The National Health Service Bill 2016-17 – Explanatory Notes

The NHS Reinstatement Bill – officially, the NHS Bill - received its first reading in the House of Commons as a Ten-Minute Rule Bill after presentation by Margaret Greenwood, MP for Wirral West, on 13th July 2016. The full version of the Bill was published on Parliament's website on 28th October 2016, ahead of the Bill's scheduled second reading on 4th November 2016, and these notes explain the full version which is available here:

http://services.parliament.uk/bills/2016-17/nationalhealthservice.html

Clause 1 – Secretary of State's duty as to health service

Clause 1(1) would reinstate the Secretary of State's legal duty to provide the NHS in England. It would do so by effectively repealing the abolition of that duty as a result of section 1 of the Health and Social Care Act 2012, and by reproducing the corresponding provision that applied from 1946 until 2006. This would, for example, prevent the Secretary of State from remaining "neutral" on the provision of health services, a position he informed the High Court he is taking in the continuing legal dispute about where responsibility lies for providing preventive sexual health services.[1]

Until 2006, the government's overarching duty had been "to provide or secure effective provision" of services. The NHS Act 2006 deleted the word "effective", and also de-coupled this duty from the duty to "promote" a comprehensive service.

The title of section 1 of the 2006 Act ("Secretary of State's duty to promote health service") would revert to the title of section 1 of the National Health Service Act 1977, which made no distinction between the connected duties of promotion and provision.

A new section 1(3) would provide that the provision of health services and of social care services shall be integrated in accordance with the Act.

A new section 1(4)(a) would declare that the NHS is a "non-economic service of general interest". This is a phrase that is used in the Treaty on European Union's Protocol on Services of General Interest, which provides that "[t]he provisions of the Treaties do not affect in any way the competence of Member States to provide, commission and organise non-economic services of general interest".

It is to be contrasted with the phrase "service of general economic interest" (SGEI), which also appears in that Protocol. It also appears in Clause 1 of the National Health Service (Amended Duties and Powers) Bill currently in the House of Commons and introduced by Clive Efford, and is used in Article 14 of the Treaty. Article 14 gives the European Parliament and the Council power to make regulations establishing principles and setting conditions for operation of such services "particularly economic and financial conditions, which enable them to fulfil their missions". This power is "without prejudice to the competence of Member States, in compliance with the Treaties, to provide, to commission and to fund such services".

[1] August update on the commissioning and provision of Pre Exposure Prophylaxis (PREP) for HIV prevention - https://www.england.nhs.uk/2016/08/august-update-on-the-commissioning-and-provision-of-pre-exposure-prophylaxis-prep-for-hiv-prevention/; *National Aids Trust v National Health Service Commissioning Board (NHS England) and others* [2016] EWHC 2005 (Admin) - https://www.judiciary.gov.uk/wp-content/uploads/2016/08/nat-v-nhs-judgment.pdf

Under Article 106(2) of the Treaty, "[u]ndertakings entrusted with the operation of services of general economic interest…shall be subject to the rules contained in the Treaties, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Union."

The NHS Reinstatement Bill does not accept that the NHS is a service of general economic interest, and proceeds on the basis that the UK Parliament and devolved legislatures have full competence to legislate for the NHS. If and when the UK leaves the EU, this provision would not be necessary.

A new section 1(4)(b) would declare the NHS to be a service supplied under governmental authority and supplied neither on a commercial nor competitive basis, so as to emphasise that the competence of the UK Parliament and devolved legislatures to legislate for the NHS should not be restricted by the World Trade Organization's General Agreement on Trade in Services.

Clause 2 - Abolition of the duties of autonomy

This clause would repeal the two sections inserted into the 2006 Act which require the Secretary of State and the NHS Commissioning Board (known generally as NHS England), respectively, to have regard to the desirability of securing, so far as consistent with the interests of the health service, 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 that unnecessary burdens are not imposed on any such person. These duties are incompatible with a national health service which the Secretary of State would, under this Bill, again have the duty to provide.

However, in order to minimise unhelpful political interference, certain elements of section 1D of the 2006 Act in relation to the Secretary of State's power of directions would be retained under Clause 12 of the Bill.

