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Select Committee on the Constitution

9th Report of Session 2021–22

Health and Care Bill

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Select Committee on the Constitution

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Baroness Drake
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Committee staff

The current staff of the committee are John Turner (Clerk), Rachel Borrell (PolicyAnalyst) and Jackie Lam (Committee Operations Officer). Professor Stephen Tierney and Professor Alison Young are the legal advisers to the Committee.

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Health and Care Bill

Introduction

1. The Health and Care Bill was introduced to the House of Commons on 6 July 2021 and brought to the House of Lords on 24 November 2021. Second reading was on 7 December 2021 and committee stage is scheduled to commence on 11 January 2022.

2. The main purpose of the Bill is to implement reforms to the NHS. These reforms stem from the NHS Long Term Plan (published in 2019)[1] and the White Paper *Integration and Innovation: Working together to improve Health and Social Care for all* (published in February 2021).[2] The commitment to "enshrine in law" the NHS Long Term Plan was in the manifesto of the Government.[3]

3. The Committee has noted in the past the importance of ensuring that legislation receives sufficient scrutiny from Parliament. **We regret that the powers under this important and complex bill are structured in a way that hampers greater detailed parliamentary scrutiny, and note that the Bill itself was not subject to pre-legislative scrutiny.**

Constitutional oversight of healthcare

4. Part 1 of the Bill makes structural reforms to the NHS and sets out the functions of the Secretary of State.

5. Our committee's report on the Health and Social Care Bill in 2011 expressed concern that that Bill could dilute the Government's responsibility for health and social care.[4] The Bill was amended to specify that the Secretary of State retained "ministerial responsibility to Parliament for the provision of the health service".[5]

6. **We note that the current Bill does not alter section 1(3) of the Health and Social Care Act 2012, which ensures that the Secretary of State retains "ministerial responsibility to Parliament for the provision of the health service".**

7. However, there is concern that the Bill risks upsetting the balance between ensuring the Government's constitutional responsibility for the provision of health care and maintaining sufficient autonomy in the health service to ensure health care is provided in a manner that can respond effectively to local needs.

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1 NHS, *The NHS Long Term Plan* (7 January 2019): https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [accessed 5 January 2022]

2 Department of Health and Social Care, 'Integration and Innovation: working together to improve health and social care for all', (11 February 2021): https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version [accessed 5 January 2022]

3 The Conservative and Unionist Party Manifesto 2019, *Get Brexit Done: Unleash Britain's Potential* (2019), p 9: https://www.conservatives.com/our-plan/conservative-party-manifesto-2019 [accessed 5 January 2022]. See also Explanatory Notes to the Health and Care Bill [Bill 71 (2021–22) - EN], para 3.

4 Constitution Committee, *Health and Social Care Bill* (18th Report, Session 2010–12, HL Paper 197), para 18

5 Health and Social Care Act 2012, section 1(3)

8. In our report on the Health and Social Care Bill in 2011 we raised concerns that that Bill could erode ministerial responsibility due to the proposed duty on the Secretary of State to promote autonomy for persons exercising functions in relation to the health service.[6] What is now section 5 of the Health and Social Care Act 2012 was amended, such that the Secretary of State instead must have regard to the desirability of securing autonomy.[7] This helps ensure a balance between enabling those providing health care services to deliver services in a manner that they consider appropriate, whilst ensuring ministerial responsibility.[8]

9. Clause 64 of the current Bill proposes to remove section 1D of the National Health Service Act, which was created by section 5 of the Health and Social Care Act 2012. It is replaced by provisions which empower the Secretary of State to give directions to NHS England or an integrated care board to perform any of the Secretary of State's public health functions, including providing directions on how these functions are to be carried out (clauses 37 and 39). Clause 40 and Schedule 6 provide the Secretary of State with powers relating to the reconfiguration of NHS services. NHS England or an integrated care board must notify the Secretary of State of any reconfiguration that may be required. The Secretary of State is empowered to give directions and to take on any decision-making role of an NHS commissioning body. Part 3 enables the Secretary of State to transfer functions between bodies.

