of England has been discharged in 2015-16 is that there has been reasonably good progress. However there is still more to do, in particular to support effective action across all communities and to strengthen the evidence and knowledge of what works"

If the above analysis is correct, the Secretary of State appears to have misinterpreted the focus of the duty by looking at health inequalities more widely rather than the inequality of benefit that NHS patients secure from universally available services. These issues may be explored further by the Court of Appeal when the *NPA* case comes to court[8].

3.18 Section 1D imposes a duty on the Secretary of State to promote the autonomy of NHS commissioning and provider bodies. It provides:

"(1) In exercising functions in relation to the health service, the Secretary of State must have regard to the desirability of securing, so far as consistent with the interests of the health service—

[8] No date for a hearing has yet been allocated.

(a) that any other person exercising functions in relation to the health service or providing services for its purposes is free to exercise those functions or provide those services in the manner that it considers most appropriate, and

(b) that unnecessary burdens are not imposed on any such person.

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

3.19 The origin of this duty appears to have been the follow-up document to the White Paper "Equity and Excellence: Liberating the NHS" which was published in July 2010. This said at paragraph 4.1:

> "The Government's reforms will liberate professionals and providers from top-down control. This is the only way to secure the quality, innovation and productivity needed to improve outcomes. We will give responsibility for commissioning and budgets to groups of GP practices; and providers will be freed from government control to shape their services around the needs and choices of patients. Greater autonomy will be matched by increased accountability to patients and democratic legitimacy, with a transparent regime of economic regulation and quality inspection to hold providers to account for the results they deliver"

3.20 Those who work in the NHS today may wonder what happened to the concept of liberating professionals and providers from top-down control since there is little, if any, evidence that this policy has been pursued in recent years. However, this policy was followed by "*Liberating the NHS: Legislative Framework and Next Steps 1"* in December 2010. This stated that the Bill, then in a preparatory stage, would:

> "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"

3.21 The Explanatory Notes to the Bill explained the purpose of clause 4 of the 2012 Act, which introduced section 1D into the NHS Act, as follows:

> **"The origin of Clause 4 - The Secretary of State's duty as to promoting autonomy.**
>
> 74. This clause seeks to establish an overarching principle that the Secretary of State should act with a view to promoting autonomy in the health service. It identifies two constituent elements of autonomy: freedom for bodies/persons in the health service (such as commissioning consortia or Monitor) to exercise their functions in a manner they consider most appropriate (1C(a)), and not imposing unnecessary burdens from those bodies/persons (1C(b)). The clause requires the Secretary of State to act with a view to securing these aspects of autonomy in exercising his functions in relation to the health service, so far as is consistent with the interests of the health service.
>
> 75. This duty would therefore require the Secretary of State, when considering whether to place requirements on the NHS, to make a judgement as to whether these were in the interests of the health service. If challenged, the Secretary of State would have to be able to justify why these requirements were necessary.
>
> 76. The duty covers the arm's length body sector and commissioners and providers of NHS services. Although the Secretary of State would not have the same direct relationship with providers of NHS services as he currently has with NHS trusts, he would still have certain functions which impact on providers. For example, he would be able to require certain terms to be included in contracts entered into by the NHS Commissioning Board and consortia for the provision of NHS services by virtue of regulations made under clause 16"

3.22 The duty does not appear to have been the subject of any judicial observations. However, the dominant thinking at the time of the 2012 Act was that efficiency and effectiveness would be promoted by setting the NHS up as a properly functioning market, with clear legal separations between commissioners and providers and a variety of private and public sector suppliers competing for the right to deliver NHS services. Thus complying with competition law was seen as a central part of the way the NHS was required to operate. The section 1D duty to respect the autonomy of providers was part of this thinking. Its aim appears to have been to encourage the

NHS to allow providers to deliver NHS services in innovative ways as opposed to forcing providers to deliver services according to well established patterns of activity.

3.23 The wording of the duty, namely that the Secretary of State must have "regard to the desirability of securing so far as consistent with the interests of the health service.." is a very weak form of words and it is difficult to envisage any circumstances in which a court would be able to hold that a Secretary of State, acting rationally, could be held to act in breach of this duty. However the rigidity of the recently published STP processes may well be hard to equate with performance of this duty because the frameworks operating tend to uniformity of service provision rather than encouraging diversity.

3.24 Section 1E contains a duty on the Secretary of State to promote research which is relevant to the NHS. It provides:

> "In exercising functions in relation to the health service, the Secretary of State must promote—
>
> (a) research on matters relevant to the health service, and
>
> (b) the use in the health service of evidence obtained from research"

3.25 This is more than a "have regard" duty but is only a duty of promotion rather than a hard duty of provision. Nonetheless, the duty requires the Secretary of State to ensure that an appropriate amount of the NHS budget is allocated for appropriate research and that procedures are in place to ensure that the product of research is used in the NHS.

3.26 Section 1F imposes a duty on the Secretary of State in relation to education and training. It provides:

> "(1) The Secretary of State must exercise the functions of the Secretary of State under any relevant enactment so as to secure that there is an effective system for the planning and delivery of education and training to persons who are employed, or who

are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England.