Clause 3 - Secretary of State's duty to provide certain services

This clause would insert a new section 3 into the NHS Act 2006.

The new section 3(1) would set out the six basic categories of services that it would be the Secretary of State's duty to provide or secure the effective provision of:

- the long-standing duty to provide the services listed in new subsection 3(2);
- high security psychiatric services (Clause 4);
- medical, dental, ophthalmic and pharmaceutical services (under Parts 4-7 of the NHS Act 2006);
- medical inspection of pupils, supply of blood and other human tissues, contraceptive services and provision of vehicles for disabled persons (Schedule 1 of the 2006 Act, as amended by Schedule 1 of this Bill);
- public health (Clause 6); and
- information (Clause 7).

The new section 3(2) would reinstate the duty of the Secretary of State to provide "throughout England" hospital accommodation, services and facilities as in section 3(1) of the 2006 Act, re-applying the duty as it was before the 2012 Health and Social Care Act. This would replace the current duty on clinical commissioning groups (CCGs) – whose role would be integrated into Health Boards under Clause 9 - to arrange provision for persons for whom they are responsible.

Clause 4 - High security psychiatric services

This would re-establish the Secretary of State's duty to provide high security psychiatric hospitals and services under section 4(1) of the NHS Act 2006. The duty extends to maintaining the same, as under the 1977 NHS Act (but which was dropped under section 41 of the Health Act 1999).

Clause 5 (and Schedule 1) - Other services

Schedule 1 of the 2006 Act sets out a number of additional services in relation to which the Secretary of State had obligations, dating back to the 1977 Act and even, in some instances, the 1946 Act. They covered medical inspection of pupils, contraceptive services, vehicles for disabled persons, a microbiological service and research. The 2012 Act added provisions relating to the weighing and measuring of children (first introduced in 2008) and the supply of blood and other human tissue – the latter functions being performed by NHS Blood and Transplant, a special health authority. The obligations for most of these services would revert to the Secretary of State.

Clause 6 - Public health functions

The 2012 Act created public health functions as a new category of services divided between the Secretary of State and local authorities. Neither of these bodies now have duties in the Act to provide or to secure provision or to make arrangements for provision as regards public health, only a metaphorically-expressed duty to "take steps" as they consider "appropriate" for protecting the public from disease or other health dangers or for improving the health of people.

Two categories of public health functions were created – taking steps to protect the public in England from disease or other dangers to health (a function of the Secretary of State under s.2A of the NHS Act 2006); and taking steps to improve the health of the people in England or a local authority area (a function, respectively, of the Secretary of State and local authority under s.2B of that Act). The Secretary of State was also given a separate duty under s.1C to 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.

Much concern has been expressed over what is happening to provision of public health services, particularly the impact of funding cuts, fragmentation of responsibilities, devaluing of public health expertise and the freedom of staff to express their honest professional opinions. Fragmentation of services has already led to a continuing legal challenge to where responsibility lies for provision of preventive sexual health services.[1] It also seems that a consensus is yet to emerge amongst public health professionals as to how to improve the situation.

Clause 6 of the Bill offers a suggestion. It would strengthen the duties of the Secretary of State under sections 2A and 2B, flesh out and develop the current skeletal duty to reduce inequalities and bring the three duties together as an integral part of the NHS. Regulations would require other parts of government to have regard to the need to reduce inequalities, including as regards social and lifestyle factors (using wording from The National Health Service (General Medical Services) Regulations 1992 dealing with the duties of GPs in respect of newly registered patients).

These duties would then be delegated to Public Health England – currently an executive agency of the Department of Health – which would be re-established as a Special Health Authority; and to NHS England, and to a local authority or Health Board under a public health scheme under Clause 9(5)(b)(i) in accordance with regulations. How public health functions would be exercised in any given area would therefore be largely based on 'bottom up' proposals from the local authority and Health Board in that area, in consultation with Public Health England.