10. **Clause 64 would remove section 5 of the Health and Social Care Act 2012, which requires the Secretary of State to have regard to the desirability of maintaining the autonomy of health service functions. Coupled with new powers for the Secretary of State of oversight, delegation and transfer of functions, this could alter the balance between the Government's constitutional responsibility for the provision of health care and providers' ability to function in a manner that can respond effectively to local needs. It also risks undermining accountability by making it more difficult to understand which body is responsible for a particular function of the NHS.**

Delegated powers

11. The Delegated Powers and Regulatory Reform Committee (DPRRC) has reported that the Bill contains 156 delegated powers in its 155 substantive

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6 Constitution Committee, *Health and Social Care Bill* (18th Report, Session 2010–12, HL Paper 197), paras 14 and 18

7 Health and Social Care Act 2012, section 5, which inserts section 1D into the National Health Service Act 2006.

8 Section 1D of the National Health Services Act 2006 (inserted by section 5 of the Health and Social Care Act 2012) "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 … to exercise their functions in a manner that they consider most appropriate … and not imposing unnecessary burdens upon those bodies/persons … The section provides that when exercising his functions in relation to the health service, the Secretary of State must have regard to the desirability of securing these aspects of autonomy so far as consistent with the interests of the health service. Subsection (2) of … section 1D makes clear that in the event of a conflict between those aspects of autonomy, on the one hand, and the discharge by the Secretary of State of his duties to promote the comprehensive health service and as to securing the provision of services on the other, it is the latter which take precedence … This duty would therefore require the Secretary of State, when considering whether to place requirements on the NHS and local authorities, to make a judgement as to whether these were in the interests of the health service. If challenged, the Secretary of State would have to be able to justify why these requirements were necessary." See Explanatory Notes to the Health and Social Care Act 2012, commentary on section 5, p.13.

provisions and found it to be "skeletal or framework legislation". It was particularly concerned about the extent to which the Bill enabled the making of legislation without parliamentary scrutiny and noted the inclusion of a Henry VIII power in clause 15 which is subject to the negative as opposed to the affirmative resolution procedure.[9]

12. **We echo the concerns of the Delegated Powers and Regulatory Reform Committee about the extent and nature of the delegated powers in the Bill, which make it difficult to assess the likely impact of the proposed legislation.**

13. The Bill gives rise to several forms of 'soft law'. For example, it provides for a series of situations in which an administrative body may or must produce 'guidance'. First, there are instances of a body having discretion to produce guidance on how it will exercise its own functions.[10] Second, it includes provisions for one administrative body to produce guidance that must be followed by another administrative body.[11] Third, the Bill imposes a duty on administrative bodies to produce guidance to regulate their own conduct which, in turn, must be complied with.[12] Despite guidance of this nature being binding, the Bill does not require that it is made subject to parliamentary scrutiny.

14. The Bill makes reference to "rules" and "directions", the latter of which are used to delegate functions and as a means for one administrative body to direct how another is to exercise its powers, often after an earlier direction has been used to delegate a function. For example, clause 8 empowers NHS England to direct that any of its relevant functions should be performed by one or more integrated care boards and to provide directions on how to perform the delegated function. Although for the most part the Bill does not impose an obligation to comply with a direction, there are exceptions.[13]

15. The DPRRC has referred to these forms of soft law as "disguised legislation",[14] noting that some of these provisions have the same effect as delegated legislation, imposing obligations on third parties to comply with their requirements. Yet the Bill provides for no parliamentary control over these provisions.

16. **We are concerned that guidance, directions and rules arising from the Bill amount to "disguised legislation" and are not subject to parliamentary control.**

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9 Delegated Powers and Regulatory Reform Committee, *Health and Social Care Bill* (15th Report, Session 2021–22, HL Paper 133), paras 3, 8, 9–12

10 For example, clause 5 empowers NHS England to produce guidance to regulate how it complies with its own duty to have regard to the likely effects of its decisions on the health and well-being of the people of England, the quality of service provision, and the efficiency and sustainability of resources when exercising its functions.

11 For example, clause 14 empowers NHS England to produce guidance as to how clinical commissioning groups establish integrated care boards. Clinical commissioning groups must have regard to this guidance.

12 See, for example, Health and Care Bill, clause 54 (HL Bill 71).

13 For example, clause 22 provides that the Secretary of State may give directions which require NHS England to use banking facilities for specific purposes. In addition, NHS England must not exceed the limit on the use of total capital or total revenue resource set by the Secretary of State by direction.

14 Delegated Powers and Regulatory Reform Committee, *Health and Social Care Bill* (15th Report, Session 2021–22, HL Paper 133), paras 5 and 8

17. In particular, the DPRRC was concerned about the ability to impose a legal liability merely by publishing a document and recommended that this be removed from the Bill.[15] ***We endorse the recommendation of the Delegated Powers and Regulatory Reform Committee that the power in clause 20 to impose legal liability merely by publishing a document without any parliamentary scrutiny should be removed from the Bill.***

18. **The Bill also risks confusion given the different effects of guidance, directions and rules**. We have previously highlighted difficulties with the unclear use of guidance, in the context of the pandemic.[16] ***The House should ensure that the Government sets out in the Bill the meaning and effect of different types of 'soft law' arising from the Bill.***

19. Schedule 17 empowers the Secretary of State to define unhealthy food and drink products. The Bill provides no precise list or guidance on the meaning of unhealthy food or drink. The Schedule does indicate that guidance, in the form of the "Nutrient Profiling Technical Guidance", produced by the Department of Health in 2011, can be used to help the Secretary of State when legislating to determine the content of unhealthy food and drink. However, this is guidance produced by a Government department, and is not derived from legislation. In addition, the Secretary of State has a power to change the meaning of "the relevant guidance" by regulations.