(2) Any arrangements made with a person under this Act for the provision of services as part of that health service must include arrangements for securing that the person co-operates with the Secretary of State and Health Education England in the discharge of the duty under subsection (1) (or, where a Special Health Authority is discharging that duty by virtue of a direction under section 7, with the Special Health Authority).

(3) In subsection (1), "relevant enactment" means—

(a) section 63 of the Health Services and Public Health Act 1968,
(b) this Act,
(c) the Health and Social Care Act 2008,
(d) the Health Act 2009, and
(e) the Health and Social Care Act 2012"

3.27 This is a stronger form of wording than some of the other duties in this Part of the Act. It requires the Secretary of State to "*secure that there is an effective system for the planning and delivery of education and training*" for staff working in the health service. In practice, this duty is delivered through Health Education England but the Secretary of State is required to have regard to the need to ensure that research remains a key function of the NHS in the discharge of all of his duties.

3.28 Section 1G required the Secretary of State to lay a report before Parliament:

"‥ on the treatment of NHS health care providers as respects any matter, including taxation, which might affect their ability to provide health care services for the purposes of the NHS or the reward available to them for doing so"

This report was (probably) laid[9] as required but it does not appear to have been referred to in any published document by the NHS at any later date.

[9] It does not appear to feature as part of any internet search.

3.29 The Secretary of State has a duty to keep the performance of NHS bodies under review and has the power to include his or her assessment of their performance in his annual report to parliament. This power is under section 247C of the NHS Act which provides:

> "(1) The Secretary of State must keep under review the effectiveness of the exercise by the bodies mentioned in subsection (2) of functions in relation to the health service in England.
>
> (2) The bodies mentioned in this subsection are—
>
> (a) the Board;
>
> (b) Monitor;
>
> (c) the Care Quality Commission and its Healthwatch England committee;
>
> (d) the National Institute for Health and Care Excellence;
>
> (e) the Health and Social Care Information Centre;
>
> (ea) Health Education England;]
>
> (f) Special Health Authorities.
>
> (3) The Secretary of State may include in an annual report under section 247D the Secretary of State's views on the effectiveness of the exercise by the bodies mentioned in subsection (2) of functions in relation to the health service"

3.30 Thus the Secretary of State has a duty to review the effectiveness of the NHS bodies in relation to the health service in England but a discretion about whether to report on the outcomes of his review in his annual report.

4. The Public Sector Equality Duty.

4.1 The Secretary of State is bound by the Public Sector Equality Duty imposed by section 149 of the Equality Act 2010 and by the non-discrimination duties set out in that Act. Section 149 provides:

> (1) A public authority must, in the exercise of its functions, have due regard to the need to—
>
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
>
> (2) A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).
>
> (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
>
> (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
>
> (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
>
> (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
>
> (4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

(5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—

(a) tackle prejudice, and

(b) promote understanding.

(6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

(7) The relevant protected characteristics are—

age;

disability;

gender reassignment;

pregnancy and maternity;

race;

religion or belief;

sex;

sexual orientation.

(8) A reference to conduct that is prohibited by or under this Act includes a reference to—

(a) a breach of an equality clause or rule;

(b) a breach of a non-discrimination rule.

(9) Schedule 18 (exceptions) has effect”

4.2 A summary of the case-law on the PSED was set out by McCombe LJ in *R (Bracking) v. Secretary of State for Work and Pensions* [2014] Eq LR 60, at [26]:

> "(1) As stated by Arden LJ in *R (Elias) v Secretary of State for Defence* [2006] 1 WLR 3213, para 274, equality duties are an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation.
>
> (2) An important evidential element in the demonstration of the discharge of the duty is the recording of the steps taken by the decision-maker in seeking to meet the statutory requirements: *R (BAPIO Action Ltd) v Secretary of State for the Home Department* [2007] EWHC 199 (QB) (Stanley Burnton J).
>
> (3) The relevant duty is upon the minister or other decision-maker personally. What matters is what he or she took into account and what he or she knew. Thus, the minister or decision-maker cannot be taken to know what his or her officials know or what may have been in the minds of officials in proffering their advice: *R (National Association of Health Stores) v Department of Health* [2005] EWCA Civ 154 at [26] and [27] per Sedley LJ.
>
> (4) A minister must assess the risk and extent of any adverse impact and the ways in which such risk may be eliminated before the adoption of a proposed policy and not merely as a 'rearguard action', following a concluded decision: per Moses LJ, sitting as a judge of the Administrative Court, in *R (Kaur) v Ealing London Borough Council* [2008] EWHC 2062 (Admin) at [23] and [24].
>
> (5) These and other points were reviewed by Aikens LJ, giving the judgment of the *Divisional Court, in R (Brown) v Secretary of State for Work and Pensions* [2009] PTSR 1506, as follows: (i) the public authority decision-maker must be aware of the duty to have 'due regard' to the relevant matters; (ii) the duty must be fulfilled before and at the time when a particular policy is being considered; (iii) the duty must be 'exercised in substance, with rigour, and with an open mind'. It is not a question of 'ticking boxes'; while there is no duty to make express reference to the regard paid to the relevant duty, reference to it and to the relevant criteria reduces the scope for argument; (iv) the duty is non-delegable; and (v) is a continuing one. (vi) It is good practice for a decision-maker to keep records demonstrating consideration of the duty.
>
> (6) '[General] regard to issues of equality is not the same as having specific regard, by way of conscious approach to the statutory criteria': per Davis J in *R (Meany) v Harlow District Council* [2009] EWHC 559 (Admin) at [84], approved in this court in *R (Bailey) v Brent London Borough Council* [2012] LGR 530, paras 74.