The regulations would also set out which public health activities need national bodies in order for them to be effectively carried out. Such activities would cover protection (e.g., from communicable disease outbreaks, specialised laboratory testing and disease surveillance, disaster preparedness, including chemical, biological, radiological and other environment hazard management such as air pollution and fracking); promotion (e.g., national health promotion campaigns for outbreaks or illnesses, common health conditions, and access to sports centres for weight loss); services (e.g., provision and management of national screening programmes for chlamydia and cervical cancer); improvement (e.g., policy recommendations based on scientific evidence for legislative purposes, such as on tobacco, minimum unit pricing for alcohol, and dietary levels of salt and fat; providing impartial, independent, expert advice to government on the health impacts of legislation); and intelligence (e.g., collation of local and regional data sources into standardized formats for comparative statistics to inform local and national policy).

Clause 7 - Distribution of functions

This Clause would re-establish NHS England as a Special Health Authority – its form before the 2012 Act - with Regional Committees, along with Health Boards. Public Health England would be formed as a Special Health Authority. The Health and Social Care Information Centre would also revert to its previous status as a Special Health Authority for the purposes of the collection, analysis, use and dissemination of information and the issuing of administrative identification numbers. This would reverse the 2012 Act's establishment of the Centre as a body corporate, and sections 250-277 of the 2012 Act would be repealed.

Clause 8 - NHS England and Regional Committees

The National Health Service Commissioning Board – the current NHS England's formal name – would be abolished after approval of the scheme referred to in Clause 9(2) and replaced by The National Health Service England Authority to be called "NHS England". It would have a number of Regional Committees covering the whole of England, and regulations would be made under Clause 8(3) dealing with its membership, appointments etc.

Clause 8(4) would set out the main duties of NHS England. These would be to exercise on behalf of the Secretary of State some of his duties under the National Health Service Act 2006, by providing or securing effective provision of the services or facilities referred to in subsection (5) in accordance with regulations. They would also include, subject to regulations, his or her public health functions under section 6, under Schedule 1 and under Parts 4-7 of the 2006 NHS Act relating to the provision of medical, dental, ophthalmic and pharmaceutical services. In the latter respect, the power to enter into contracts for primary medical (i.e., GP) services would no longer permit contracts with commercial companies such as Virgin and United Health – known as Alternative Personal Medical Services (APMS) contracts.

The specific services and facilities listed in subsection (5) are those for which the current NHS England may be required to make arrangements in accordance with regulations under section 3B of the 2006 Act - dental services; services or facilities for members of the armed forces, their families or prisoners. NHS England, through its Regional Committees, would also have important strategic planning functions set out in regulations to support Health Boards, as well as other prescribed functions if more appropriate for NHS England to provide or secure effective provision of services rather than the Secretary of State or Health Boards. In deciding whether it would be appropriate, the Secretary of State would have to have regard to the same matters as currently under section 3B(3) and (4).

NHS England would perform its functions through its Regional Committees, save to the extent that regulations provide otherwise; and regulations could provide otherwise where the Secretary of State considers that provision is more appropriate on a national basis rather than on regional bases.

NHS England would be permitted to contract with voluntary organisations (e.g., hospices), but could only enter into short-term contracts with private companies exceptionally (Schedule 3, paragraph 1(c)).

The Public Contracts Regulations 2006 – which can require tendering for contracts – will not apply (Clauses 8(14) for NHS England, and Clause 9(8) for Health Boards). If and when the UK leaves the EU, these provisions would not be necessary.

Clause 12 of the Bill covers directions by the Secretary of State, but the power is limited in order to minimise inappropriate political interference.

Clause 9 – Health Boards

Under Clause 9, Health Boards would become the heart of NHS services on the ground. They would have the duty to exercise on behalf of the Secretary of State his duty in section 1(1) of the National Health Service Act 2006 by exercising his or her functions under specified provisions of that Act, including hospital and other accommodation; medical, dental, nursing and ambulance services; facilities for the care of expectant and nursing mothers and young children; facilities for the prevention of illness and the aftercare of persons who have suffered from illness; and services under Schedules 1 and 3.

This will require hospitals and community services currently run by NHS trusts and NHS foundation trusts to be transferred to the Health Boards under a 'bottom up' scheme approved by the Secretary of State in accordance with regulations. The regulations would provide for the scheme to minimise disruption to services, patients, clinicians and other staff employed; and enable such persons as well as voluntary organisations, trade unions and academics to participate in preparing the scheme.