20. Whilst the Bill stipulates that these regulations may be made only after the Secretary of State has consulted such persons as the Secretary of State considers appropriate, and after a draft has been laid before and approved by Parliament, these mechanisms may not amount to adequate scrutiny. As the DPRRC has noted, legislation should not be alterable by guidance.[17] This is particularly significant given that those who breach the regulations could be subject to enforcement notices from Ofcom and financial penalties for failing to comply with these enforcement notices.

21. **We endorse the conclusion of the Delegated Powers and Regulatory Reform Committee that the power to define unhealthy food and drink products should be exercised exclusively through the making of regulations and not also through the making of guidance.**

Devolution issues

22. Clause 144 regulates the advertising of unhealthy food and drink on television and on-demand services, and over the internet. Detailed provisions are in Schedule 17, which empowers the Secretary of State to enact regulations that may extend the prohibition of such advertising on the internet. This is a Henry VIII clause, enabling the Secretary of State to modify an Act of Parliament, an Act of the Scottish Parliament, a Measure or an Act of the Senedd Cymru, or Northern Ireland legislation. The Secretary of State is required to consult those he or she considers appropriate before making regulations via the affirmative resolution procedure.

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15 Delegated Powers and Regulatory Reform Committee, *Health and Social Care Bill* (15th Report, Session 2021–22, HL Paper 133), para 16

16 Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (3rd Report, Session 2021–22, HL Paper 15), paras 165–67

17 Delegated Powers and Regulatory Reform Committee, *Health and Social Care Bill* (15th Report, Session 2021–22, HL Paper 133), para 25

23. Legislative consent is not generally necessary for making delegated legislation. The explanatory notes conclude that a legislative consent motion is not necessary for these provisions.[18] Nevertheless, a form of legislative consent has previously been incorporated into legislation which empowers ministers to make delegated legislation on devolved matters.[19] Health is a devolved matter and, in turn, restrictions on advertising may fall within the scope of the market access principles of mutual recognition and non-discrimination in the UK Internal Market Act 2020.[20] Schedule 17 could provide a further means of modifying devolved legislation to achieve market harmonisation that may undermine the power of devolved legislatures to enact measures on a devolved matter—the protection of health.

24. ***The House should consider amending Schedule 17 to require either the consultation of the relevant devolved administration or the consent of the relevant devolved legislature if the Secretary of State were to use this power to enact regulations modifying devolved legislation.***

18 Explanatory Notes to the Health and Care Bill [Bill 71 (2021–22) – EN], Annex A: Territorial extent and application in the United Kingdom

19 See, for example, European Union (Withdrawal) Act 2018, section 12.

20 United Kingdom Internal Market Act 2020

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

Baroness Doocey
Baroness Drake
Lord Dunlop
Lord Faulks
Baroness Fookes
Lord Hennessy of Nympsfield
Lord Hope of Craighead
Lord Howarth of Newport
Lord Howell of Guildford
Lord McAvoy
Lord Sherbourne of Didsbury
Baroness Suttie
Baroness Taylor of Bolton (Chair)

Declarations of interest

Baroness Doocey
No relevant interests
Baroness Drake
No relevant interests
Lord Dunlop
Shareholding in Primary Healthcare Properties plc
Lord Faulks
No relevant interests
Baroness Fookes
President & Trustee, League of Friends of Royal Eye Infirmary, Plymouth
President, Chiropractic Patients' Association
President, Friends of Derriford Hospital Kidney Unit
Vice President, Plymouth & District Leukaemia Fund
Vice President, Stars Foundation for Cerebral Palsy (formerly SOS)
Lord Hennessy of Nympsfield
No relevant interests
Lord Hope of Craighead
No relevant interests
Lord Howarth of Newport
President, Culture, Health and Wellbeing Alliance
Chair of Trustees, National Centre for Creative Health
Lord Howell of Guildford
No relevant interests
Lord McAvoy
No relevant interests
Lord Sherbourne of Didsbury
Shareholdings in Lonza Group AG, Novo Nordisk A/S, Stryker Corporation and Thermo Fisher Scientific
Baroness Suttie
No relevant interests
Baroness Taylor of Bolton (Chair)
No relevant interests