(7) Officials reporting to or advising ministers/other public authority decision-makers, on matters material to the discharge of the duty, must not merely tell the minister/decision-maker what he/she wants to hear but they have to be 'rigorous in both inquiring and reporting to them': *R (Domb) v Hammersmith and Fulham London Borough Council* [2009] LGR 843, para 79, per Sedley LJ.

(8) Finally, and with respect, it is I think, helpful to recall passages from the judgment of Elias LJ in *R (Hurley) v Secretary of State for Business, Innovation and Skills* [2012] HRLR 374 (Divisional Court) as follows: (i) at paras 77–78: '77. Contrary to a submission advanced by Ms Mountfield, I do not accept that this means that it is for the court to determine whether appropriate weight has been given to the duty. Provided the court is satisfied that there has been a rigorous consideration of the duty, so that there is a proper appreciation of the potential impact of the decision on equality objectives and the desirability of promoting them, then as Dyson LJ in *Baker v Secretary of State for Communities and Local Government (Equality and Human Rights Commission intervening)* [2009] PTSR 809, para 34 made clear, it is for the decision-maker to decide how much weight should be given to the various factors informing the decision.

The concept of 'due regard' requires the court to ensure that there has been a proper and conscientious focus on the statutory criteria, but if that is done, the court cannot interfere with the decision simply because it would have given greater weight to the equality implications of the decision than did the decision-maker. In short, the decision-maker must be clear precisely what the equality implications are when he puts them in the balance, and he must recognise the desirability of achieving them, but ultimately it is for him to decide what weight they should be given in the light of all relevant factors. If Ms Mountfield's submissions on this point were correct, it would allow unelected judges to review on substantive merits grounds almost all aspects of public decision making.' (ii) At paras 89–90: '89. It is also alleged that the PSED in this case involves a duty of inquiry. The submission is that the combination of the principles in *Secretary of State for Education and Science v Tameside Metropolitan Borough Council* [1977] AC 1014 and the duty of due regard under the statute requires public authorities to be properly informed before taking a decision. If the relevant material is not available, there will be a duty to acquire it and this will frequently mean than some further consultation with appropriate groups is required. Ms Mountfield referred to the following passage from the judgment of Aikens LJ in the Brown case at para 85: 'the public authority concerned will, in our view, have to have due regard to the *need* to take steps to gather relevant information in order that it can properly take steps to take into account disabled persons' disabilities in the context of the particular function under consideration. 90. I respectfully agree …'"

4.3 The importance of compliance with the PSED has very recently been re-emphasised by the Supreme Court. *Per* Lord Toulson, with whom Lord Neuberger, Lord Mance, Lord Sumption and Lord Hughes agreed, in *R (Carmichael) v. Secretary of State for Work and Pensions* [2016] UKSC 58, [2016] 1 WLR 4550:

> "67. As Lord Dyson MR said, the PSED is a duty on the part of a public authority to follow a form of due process, that is, an obligation to have due regard to the need to eliminate discrimination, and advance equality of opportunity, between those with and without a relevant protected characteristic. …
>
> 68. … it was not sufficient for a decision-maker to have a vague awareness of his legal duties. Rather, he must have a focused awareness of the duties under section 149 of the Equality Act and, in a disability case, their potential impact on people with disabilities. …"

4.4 A challenge to the rules for charging overseas visitors succeeded on the grounds that the Secretary of State had failed to have regard to the PSED in *R (Cushnie) v Secretary of State for Health* [2014] EWHC 3626 (Admin). The court held the Secretary of State had acted unlawfully for failing properly to consider the impact of the National Health Service (Charges to Overseas Visitors) Regulations 2011 on overseas visitors who had a disability. Singh J said[10]:

> "The purpose of the duty is to make sure that public authorities do not inadvertently overlook the impact of their decisions on relevant groups, because too often in the past they were overlooked"

4.5 Whilst this duty is wide-ranging in theory, its impact may have been considerably reduced by the decision of the Court of Appeal in *Secretary of State for Communities and Local Government v West Berkshire District Council & Anor* [2016] EWCA Civ 441 which has, in effect, sanctioned public bodies undertaking Equality Impact Assessments after a decision has been taken and thus validating them *ex post facto*.

5. **The Secretary of State's powers and duties to make Regulations.**

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[10] See paragraph 115 at http://www.bailii.org/ew/cases/EWHC/Admin/2014/3626.html

5.1 The NHS Act and other statutes governing the operation of the NHS frequently provide a power for the Secretary of State to make Regulations. This power is often subject to a prior duty of consultation with a representative body and with such other persons as the Secretary of State considers fit. Hence, by way of example, the Secretary of State has the power to make Regulations about direct payments: see section 12(1) of the NHS Act[11].

