The Health and Care Bill: Delegated Powers

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Introduction

The Health and Care Bill[1] is the most significant piece of healthcare legislation to be laid before Parliament in almost a decade. This briefing paper has been produced to inform the debate during the Committee stage in the House of Commons from 7 September 2021.

The paper focuses exclusively on some of the delegated powers in the Bill. While these might at first glance appear to be merely technical matters, in this as in most Bills they raise important questions of constitutional, legal and procedural principle that matter, regardless of party allegiance or views on the policy merits of the Bill. MPs should be clear about the level of authority they are delegating to government Ministers and be confident that they will not regret forgoing their ability to fully scrutinise future government decisions.

The role of MPs in the scrutiny of delegated powers

The scope and design of the delegation of power sought in any bill raise important questions for MPs that go to the heart of their role as legislators. For example:

- To what extent are MPs willing to continue accepting the troubling arrogation of power by the executive (by successive governments) at the expense of Parliament?
- What scrutiny or other safeguards do Members think are desirable or necessary to constrain use of delegated powers? Given the inadequacy of scrutiny procedures that apply to delegated legislation in the House of Commons, can they really remedy a delegation of legislative power otherwise deemed unacceptable?
- If Parliament accepts controversial powers in a bill, it creates a precedent that may be used by government to justify taking similar powers in other bills in the future. However, if Parliament has reluctantly accepted a power in exceptional circumstances - for example, during the Brexit process when there was a need to legislate at speed - are MPs content for Ministers to rely on that precedent for the establishment of new powers?
- The inclusion of 'Henry VIII powers' enabling Ministers to amend or repeal primary legislation by Statutory Instrument challenges the constitutional principle that Parliament is sovereign; that it is the sole legislative authority with the power to create, amend or repeal any law. How content are MPs for such powers to continue to be a relatively common feature of the law?
- How much discretion do MPs think should be conferred on Ministers by the legislature? Ministers may use broadly defined and ambiguously worded powers in ways that that go beyond the original intention of the legislation. How content are MPs that such powers continue to be claimed by the executive, particularly when in many instances such powers will be available to Ministers in future governments of a different political stripe, possibly decades later, and may therefore be used by Ministers with radically different policy objectives from those who sought the powers in the first place?
- Do MPs think that government should be granted 'reserve' or 'holding' powers, the use of which is not fully explained or defined, simply because it is administratively convenient or because Ministers may desire freedom to act at a later date? Are MPs content that Ministerial claims of exigency and convenience should trump parliamentary scrutiny?
- When Ministers acknowledge that the relevant policy development process - particularly the consultation stage - is unfinished, should they nonetheless be granted powers to act in that area of policy?

If MPs are solicitous of the proper role and function of Parliament and their responsibilities as legislators, then the answers to these questions should inform the debate about the scope of, and

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[1] The *Health and Care Bill*, HC Bill 140, 2021-22 (as introduced) ('the Bill'). All references to the Bill in this paper are to this version.

safeguards applied to, each clause in a bill that contains a proposed delegation of power. Changes which tighten the use of powers, limit the extent of discretion, incorporate scrutiny safeguards, or resist the gravitational pull of precedent, are designed to buttress the role of Parliament in scrutinising future executive action and regulations; they need not interfere with or prevent the implementation of the intended policy.

Hansard Society Review of Delegated Legislation

The Hansard Society has long argued that the system for parliamentary scrutiny of delegated legislation is flawed and now represents one of the most significant constitutional challenges of our time. With the support of the Legal Education Foundation, we have therefore embarked on a Review of Delegated Legislation. As part of the Review, we will be examining the delegation of powers in a range of government bills and drawing attention to some of the clauses of greatest concern.

The rest of this briefing falls into two parts:

- The first, after an overview of the Bill, summarises our key thematic concerns about some of the delegated powers in the Health and Care Bill.
- The second provides a detailed analysis of the clauses of concern, drawing on the Bill and the Explanatory Notes (EN)[2] and Delegated Powers Memorandum (DPM)[3] that accompany the legislation.