The scheme would be a devolved and participatory exercise led by a local authority or authorities (including elected mayors), assisted by the trusts, CCGs and NHS England, and schemes could be approved at any time before the cut-off date. They would cover the transfer of planning and provider functions to the Health Boards – and so ending the purchaser-provider split - their membership, performance of their functions and their internal management.

NHS trusts, NHS foundation trusts and CCGs would not be abolished as legal entities, NHS England would not revert to a Special Health Authority, and Health Boards would not formally come into existence until the scheme had been completed and approved, with a proposed cut-off date of 1st January 2019. The cut-off date is clearly important. If it is too soon, the risk of not carrying out those tasks well is increased; if it is too late, the risk of vested interests seeking to delay implementation increases.

Health Boards would also be required to join with local authorities in drawing up two other schemes for working out how public health functions and how health and social services can best be integrated in their areas.

As for NHS England, Health Boards would be able to contract with voluntary organisations and would be subject to directions under Clause 12 from the Secretary of State, limited in order to minimise inappropriate political interference.

Schedule 2 of the Bill would require the Secretary of State to make sure that the whole of England was covered by Health Boards; and sets out organisational issues relating to Health Boards, including their membership in default of proposals from local authorities, which draws from the membership provisions for Health and Well-being Boards as well as the Scottish and Welsh Health Boards.

The Secretary of State would be obliged to consult with local authorities which have entered into agreements for the purposes of the Cities and Local Government Devolution Act 2016. The number of Health Boards is not specified.

Schedule 3 would set out the many other functions that were necessarily part of the Secretary of State's functions for the running of the NHS. As for NHS England, Health Boards would be permitted to contract with voluntary organisations (e.g., hospices), but could only enter into short-term contracts with private companies exceptionally (Schedule 3, paragraph 1(c)).

In carrying out their functions, Health Boards would consult with and have regard to the views of Community Health Councils (Clause 9(10)).

Clause 12 of the Bill covers directions by the Secretary of State, but the power is limited in order to minimise inappropriate political interference.

Clause 10 - Administration of medical, dental, ophthalmic and pharmaceutical services

Clause 10 provides that the Health Boards would administer the arrangements made under Parts 4-7 of the National Health Service Act 2006 for the provision of medical, dental, ophthalmic and pharmaceutical services for the district of the Authority, and to perform such other functions relating to those services as may be prescribed.

Clause 11 - Special health authorities

Clause 11 makes clear that the Secretary of State retains full powers to establish Special Health Authorities for performing any functions which he may direct the body to perform on his behalf, or on behalf of NHS England or Health Boards.

Exercising this power, however, should not increase bureaucracy, and when it is exercised the Secretary of State would have to explain how bureaucracy will be reduced as a consequence.

Section 28A of the National Health Service Act 2006 is repealed, as this limits the duration of new Special Health Authorities to a maximum period of three years.

Clause 12 – Directions

This clause would give the Secretary of State a general but limited power of giving directions to NHS England, a Health Board, a Special Health Authority, the National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, and other bodies as prescribed, such as the NHS Blood and Transplant special health authority.

This power would not usually be unrestricted. The Secretary of State would be obliged to have regard to the desirability, so far as consistent with the interests of the health service and relevant to the exercise of the power in all circumstances, of protecting and promoting the health of patients and the public, and of the bodies being free to exercise their functions in the manner that they consider best calculated to promote the NHS.

Neither could the power be used to interfere with the professional independence of health service staff, including local authority and Public Health England staff. Their professional autonomy and right to participate in scientific and public debate on matters relating to health and health services would be guaranteed.

These directions must be contained in regulations, except in a genuine emergency, so that the exercise of executive power would be open to Parliamentary scrutiny and procedure.

This provision is a modified version of the duties of autonomy (the hands-off clauses) introduced by the 2012 Act and which would be abolished by Clause 2.