5.2 Where the Secretary of State has power to make Regulations, the Regulation must be laid before parliament for 40 days once it is made. A Regulation will be either subject to a positive or negative resolution power, namely it either requires a positive resolution of both Houses of Parliament to affirm the Regulations or will have effect unless a resolution of both Houses of Parliament objects to the Regulations. However, the Regulations have legal effect on the date when they are made, not at the expiry of the 40 day period: see the Statutory Instruments Act 1946.

5.3 An important example of the Secretary of State's regulation making powers is under section 251 of the NHS Act which gives the Secretary of State wide powers to make Regulations about the extent to which NHS bodies can use patient data, including without obtaining the informed and explicit consent from patients to use data about their health conditions. It provides:

> "(1) The Secretary of State may by regulations make such provision for and in connection with requiring or regulating the processing of prescribed patient information for medical purposes as he considers necessary or expedient—
>
> (a) in the interests of improving patient care, or
>
> (b) in the public interest.
>
> (2) Regulations under subsection (1) may, in particular, make provision—

[11] Please see the chapter on direct payments for details as to how the Regulations operate to bring a system of direct payments into force.

(a) for requiring prescribed communications of any nature which contain patient information to be disclosed by health service bodies or relevant social care bodies in prescribed circumstances—

(i) to the person to whom the information relates,

(ii) (where it relates to more than one person) to the person to whom it principally relates, or

(iii) to a prescribed person on behalf of any such person as is mentioned in sub-paragraph (i) or (ii),

in such manner as may be prescribed,

(b) for requiring or authorising the disclosure or other processing of prescribed patient information to or by persons of any prescribed description subject to compliance with any prescribed conditions (including conditions requiring prescribed undertakings to be obtained from such persons as to the processing of such information),

(c) for securing that, where prescribed patient information is processed by a person in accordance with the regulations, anything done by him in so processing the information must be taken to be lawfully done despite any obligation of confidence owed by him in respect of it,

(d) for creating offences punishable on summary conviction by a fine not exceeding level 5 on the standard scale or such other level as is prescribed or for creating other procedures for enforcing any provisions of the regulations.

(3) Subsections (1) and (2) are subject to subsections (4) to (7).

(4) Regulations under subsection (1) may not make provision requiring the processing of confidential patient information for any purpose if it would be reasonably practicable to achieve that purpose otherwise than pursuant to such regulations, having regard to the cost of and the technology available for achieving that purpose.

(5) Where regulations under subsection (1) make provision requiring the processing of prescribed confidential patient information, the Secretary of State—

(a) must, at any time within the period of one month beginning on each anniversary of the making of such regulations, consider whether any such

provision could be included in regulations made at that time without contravening subsection (4), and

(b) if he determines that any such provision could not be so included, must make further regulations varying or revoking the regulations made under subsection (1) to such extent as he considers necessary in order for the regulations to comply with that subsection.

(6) Regulations under subsection (1) may not make provision for requiring the processing of confidential patient information solely or principally for the purpose of determining the care and treatment to be given to particular individuals.

(7) Regulations under this section may not make provision for or in connection with the processing of prescribed patient information in a manner inconsistent with any provision made by or under the Data Protection Act 1998.

(8) Subsection (7) does not affect the operation of provisions made under subsection (2)(c).

(9) Before making any regulations under this section the Secretary of State must, to such extent as he considers appropriate in the light of the requirements of section 252, consult such bodies appearing to him to represent the interests of those likely to be affected by the regulations as he considers appropriate.

(10) In this section “patient information” means—

(a) information (however recorded) which relates to the physical or mental health or condition of an individual, to the diagnosis of his condition or to his care or treatment, and

(b) information (however recorded) which is to any extent derived, directly or indirectly, from such information,

whether or not the identity of the individual in question is ascertainable from the information.

(11) For the purposes of this section, patient information is “confidential patient information” where—

(a) the identity of the individual in question is ascertainable—

(i) from that information, or

(ii) from that information and other information which is in the possession of, or is likely to come into the possession of, the person processing that information, and

(b) that information was obtained or generated by a person who, in the circumstances, owed an obligation of confidence to that individual.

(12) In this section "medical purposes" means the purposes of any of—

(a) preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of health and social care services, and

(b) informing individuals about their physical or mental health or condition, the diagnosis of their condition or their care and treatment.

(12A) In this section—

"care" includes local authority social care,

"local authority social care" means—

(a) social care provided or arranged for by a local authority, and

(b) any other social care all or part of the cost of which is paid for with funds provided by a local authority,

"patient" includes an individual who needs or receives local authority social care or whose need for such care is being assessed by a local authority,

"social care" includes all forms of personal care and other practical assistance provided for individuals who are in need of such care or assistance by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs or other similar circumstances.

