The proposed National Health Service Reinstatement Bill, July 2018

Explanatory Notes

These Notes are intended to explain the Bill that was provided to Eleanor Smith, MP for Wolverhampton South West, for presentation in the House of Commons on 11th July 2018.

Overview

In short, the Bill proposes to fully restore the NHS in England by 2021 as an accountable public service by reversing nearly 30 years of marketization, by abolishing the purchaser-provider split, ending contracting and re-establishing public bodies which plan and provide integrated services and accountable to local communities.

The Bill gives flexibility in how it would be implemented, led by current bodies, including local authorities.

It would:

- reinstate the government's duty to provide the key NHS services throughout England, including hospitals, medical and nursing services, primary care, mental health and community services,
- integrate health services under the Secretary of State, whilst allowing delegation of public health services to local authorities, and allowing for integration of social care services following and subject to further legislation,
- declare the NHS to be a "non-economic service of general interest" and "a service supplied in the exercise of governmental authority" so asserting the full competence of Parliament and the devolved bodies to legislate for the NHS without being trumped by EU competition law (for so long as the UK is an EU Member State) and the World Trade Organization's General Agreement on Trade in Services,
- exclude the NHS from international trade deals,
- require the NHS Commissioning Board (NHS England), clinical commissioning groups (CCGs), NHS trusts, NHS foundation trusts, and local authorities, including combined authorities and elected mayors, to develop a 'bottom up' process so that by 2021 services would be planned and provided without contracts through regional and local public bodies - which could cover more than one local authority area if there was local support, and taking into account English devolution – to be known as Strategic Integrated Health Boards and Local Integrated Health Boards,
- allow Health Boards to employ GPs, end pay beds and private practice in NHS hospitals and end contracts for GP services with commercial companies,

- abolish NHS England, CCGs, NHS trusts and NHS foundation trusts, following completion and approval by the Secretary of State of the Health Boards,
- repeal the competition and core marketization provisions of the 2012 Act, and abolish Monitor – the regulator of NHS foundation trusts, commercial companies and voluntary organisations,
- re-establish Community Health Councils to represent the interest of the public in the NHS,
- stop licence conditions taking effect which have been imposed by Monitor on NHS foundation trusts and that will have the effect of reducing by April 2016 the number of services that they currently have to provide,
- introduce a system for collective bargaining across the NHS,
- impose a duty on the Treasury to minimise, and if possible to end, the expenditure of public money on private finance initiatives in the NHS in England, and
- abolish the legal provisions passed in 2014 requiring certain immigrants to pay for NHS services.

Clause-by-Clause explanations

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 in essence the corresponding provision that applied from 1946 until 2006.

Until 2006, the government's overarching duty had been "to promote in England a comprehensive health service" and for that purpose "to provide or secure effective provision of services in accordance with" the legislation. The NHS Act 2006 de-coupled the duty to provide from the duty to promote, and deleted the word 'effective'. The Clause would reverse that de-coupling and deletion.

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 Secretary of State's duty shall be exercised with a view to integrating provision of health and social care services in accordance with the Act. Clause 8(2) and (3) of the Bill make clear that this integration can only occur after a report the Secretary of State has reported to Parliament by the end of 2019 on the legislative changes that would be needed (e.g. in relation to funding, and structures) to enable effective, transparent and accountable integration.

For as long as the UK remains an EU Member State, or is subject to relevant EU laws, a new section 1(4)(a) would declare that the NHS is a "non-economic service of general interest", with a view to preventing EU competition rules applying. 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", which also appears in that Protocol. Article 14 of the Treaty 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".

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 proceeds on the basis that the UK Parliament and devolved legislatures have full competence to legislate for the NHS, even whilst an EU member state or if otherwise subject to EU rules.

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, 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 five 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);
- functions relating to high security psychiatric services (Clause 4);
- duties and powers relating to provision of medical, dental, ophthalmic and pharmaceutical services (under Parts 4-7 of the NHS Act 2006);
- functions in relation medical inspection of pupils, contraceptive services and provision of vehicles for disabled persons (Schedule 1 of the 2006 Act, as amended by Schedule 1 of this Bill); and
- functions regarding 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) 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 would also extend 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 human tissue. 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 legal category of services, divided between the Secretary of State and local authorities. Neither of these bodies now have duties 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 sub-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 section 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. 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, under regulations, be delegated, as the case may, to Public Health England – currently an executive agency of the Department of Health – which would be re-established as a Special Health Authority; to a local authority, and /or to a Health Board under public health proposals and schemes under Clause 9(2)(a). 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 (and Schedule 2) – Integrated Health Boards and Special Health Authorities

This Clause would establish Strategic Integrated Health Boards and Local Integrated Health Boards as public statutory bodies with the primary function of together providing and supporting provision of services on the behalf of the Secretary of State (see Clause 8). The Local Integrated Health Boards would become the heart of NHS services on the ground, and the Strategic Boards would operate regionally. The regions and areas they would cover would be determined after consultation with, in particular, devolved authorities and trade unions, and consideration of the draft local schemes and regional proposals worked up locally (see Clause 9).