Clauses 13 – 16 - Abolition of bodies, and staff transfer, after approval of draft schemes

CCGs, NHS trusts and NHS foundation trusts would assist local authorities in establishing the Health Boards and in transferring planning and provider functions and providing for their membership, performance of their functions and their internal management; and thereafter would be abolished under Clauses 13-15. Property, rights and liabilities would transfer to the Secretary of State, or to any other NHS body determined by him or her, such as Health Boards.

Clause 16 would require the Secretary of State, after consultation with trade unions, to make regulations which would set out the terms and conditions applying to the transfer of staff from NHS trusts, NHS foundation trusts and CCGs to Health Boards, NHS England and other NHS bodies. These include entitlement to redundancy payments, particularly for senior staff whose job loss is technical rather than real. In making the regulations, regard must be had to minimising the loss of skills and disruption.

Clause 17 - Community Health Councils

This clause (with Schedule 4) would re-establish Community Health Councils, with the duty of representing the interests of the local public in the health service. These were initially established under section 9 of the NHS Reorganisation Act 1973, and were abolished in England by section 22 of the NHS Reform and Health Care Professions Act 2002.

Clauses 18 - Abolition of Monitor, Competition, Licensing, Pricing, Health Special Administration etc.

Clause 18 would abolish Monitor, and repeal the other core market provisions in Part 3 of the 2012 Act covering competition, licensing, pricing and health special administration, including The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (SI 2013 No. 500).

This would cover the repeals of sections 62(2), 62(3), 62(10), 67(3)(a), and of sections 72 to 80 of the 2012 Act that would have been repealed by Clause 10 of the NHS (Amended Duties and Powers Bill) that was introduced into the House of Commons on 7th November 2014 by Clive Efford MP. In addition it would mean that the first two of the three aims of Clause 11 of that Bill would also be achieved – namely, that the Competition Act 1998 and its 'undertaking' concept would not apply to the NHS. The third aim – to disapply the Enterprise Act 2002 to proposed mergers involving NHS trusts or NHS foundation trusts – would become otiose, as the NHS Reinstatement Bill would abolish those trusts.

Clause 19 - Continuity of mandatory services

Monitor has imposed licence conditions on NHS foundation trusts under which currently mandatory services - basically those which had to be provided, under the old NHS foundation trust authorisation system - ceased to be mandatory after April 2016, and a new set of 'commissioner requested services' were to be put in their place. Under its associated guidance issued in March 2013, Monitor asks commissioners to consider the current list, and states that it expects the number of mandatory services to decrease as a result. Clause 19 would have the effect of annulling these licence conditions.

Clause 20 – Collective bargaining of terms and conditions

Clause 20 would introduce a system for collective bargaining across the NHS, as part of a much needed wider labour law change to help counter the unequal power of the employer, reduce inequality in wealth and health and promote a stable and productive economy. The Clause is a development of statutory provisions applied after the second world war to several nationalised industries, whilst acknowledging the several discrete systems establishing terms and conditions currently in place and informed by the previous Whitely Council system under whose auspices national terms and conditions were negotiated for most staff.

It would require the Secretary of State to negotiate with trade unions to establish agreed arrangements ("joint machinery") for settling by negotiation the terms on which people work in or for the NHS. This would include, for example, whistle-blowing and disciplinary procedures, training, pensions and welfare at work. Binding arbitration would apply if either the arrangements or the terms of engagement could not be agreed. Different arrangements would apply to different categories of workers.

Employers and trade unions operating the various current systems establishing terms and conditions – such as the UK-wide Agenda for Change system under the NHS Staff Council, the Doctors' and Dentists' Review Body, and the different independent contractor systems for GP, dental, ophthalmic and pharmaceutical services – would consider those systems in the light of the requirements of the joint machinery; no further negotiation to establish such machinery would be necessary to the extent that the employers and trade unions are satisfied that the relevant system already meets those requirements.

Under the Bill, the only exceptions to 'public' employers would be voluntary organisations (e.g., hospices); and exceptionally and for the short-term only, private companies. Clause 20(6) makes clear the collective bargaining system would also apply to them.

The Secretary of State would have the supplementary power to make an order imposing any agreement terms, including civil or criminal sanctions.