(13) In this section—

"health service body" means any body (including a government department) or person engaged in the provision of the health service that is prescribed, or of a description prescribed, for the purposes of this definition,

"processing", in relation to information, means the use, disclosure or obtaining of the information or the doing of such other things in relation to it as may be prescribed for the purposes of this definition,

"relevant social care body" means—

(a) a local authority, or

(b) any other body or person engaged in the provision of local authority social care"

5.4 The use of these powers are hugely controversial because of the tensions between the free-flow of information being available to clinicians and researchers to assist patients (both individually and generally) and the strongly expressed desire of many people to hold on to the confidentiality of information about their health and not to allow that confidential information to be used without their consent. The Secretary of State has made the Health Service (Control of Patient Information) Regulations 2002. Regulation 3 provides powers for the NHS to process patient information relating to communicable diseases without the consent of the patient. Use of data can also be justified as part of clinical audit: see paragraph 5 of the Schedule to these Regulations. However the recent problems of "Care.Data"[12] (which was abandoned in July 2016) shows that this is an area where there are acute sensitivities and thus the powers are used sparingly.

6. **The Secretary of State's power to issue Directions.**

6.1 A direction is an order issued by the Secretary of State[13] which creates a public law duty on the person named in the order to do the thing which is referred to within the direction or to refrain from doing a specific thing referred to in the direction. A direction can set a level of remuneration for those providing a specified type of NHS services, require an NHS commissioner to exercise its powers in a certain way or

[12] There are many articles on the problems of NHS Digital and the use of patient data but for a summary see: https://www.theguardian.com/technology/2016/jul/06/nhs-to-scrap-single-database-of-patients-medical-details

[13] Or another public body such as NHS England which is authorised by statute to issue the direction.

require a named individual to be removed from a post within an NHS organisation. There are 2 types of directions within the scheme of NHS law, namely:

a) Directions to NHS bodies or others which are subject to a general direction making power; and

b) Directions governing a specific function or payment scheme.

6.2 **General direction making powers:** Until the implementation of the 2012 Act, all NHS bodies other than NHS Foundation Trusts were capable of being the subject of general directions issued by the Secretary of State. This general direction making power was contained in section 8 of the NHS Act which, when passed, provided:

> "(1) The Secretary of State may give directions to any of the bodies mentioned in subsection (2) about its exercise of any functions.
>
> (2) The bodies are—
>
> (a) Strategic Health Authorities,
>
> (b) Primary Care Trusts,
>
> (c) NHS trusts, and
>
> (d) Special Health Authorities.
>
> (3) Nothing in provision made by or under this or any other Act affects the generality of subsection (1)"

6.3 The general power to make directions to require any NHS body to do something (or refrain from doing something) gave the Secretary of State (or in practice civil servants working for the Department of Health) the ability to intervene in virtually any part of the NHS. In practice, the existence of the power meant that Directions rarely needed to be issued to force a Chief Executive to step down when there was a perceived fault (such as the infamous incident where the Bedford Hospitals Chief Executive stepped

down after being criticised by the then Secretary of State for permitting dead bodies to be stored in the hospital's chapel of rest). However, the ability to issue directions came to be seen in Whitehall as a burden on the Secretary of State. If the Secretary of State had the ability to intervene to correct something, it was entirely legitimate for MPs or the media to call on the Secretary of State to exercise that power by intervening. The cry "something must be done" is often made in the NHS when things do not work out as well as anyone hopes and a general power for the Secretary of State to issue directions often meant that the "something" had to be done directly by the Secretary of State.

6.4 A decision was taken that the Secretary of State should not have the ability to issue directions to NHS Foundation Trusts when this new form of "independent" NHS body was created by the Health and Social Care (Community Health and Standards) Act 2003. That policy was substantially extended by the 2012 Act, which created clinical commissioning groups in place of primary care trusts as the local NHS commissioners. Clinical commissioning groups were subject to oversight by NHS England but could not be made the subject of directions issued by the Secretary of State. The present form of section 8 thus reads as follows:

> "(1) The Secretary of State may give directions to any of the bodies mentioned in subsection (2) about its exercise of any functions.
>
> (2) The bodies are—
>
> (a) . . .
>
> (b) . . .
>
> (c) NHS trusts, and
>
> (d) Special Health Authorities.
>
> (3) Nothing in provision made by or under this or any other Act affects the generality of subsection (1)

6.5 The original scheme of the 2012 Act was that all NHS Trusts should either become NHS Foundation Trusts by April 2016 or be taken over by an NHS Foundation Trust by that date. The 2012 Act accordingly contained power for all of the legislative provisions relating to NHS Trusts, including the power to issue directions, to be repealed: see Schedule 14 to the 2012 Act. The growing financial crisis in the NHS and the reversion to central control of NHS bodies (with the effective abandonment of the concept of the managed NHS market) has meant that the policy of forcing all NHS Trusts to become NHS Foundation Trusts has not been a priority. Accordingly, NHS Trusts continue in existence and continue to be subject to the Secretary of State's direction making powers.

6.6 The remaining category of NHS bodies who can be the subject of directions is Special Health Authorities ("SHAs"). Prior to 2006 there was a long list of SHAs but there are now only 3, namely NHS Blood and Transplant, the NHS Business Services Agency and the NHS Litigation Authority.