A glossary of key procedural terms is provided at the end of the paper for ease of reference.

Our analysis draws heavily on 'legislative standards' which we have derived from reports of the House of Lords Delegated Powers and Regulatory Reform Committee (DPRRC). The DPRRC is an influential committee and provides the nearest thing to a form of 'jurisprudence' (or 'legisprudence') in the area of delegated powers.

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[2] House of Commons, *Health and Care Bill*, 2021-22, Explanatory Notes on the Bill as introduced, 6 July 2021, (HC Bill 140–EN) (EN)
[3] Department of Health and Social Care, *Memorandum Concerning the Delegated Powers in the Health and Care Bill for the Delegated Powers and Regulatory Reform Committee*, 6 July 2021 (DPM)

1. Overview and Key Concerns

Overview of the Bill

The Bill contains 135 clauses and 16 schedules. It proposes to make changes to several existing Acts – notable examples of relevance to this paper are the Communications Act 2003, the National Health Service Act 2006, the Health and Social Care Act 2012, and the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019.

The policy objectives of the Bill are equally broad. The Bill formally merges NHS England and NHS Improvement; includes provisions to support integration of health and social care; introduces additional powers for the Secretary of State relating to his/her relationship with NHS England and the transfer of functions between arm's-length bodies; makes changes to procurement and competition rules relating to health services; makes changes to social care relating to payments, hospital discharges and Care Quality Commission assessments; includes provisions relating to the collection and sharing of health and social care data; establishes the Health Services Safety Investigations Body; and includes provisions relating to medical examiners, professional regulation, workforce assessments, international healthcare, and certain public health matters, such as food and drink advertising, food labelling requirements, water fluoridation and hospital food.

Clauses of concern

The Delegated Powers Memorandum (DPM) states that the Bill contains a total of 138 delegated powers, seven of which include powers that can be exercised to amend primary legislation ('Henry VIII powers').[4]

In this briefing we have chosen to focus on just five clauses that contain powers that are of particular concern and that highlight different aspects of the problems with the system of delegated powers. The five clauses are:

- Clause 14 - People for whom integrated care boards have core responsibility (page 8);
- Clause 68 - Procurement regulations (page 10);
- Clause 87 - Power to transfer functions between bodies (page 13);
- Clause 120 - International healthcare arrangements (page 17);
- Clause 125 - Advertising of less healthy food and drink (page 21).

Clause 14 - People for whom Integrated Care Boards (ICBs) have core responsibility (see page 8)

This power grants extensive discretion to the Minister but:

- little detail is provided about when and in what circumstances the government envisages the power will be used;
- there is no clear and proportionate criteria test to be met by the Minister to make regulations using the power;
- there is no requirement for the Minister to consult NHS England or the affected ICBs prior to making regulations using this power, even though such regulations may have nationwide ramifications for the NHS;
- this power amends primary legislation and therefore should be subject, as a minimum, to the affirmative procedure rather than the prescribed negative procedure. Though flawed, the

[4] *Ibid.*, para. 14

affirmative procedure would at least ensure Parliament had an opportunity to debate the regulations and thus judge whether the proposals are appropriate at the time the Minister brings forward the regulations.

Clause 68 - Procurement regulations (see page 10)

- The section of the Bill dealing with procurement is skeleton in form: the lack of detail will inhibit parliamentary scrutiny of a critically important area of policy.
- The results of the government consultation on procurement policy have not yet been fully analysed. MPs are being asked to approve a delegation of power to enable Ministers to establish a new procurement regime for the health sector by regulations, subject only to the negative scrutiny procedure and therefore unlikely to be the subject of further parliamentary debate or vote. This is buttressed only by a vague promise that "*a Cabinet Office procurement Bill will most likely follow*", which may result in the amendment of the Clause 68 power, potentially including a reconsideration of the applicable scrutiny procedure. If the government does have plans for a procurement bill then it is unclear why it is not seen as the appropriate place to legislate on this matter.
- It is proposed that statutory guidance to which 'regard must be had' should not be subject to any parliamentary scrutiny procedure, contrary to previous DPRRC recommendations.