Schedule 2 sets out how membership of the Boards would be determined. The Schedule draws from the membership provisions for Health and Well-being Boards, as well as the Scottish" and Welsh Health Boards, and Regional Health Authorities under the 1977 NHS Act.

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 – Primary functions of Integrated Health Boards

Clause 8 would impose the primary function on both Boards to provide and support provision of health services, which would include needs assessment and planning. The exact delineation of the different activities as between the Boards would depend on the local schemes and regional proposals submitted and approved under Clause 9.

The Clause makes clear that the integration of all health services, including public health services, would fall under the primary function (subject to regulations under Clause 6(6) and the public health scheme and proposals under Clause 9(2)(a)), and would extend to integration of health and social care services but only after a review of social care services and a report by the Secretary of State to Parliament by the end of 2019 on the legislative changes that would be needed (e.g. in relation to funding, and structures) to enable effective, transparent and accountable integration.

Schedule 3 of the Bill sets out additional functions that Boards could carry out on behalf of the Secretary of State, subject to regulations. These cover arrangements with voluntary organisations. Only exceptional and short-term arrangements with commercial companies would be permitted.

Clause 8(5)(a) and (b) would prohibit 'pay beds' and private practise in NHS hospitals; and clause 8(5)(c) would prevent the Boards, when providing GP services, from making contracts with commercial companies such as Virgin and United Health (Alternative Provider Medical Services contracts).

Clause 9 – Establishing and managing Integrated Health Boards

Clause 9 places a duty on current NHS bodies – NHS England, clinical commissioning groups and trusts – and local authorities, including mayors and devolved bodies – to work out how best to establish and manage the Boards in their locality and region, how best to transfer functions and how they would carry out their functions transparently, accountably and in an integrated way. Their plans would be submitted as draft local schemes and regional proposals for the approval of the Secretary of State by 1 January 2021. These plans would extend to public health, and could extend to integration with social care services, subject to the preconditions relating to the review, report and enactment of legislative changes as referred to in Clause 8(2)(c) and 8(3).

Regulations would cover the detail of the procedure, and they would, for example, require disruption to be minimised, allow Boards to employ GPs, and allow any individual living in an area to participate in developing the plans.

The Boards would be subject to directions under Clause 12 from the Secretary of State, limited in order to minimise inappropriate political interference.

Clause 9(7) is intended to make clear that the Public Contracts Regulations 2015 – which set out rules on the award of public contracts as required by Directive 2014/24/EU on public procurement, and would not apply in any event after the EU ceases to be an EU Member State or to be subject to its laws – do not apply to arrangements made by the Health Boards, and none of those arrangements shall give rise to contractual rights or liabilities.

In carrying out their functions, the Boards would be obliged to consult with and have regard to the views of Community Health Councils.

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

Clause 10 provides that the local 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 area, 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 or she may direct the body to perform on his or her behalf, or on behalf of any of the 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 the Boards, a Special Health Authority, the National Institute for Health and Care Excellence and the Health and Social Care Information Centre.

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, here and here) introduced by the 2012 Act and which would be abolished by Clause 2.

Clauses 13-15 – Abolition of NHS England, CCGs, NHS trusts and NHS foundation trusts

Once these bodies have by 2021 developed the draft schemes and proposals approved by the Secretary of State under Clause 9, they would be abolished and their functions transferred.

The cut-off date of 1st January 2021 is 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.

Clause 16 – Terms and conditions of staff transfers

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 (and Schedule 4) - 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.

Clause 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).

Clause 19 - Continuity of mandatory services

Monitor has imposed licence conditions on NHS foundation trusts under which previously 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 list of services, characterised as Commissioner Requested Services (CRS), were put in place. Under its associated guidance issued in March 2013, Monitor asked commissioners to consider the then current list, and stated that it expected the number of mandatory (CRS) services to decrease as a result. Clause 19 would have the effect of annulling these licence conditions, which would not in any event apply once the Health Boards were up and running, and NHS foundation trusts and Monitor had been abolished.