6.7 **Powers to make directions governing a specific function or payment scheme:** The Secretary of State retains the right to make directions about specified matters under a number of different provisions within the NHS Act. This direction making power gives the Secretary of State a considerable ability to influence how the NHS functions and to set priorities for spending. By way of example, the Secretary of State has the right to make directions which define the payments that GP practices working under General Medical Services Contracts will receive: see section 87(1) NHS Act. The Secretary of State has used that power to set both a complex set of directions which define how much GMS GP practices should be paid for providing services to NHS patients, namely the General Medical Services Statement of Financial Entitlements Directions. Changes to these Directions are negotiated on an annual basis between NHS Employers, which is part of the NHS Confederation[14]. The changes are published annually and then,

[14] NHS Employers was described as follows by Mr Justice Green in the recent junior doctors judicial review challenge: *R (Justice for Health Ltd) v The Secretary of State for Health* [2016] EWHC 2338 (Admin) "The NHS Confederation is a charity and company limited by guarantee that acts as a membership organisation for entities that commission and provide NHS services. Its members include: acute trusts, ambulance trusts,

from time to time, the changes are consolidated into a new set of directions. Hence, the present GMS Statement of Financial Entitlements directions constitutes the 2013 set of directions[15], as amended by directions made between 2014 and 2017[16]. There are also a separate set of directions which define the way in which GMS GP practices are remunerated for providing appropriate premises, namely the NHS (General Medical Services - Premises Costs) Directions 2013[17].

6.8 The Secretary of State also has the right to make numerous other types of specific directions including, for example, to set the remuneration paid to pharmacists under the Drug Tariff: see section 127(3) of the NHS Act.

7. **The power of the Secretary of State to issue Guidance.**

7.1 There is no specific power in the NHS Act to permit the Secretary of State to issue Guidance. However the Secretary of State has a general power in section 2 of the NHS Act[18] as follows:

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community health service providers, foundation trusts, mental health providers, clinical commissioning groups, and some independent and voluntary healthcare organisations. It is right to observe that there are some employers who are not represented by the NHS Confederation. One component of its membership comprises a network that represents trusts in England on employment and workforce issues. This is known as "NHS Employers". Detailed evidence on behalf of the NHS Confederation was given by Mr Daniel Mortimer, the Chief Executive of NHS Employers. As observed this body is part of the NHS Confederation and has no separate legal personality or status. It is therefore the individual members of NHS Employers that employ junior doctors and who will in due course introduce the new contracts either (i) when doctors join the NHS for the first time, or (ii) transfer to a new post within the NHS as part of their training, with effect from 5th October 2016". See http://www.bailii.org/ew/cases/EWHC/Admin/2016/2338.html

[15] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/233366/gen_med_servs_statement_financial_entitlements_directions_2013_acc.pdf

[16] These are listed at https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013

[17] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184017/NHS__General_Medical_Services_-_Premises_Costs__Directions_2013.pdf

[18] As amended by the 2012 Act. Section 2(1) of the NHS Act, as originally passed, read "(1)The Secretary of State may (a) provide such services as he considers appropriate for the purpose of discharging any duty imposed on him by this Act, and (b) do anything else which is calculated to facilitate, or is conducive or incidental to, the discharge of such a duty"

"The Secretary of State, the Board or a clinical commissioning group may do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any function conferred on that person by this Act"

7.2 In *R (Rogers) v Swindon NHS Primary Care Trust & Anor* [2006] EWHC 171 (Admin) Bean J said at §52:

"The origin of the power to issue guidance is to be found in the general enabling powers of section 2"

7.3 The effect of Guidance given by the Secretary of State has been considered in a number of cases. In *R (Fisher) v North Derbyshire Health Authority* [1997] EWHC Admin 675 Dyson J (as he then was) was concerned with strong statements made by the Secretary of State in favour of the use of Interferon for patients suffering from the relapsing/remitting form of Multiple Sclerosis. He said at §10:

"The difference between a policy which provides mere guidance, and one in which the health authority is obliged to implement is critical. Policy which is in the form of guidance can be expressed in strong terms and yet fall short of amounting to directions. There is no reference in the Circular to the word "directions", and read as a whole there is no indication that the Circular is intended to trigger the statutory duty of compliance to be found in section 13(1) of the 1977 Act[19]. The Circular includes words such as "asks", "suggested", "taking into account". It does not include the word "shall" or any of the other badges of mandatory requirement"

7.4 Hence, an NHS Body is not under any absolute duty to act in accordance with Guidance made by the Secretary of State, however strongly that guidance is expressed. However the Judge then expressed the effect of Guidance as follows at §11:

"If the Circular provided no more than guidance, albeit in strong terms, then the only duty placed upon health authorities was to take it into account in the discharge of their functions. They would be susceptible to challenge only on Wednesbury principles

[19] The part of the NHS Act 1977 covering the power of the Secretary of State to issue directions.