Clause 87 - Power to transfer functions between bodies (see page 13)

- The government justifies this power on the basis of precedent: that there are comparable powers in the Public Bodies Act 2011 which apply to a wider range of bodies than is proposed in this Health and Care Bill. However, in 2011 Parliament inserted safeguards into the Public Bodies Bill - a strengthened scrutiny procedure (known as the 'enhanced affirmative' procedure) and the sunsetting of some provisions - which are not reflected in this latest Bill. The government claims the precedent for the power but ignores the precedent for the scrutiny procedure.
- The transfer of functions is not always a technical, administrative exercise; changes to the constitutional arrangements of health bodies are often matters of considerable interest to MPs and their constituents. However, the only control in the House of Commons on the exercise of this power would be a 90-minute debate in a Delegated Legislation Committee followed by an approval motion. In contrast, the powers in the 2011 Public Bodies Act that the government claims as a precedent were made subject to a strengthened scrutiny process involving consultation, and the possibility of an extended scrutiny period of up to 60 days determined by a designated select committee in each House. In 2011 Parliament required that the representations, resolutions and/or recommendations of these committees must be taken into account by the Minister, who might then choose either to press ahead with approval of the Public Bodies Order or withdraw it and lay a revised version. In the current Health and Care Bill, emphasis is placed by the government only on a requirement to consult. This is not a substitute for parliamentary scrutiny, and the clause also does not require the government to lay a report about the consultation before Parliament when it lays the instrument.
- If granted, the power in the current Bill will be available to Ministers indefinitely. The government acknowledges that it has no immediate plans to change or transfer functions of the relevant health bodies but seeks the "*utility of having such flexibility in the future*". If this power is granted, it will be available to Ministers in future governments who may not use it in ways anticipated by the current administration.
- The government claims that the exercise of the clause 87 power, and the application of the affirmative scrutiny procedure to regulations made under it, would be appropriate because in many cases the changes made would be "small". However, there is no such restriction or requirement on the face of the Bill. MPs should judge the clause on the basis of what it might permit, rather than how Ministers suggest they will use it, particularly given that the power is

indefinite and therefore could be used in different ways, by different Ministers, at different points in time.

Clause 120 - International healthcare arrangements (see page 17)

- It has been conventional that primary legislation not delegated legislation should be used when international agreements require changes to be made to UK law, in reflection of the greater opportunity for scrutiny afforded to MPs by the former. This clause departs from this constitutional convention.
- The government justifies this power on the basis of precedent: that there are comparable powers in the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019. However, in 2019 the government's justification for its approach was partly the need for speed and flexibility imposed by the EU withdrawal process. Parliament still imposed limitations on the use of the provisions: it did not accept that the powers should be geographically and temporally unlimited. Parliament required that the powers be confined to the EEA and Switzerland and some of the powers be sunsetted.
- There is no clear and proportionate criteria for what constitutes 'exceptional circumstances' to justify payments in respect of healthcare overseas outside the scope of an international healthcare agreement. However, regulations made under this power will be subject only to the negative scrutiny procedure and therefore are unlikely to be debated or voted on by MPs in the future. In the absence of any definition about what might constitute 'exceptional circumstances', the potential scope for the use of the power is quite broad and again accords Ministers considerable discretion.

Clause 125 - Advertising of less healthy food and drink (see page 21)

- This clause confers powers on Ministers to reshape the prohibition on advertisements of 'less healthy' food and drink. The government recognises that Parliament should be able to debate changes with significant policy and budgetary implications for the food or drink sector. However, it proposes that the affirmative scrutiny procedure should apply only where the exercise of the power involves an amendment to primary legislation - such as amending the meaning of 'the relevant guidance'. In contrast, an exercise of the power which may engage broader policy implications and costs, but which does not require the amendment of primary legislation, is subject only to the negative scrutiny procedure. Regulations in these circumstances are therefore unlikely to be debated or voted on by MPs in the future.
- Although a consultation requirement is imposed on Ministers in relation to the exercise of this power, there is – as with previous clauses – again no requirement formally to lay a report about the consultation before Parliament to accompany the relevant Instrument.