Clause 21 - Centralisation and reduction of PFI obligations

The Private Finance Initiative (PFI) in the NHS has placed excessive financial burdens on NHS trusts and NHS foundation trusts which detrimentally affects their ability to deliver services to patients. Clause 21 would transfer financial obligations under NHS PFI agreements to the Treasury, which would have the duties to assess and publish the obligations, and to explain to Parliament how it proposed to reduce them. The purpose of this Clause is to reduce the cost to the public purse, and if there are better ways to do this then these should be given careful consideration.

Clause 22 - Abolition of immigration health charge

Section 38 of the Immigration Act 2014 and The Immigration (Health Charge) Order 2015 made under it require people from non-EEA countries applying for visas to come to the UK for more than six months – or for less than six months if they are already here – to pay an 'immigration health surcharge' at the time they apply for the visa - £200 per person, or £150 for students, including additionally the same amount for each dependant, annually. Exemptions apply to certain people, such as diplomats, visiting armed forces, asylum seekers, identified victims of human trafficking, people to whom the Home Office's domestic violence concession applies and "Tier 2 intra-company transfer migrants". Until the passing of that Order, such people were considered entitled to free NHS treatment as 'ordinary residents'.

Section 39 of that Act states that people needing leave to enter or remain and not having it, and people who have limited leave to enter or remain, are not to be treated as ordinarily resident, "so [in the words of the Explanatory Notes to the Act] ensuring they can potentially be charged for health services throughout the UK." This section is not yet in force. The Department of Health's Visitor and Migrant Cost Recovery Centre is currently considering responses to its now closed consultation on extending charging, which proposes that "all secondary care should become chargeable".[2]

These sections offend against the fundamental principles of the NHS. They are also potentially in violation of the United Kingdom's long-standing international legal obligation under the International Covenant on Economic, Social and Cultural Rights to respect, protect and fulfil the right to health without discrimination. They were criticised in July 2016 by the UN Committee on Economic, Social and Cultural Rights, which "notes that the Immigration Act 2014 has further restricted access to health services by temporary migrants and undocumented migrants…[and] reminds the State party that health facilities, goods and services should be accessible to everyone without discrimination, in line with article 12 of the Covenant". The sections would therefore be repealed by Clause 22 of the Bill.

Clause 23 – Treaty requirements

This Clause follows the spirit of the example of section 6 of the European Assembly Elections Act 1978 which provided for any increase in the powers of the Assembly, now called the European Parliament, to be ratified by the United Kingdom only if there had been prior approval by an Act of Parliament.

The intention of this Clause is to make it impossible for any trade, investment or similar international agreement – such as the proposed Transatlantic Trade and Investment Partnership (TTIP) being negotiated between the European Union and the US - in effect to legislate for the NHS without Parliament (or the relevant devolved legislature) giving its approval prior to signature or agreement. If and when the UK leaves the EU, this provision would have to be revisited.

Clause 23(2)-(5) is aimed through annual reports at improving transparency and the accountability of the Secretary of State to Parliament and the devolved legislatures for what he or she does internationally in the name of the UK which might affect the NHS.

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[2] Making a fair contribution: A consultation on the extension of charging overseas visitors and migrants using the NHS in England - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/483870/NHS_charging_acc.pdf

Clause 24 - Commencement and transitional arrangements

Clause 24 gives flexibility as to the way in which the Act, except for section 1, is brought into effect; and thus the timescale for its implementation.

Central to this flexibility is making the abolition of CCGs, NHS trusts and NHS foundation trusts (as well as NHS England's reversion to a Special Health Authority) – and the formal creation of Health Boards - follow on from the assistance that those bodies would have given to local authorities in developing the 'bottom up' scheme for transferring functions to the Health Boards, their membership, performance of their functions and their internal management under Clause 9.

Clauses 25-29 – Further technical provisions

These Clauses contain further technical provisions, including the need for further legislation containing consequential amendments. It is envisaged – though for technical reasons not mentioned in the Bill - that at the same time as passing the Bill, Parliament would enact a National Health Service (Consequential Provisions) Bill, as it did in 2006 to accompany the NHS Act 2006.