> if they failed to consider the Circular, or they misconstrued or misapplied it whether deliberately or negligently: see *Grandsden & Co Ltd and another -v- Secretary of State and Another* (1985) 54 P&CR 86, 93 – 94"

7.5 Hence an NHS body acts unlawfully if it:

a) Fails to consider guidance issued by the Secretary of State;

b) Misconstrues it (i.e. reads it but misunderstands what the NHS body is required to consider doing); or

c) Misapplies it (i.e. reads and understands it but applies it in a way that the Secretary of State did not intend).

7.6 However even if the NHS body properly considers the guidance, understands its meaning and does not misapply it, an NHS body is only entitled to depart from Guidance if it has a good reason to do so. This was expressed by Dyson J at §54 where he said:

> "They were not obliged to follow the policy, but if they decided to depart from it, they had to give clear reasons for so doing, and those reasons would have been susceptible to a Wednesbury challenge"

7.7 In the *Fisher* case, the Health Authority were somewhat unclear as to why they had refused to implement the Guidance by making Interferon available to NHS patients in accordance with the Secretary of State's Guidance. However a substantial factor was that the local clinicians disagreed with the Secretary of State's assessment that the drug had been sufficiently tested to prove that it was clinically effective. The Judge appears to have considered that it was not open to the local Health Authority to form a different view on clinical effectiveness to the Secretary of State. He said at §56:

> "The respondents failed to implement any aspect of national policy, principally because they disagreed with it altogether. They now seek to argue that at least they

acted consistently with that policy, although for the reasons that I have given that is plainly not the case. Accordingly, they do not seek to justify their policy as a rational exception to the national policy. That is hardly surprising, since I expect that the situation in which the respondent found themselves when the Circular was issued was not materially different from that faced by most other health authorities. The respondents did not take the Circular into account and decide exceptionally not to follow it. They decided to disregard it altogether throughout 1996, because they were opposed to it. That is something which in my judgment they were not entitled to do"

7.8 However, this part of the judgment needs to be treated with some caution as the observations appear to have been grounded in the explanations or lack of explanations advanced on behalf of the health authority. Local NHS commissioners are the decision makers as to which treatments should be funded for the patients for whom they have commissioning responsibility and are under a duty to use their resources in an effective manner. If local clinicians reach a rational view that a drug or other treatment is not either clinically effective or a cost effective use of NHS resources, they probably have the right to decline to follow NHS Guidance: see *R (Condliff) v North Staffordshire Primary Care Trust* [2011] EWHC 872 (Admin). A local prioritisation decision not to follow the NICE Guidelines on bariatric surgery for resources reasons was upheld in both the High Court and the Court of Appeal.

8. The role of the Secretary of State in the Trust failure regime.

8.1 The Health Act 2009 grappled with the problem as to what action should be taken where there was a wholesale failure by an NHS body. This is a problem that has vexed the NHS for many years – what should the centre do if an NHS body fails. The scheme under the 2009 Act involved the appointment of a Trust Special Administrator ("TSA") by the Secretary of State. This power was used by the Secretary of State to appoint a TSA to take over South London Healthcare National Health Service Trust ("SLHT"): see the South London Healthcare National Health Service Trust (Appointment of Trust Special Administrator) Order 2012.

8.2 Unfortunately part of the TSA's proposed remedy for the woes of SLHT, which was losing about £1M per week at that stage, was to require major changes at the neighbouring Lewisham Hospital. However Lewisham Hospital was not run by SLHT but by a different Trust. The Secretary of State accepted the TSA's recommendation but his decision was challenged in a Judicial Review. Both the High Court and the Court of Appeal sided with the objectors and so that part of the plan was quashed: see *Trust Special Administrator Appointed To South London Healthcare NHS Trust & Anor v London Borough of Lewisham & Anor* [2013] EWCA Civ 1409[20]. The High Court and the Court of Appeal determined that NHS trusts were separate legal entities and the powers of the TSA in relation to SLHT did not extend to either the TSA or the Secretary of State, in reliance on a report produced by the TSA, making decisions which affected Lewisham Hospital, which was run by a wholly different NHS Trust[21].

8.3 The 2012 Act removed the powers to appoint a TSA from the Secretary of State and provided that they be exercised by Monitor. They have only been used once, namely in the case of Mid-Staffordshire NHS Foundation Trust following the well-publicised quality problems at Stafford Hospital. Those problems were laid bare in the comprehensive report by Robert Francis QC[22]. However, the consequent TSA process proved to be an astonishingly expensive and legally cumbersome way of dealing with management failure at a provider Trust.

8.4 It thus seems far more likely that the NHS will return to the traditional way of dealing with provider failure, namely by using a mixture of powers and influence to change management, remove a Chair (often with Monitor exercising powers to do so under the 2012 Act) or to require an effective take-over of a failing Trust by a nearby successfully operating Trust. It thus seems highly unlikely that the Trust failure regime in the 2006 Act (as amended by the 2012 Act) will be used in the foreseeable future.

[20] See http://www.bailii.org/ew/cases/EWCA/Civ/2013/1409.html

[21] This restriction on the powers of the TSA was subsequently amended by the Care Act 2014. However the new powers have not yet been used.