Clause 20 – Collective bargaining of terms and conditions

This Clause, based on a draft kindly provided by John Hendy QC, with the help of Professor Keith Ewing, requires the Secretary of State to negotiate with NHS trade unions to establish 'joint machinery' for settling by negotiation the terms and conditions of NHS employment, with binding arbitration in default of agreement. The current arrangements of the NHS Staff Council and the Agenda for Change system, and of the Doctors' and Dentists' Review Body, as well as any other current arrangements for NHS workers not so covered, can remain in place if NHS employers and NHS trade unions agree.

Clause 21 – Ending PFI

This Clause would impose a new statutory duty on the Treasury a duty to minimise, and if possible end, the expenditure of public money on private finance initiatives in the NHS. To that end, the Treasury would be obliged to assess, explain and report to Parliament by 31 December 2019 on the financial obligations of the different NHS bodies holding PFI contracts, setting out its proposals for meeting its new statutory duty and outlining any legislation that would be needed in order to implement those proposals. Without mandating any particular mechanism, the Clause would require the Treasury in its report to Parliament to assess and explain the extent to which the new statutory duty can be fulfilled by transferring those financial obligations to the Treasury, by public ownership of the special purpose vehicles to which those obligations are owed, and/or by any other mechanism or combination of mechanisms. Until the new duty has been fulfilled, and in default of better alternatives, the financial obligations would become the obligations of the Treasury. Publication of all NHS PFI contacts would be required under Clause 21(5).

Clause 22 - Abolition of immigration health charge

Policy developments since 2010 have extended the charges for NHS services that people deemed to be visitors or migrants have to pay. The House of Commons Library provided an outline of the developments in October 2017.

The government now requires certain people to pay £200 annually (£150 for students) for healthcare as part of their immigration application. The 2017 Conservative Party manifesto stated that "we will increase the Immigration Health Surcharge, to £600 for migrant workers and £450 for international students" (page 67).

The charge is payable in advance when applying for leave to enter or remain in the UK or when applying for entry clearance. The legal basis for the Home Office levying the charge is the Immigration (Health Charge) Order 2015, amended in 2016 and 2017. The power to make such an order is set out in section 38 of the Immigration Act 2014.

Further, section 39 of that Act provides 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 ensuring they can potentially be charged for health services throughout the UK."

Parliament first authorised the government to make regulations to charge people for health services if they do not usually live in the UK, in section 121 of the NHS Act 1977, and now in section 175 of the NHS Act 2006. Regulations were first made in 1982. New regulations were introduced in 2015, and under amendments made in 2017, payment must be made before providing secondary, community and other services (but not primary medical, dental or ophthalmic services) "unless doing so would prevent or delay the provision of— (a) an immediately necessary service; or (b) an urgent service".

Clause 22 would repeal sections 38 and 39 of the 2014 Immigration Act as they 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. This was drawn to the government's attention in July 2016 by the UN Committee responsible for supervising these obligations (original emphasis, hyperlink added):

> "**Access to health**
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> 55.The Committee is concerned that refugees, asylum seekers and refused asylum seekers, as well as Roma, Gypsies and Travellers, continue to face discrimination in accessing health-care services. The Committee notes that the Immigration Act 2014 has further restricted access to health services by temporary migrants and undocumented migrants (art. 12).
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> **56. The Committee recommends that the State party take steps to ensure that temporary migrants and undocumented migrants, asylum seekers, refused asylum seekers, refugees and Roma, Gypsies and Travellers have access to all necessary health-care services 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 Committee draws the State party's attention to its general comment No. 14 (2000) on the right to the highest attainable standard of health**."

Clause 23 – Exclusion of the NHS from trade deals and other treaties

This Clause would prevent the government from including the NHS in any part of the UK in any trade deal or other international agreements.

The Clause would also require the Secretary of State to review current international obligations, if any, which might affect the NHS, and report on the results of the review to Parliament in order for the public to understand transparently the current situation. This would include the effect in the UK,

pre- and post-Brexit, of the EU commitments under the WTO's General Agreement on Services' Schedule of Specific Commitments.

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 NHS England, CCGs, NHS trusts and NHS foundation trusts, and the formal creation of the Health Boards, follow on from the performance (with local authorities) of their duty under Clause 9 to develop the 'bottom up' schemes and proposals for transferring functions to the Boards, their membership, performance of their functions and their internal management.