[22] See http://webarchive.nationalarchives.gov.uk/20130104234315/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018

9. **Schedule 1 powers and duties.**

9.1 Schedule 1 of the NHS Act contains a series of powers and duties on the Secretary of State covering a series of ancillary matters relating to the operation of the NHS. Hence, for example, paragraph 7C provides:

> "The Secretary of State must for the purposes of the health service make arrangements for—
>
> (a) collecting, screening, analysing, processing and supplying blood or other tissues,
>
> (b) preparing blood components and reagents, and
>
> (c) facilitating tissue and organ transplantation"

This is the origin of the requirements for NHS Blood and Transplant, which is a Special Health Authority which performs these tasks for the wider NHS.

9.2 Schedule 1 also contains a specific power on the Secretary of State to make arrangements for contraceptive services. Paragraph 8 provides:

> "The Secretary of State must arrange, to such extent as he considers necessary to meet all reasonable requirements, for—
>
> (a) the giving of advice on contraception,
>
> (b) the medical examination of persons seeking advice on contraception,
>
> (c) the treatment of such persons, and
>
> (d) the supply of contraceptive substances and appliances"

9.3 The Secretary of State also has wide powers to fund research under Schedule 1. Paragraph 13 provides:

"(1) The Secretary of State, the Board or a clinical commissioning group may conduct, commission or assist the conduct of research into—

(a) any matters relating to the causation, prevention, diagnosis or treatment of illness, and

(b) any such other matters connected with any service provided under this Act as the Secretary of State, the Board or the clinical commissioning group (as the case may be) considers appropriate.

(2) A local authority may conduct, commission or assist the conduct of research for any purpose connected with the exercise of its functions in relation to the health service.

(3) The Secretary of State, the Board, a clinical commissioning group or a local authority may for any purpose connected with the exercise of its functions in relation to the health service—

(a) obtain and analyse data or other information;

(b) obtain advice from persons with appropriate professional expertise.

(4) The power under sub-paragraph (1) or (2) to assist any person to conduct research includes power to do so by providing financial assistance or making the services of any person or other resources available"

9.4 The references to the Secretary of State in many of the other parts of Schedule 1 in the original form of the NHS Act were replaced by references to other NHS bodies by the 2012 Act, as part of the general policy of moving the role of the Secretary of State away from an operational role to a strategic role.

10. **The Emergency Powers of the Secretary of State.**

10.1 Section 253 of the NHS Act contains extremely wide emergency powers which are available to the Secretary of State to deal with any emergency in the NHS. It provides:

"(1) The Secretary of State may give directions under this section if he considers that by reason of an emergency it is appropriate to do so.

(1A) A direction under this section may be given to—

(a) an NHS body other than a Local Health Board;

(b) the National Institute for Health and Care Excellence;

(c) the Health and Social Care Information Centre;

(d) any body or person, other than an NHS body, providing services in pursuance of arrangements made—

(i) by the Secretary of State under section 12,

(ii) by the Board or a clinical commissioning group under section 3, 3A, 3B or 4 or Schedule 1,

(iii) by a local authority for the purpose of the exercise of its functions under or by virtue of section 2B or 6C(1) or Schedule 1, or

(iv) by the Board, a clinical commissioning group or a local authority by virtue of section 7A.

(2) In relation to a body within subsection (1A)(a) to (c), the powers conferred by this section may be exercised—

(a) to give directions to the body about the exercise of any of its functions;

(b) to direct the body to cease to exercise any of its functions for a specified period;

(c) to direct the body to exercise any of its functions concurrently with another body or person for a specified period;

(d) to direct the body to exercise any function conferred on another body or person under or by virtue of this Act for a specified period (whether to the exclusion of, or concurrently with, that body or person).

(2A) In relation to a body or person within subsection (1A)(d), the powers conferred by this section may be exercised—

(a) to give directions to the body or person about the provision of any services that it provides in pursuance of arrangements mentioned in subsection (1A)(d);

(b) to direct the body or person to cease to provide any of those services for a specified period;

(c) to direct the body or person to provide other services for the purposes of the health service for a specified period.

(2B) The Secretary of State may direct the Board to exercise the functions of the Secretary of State under this section.

(2C) The Secretary of State may give directions to the Board about its exercise of any functions that are the subject of a direction under subsection (2B).

(2D) In this section, "specified" means specified in the direction.

(3) The powers conferred on the Secretary of State by this section are in addition to any other powers exercisable by him"

10.2 The bodies to whom directions can be given in an emergency include any NHS body. The term an "NHS body" is defined in section 275 as follows:

"NHS body" means—

(a) the Board,

(b) a clinical commissioning group,

(c) a Special Health Authority,

(d) an NHS trust,

(e) an NHS foundation trust, and

(f) a Local Health Board"

10.3 However the Secretary of State cannot use emergency powers to direct a “Local Health Board” because the LHBs fall within the scope of the Government of Wales: see section 253(1A)(a).

10.4 The powers to give directions in an emergency situation also extend to any commercial or voluntary sector provider who delivers NHS services under contract with NHS England or a CCG. Thus any contractor who supplies NHS services could be subject to a legal duty to act in accordance with directions made by the Secretary of State. It is unclear precisely how this could work if, for example, a contractor was required to expend money to comply with the directions without being provided with a proper level of remuneration.