2. Five Clauses of Concern: Detailed Analysis

Clause 14 - People for whom Integrated Care Boards (ICBs) have core responsibility

Overview of the clause		
Under current arrangements, Clinical Commissioning Groups (CCGs) are responsible for the planning and commissioning of health care services in local areas. The Bill will establish statutory Integrated Care Boards (ICBs) that will take on the commissioning functions of the CCGs (which will be abolished) as well as some of NHS England's commissioning functions.[5] Clause 14 provides for people for whom ICBs have core responsibility. Clause 14(2) will insert section 14Z31 into the National Health Service Act 2006 ('the 2006 Act'). Clause 14(4) creates a delegated power to substitute an alternative version of section 14Z31 into the 2006 Act at the Secretary of State's discretion. This is the provision of particular concern.		
Summary of sub-sections relevant to concerns raised in this clause		
Clause(s)	**What the provision does**	**Applicable parliamentary procedure**
Clause 14(2) (newly inserted section 14Z31(1))	Provides that NHS England must from time to time publish rules for determining the group of people for whom each ICB has core responsibility	None (clause 14(3)(a))
Clause 14(2) (newly inserted section 14Z31(2))	Provides that the rules made under the newly inserted section 14Z31 must ensure that the following are allocated to at least one group: (a) everyone who is provided with NHS primary medical services; and (b) everyone who is usually resident in England and is not provided with NHS primary medical services	
Clause 14(2) (newly inserted section 14Z31(3))	Provides that the Secretary of State may make regulations that create exceptions to the newly inserted section 14Z31(2) in relation to people of a prescribed description	Affirmative (clause 14(3)(b))
Clause 14(2) (newly inserted section14Z31(4))	Provides that references in this Bill to the group of people for whom an ICB has core responsibility are to be read in accordance with the newly inserted section 14Z31	
Clause 14(4)	Provides that the Secretary of State may by regulations change the definition of the people for whom ICBs are responsible, by inserting a substituted version of section 14Z31, and repeal and amend provisions of the 2006 Act that would have been amended by clause 14(2)	Negative (by virtue of section 272(4) of the 2006 Act)

[5] Bill, clause 13

Government position

The Department of Health and Social Care ('the Department') provides two main arguments for taking the power in clause 14(4) to substitute an alternative version of section 14Z31 into the 2006 Act:

- *"The effect of the regulations would be that the people for whom each ICB is responsible is determined differently, but it continue[s] to provide that one or another ICB must be responsible for everyone who is usually resident in England"*;[6]
- *"The details of which ICB is responsible for which individuals is administrative and technical in nature"*.[7]

Analysis

Clause 14(4) gives rise to two main concerns:

1. Clear and proportionate criteria have not been provided on the face of the Bill to govern the exercise of the power in clause 14(4).

The power in clause 14(4) would remove the ability for NHS England to publish rules that determine the group of people for whom each ICB has core responsibilities. The power could be exercised at any point after the other provisions in the Bill have commenced. Parliament is therefore being asked to approve simultaneously both a new section and a power that could be used to substitute the new section in its entirety at the Secretary of State's discretion.

The Department has not provided a justification as to why this power to substitute is required, or why the Secretary of State has the discretion to exercise it indefinitely. It has also not provided any information – in the supporting documents or on the face of the Bill – on when and in what circumstances the Department envisages the power being used, or any clear and proportionate criteria that the Secretary of State would have to fulfil to make regulations under this power. There is also no requirement to consult NHS England or the impacted ICBs prior to making regulations under this power, even though it may have nationwide ramifications for the provision of health services.

2. The exercise of the power in clause 14(4) is subject only to the negative procedure.

Regulations under the power in clause 14(4) are to be subject to the negative parliamentary procedure. This is despite the fact that such regulations would in effect amend primary legislation, albeit in a pre-defined manner. There is a strong presumption for the affirmative procedure to apply to powers where their exercise amends or repeals primary legislation.[8]

When justifying the proposed procedure, the Department states that the details of which ICB is responsible for which individuals are administrative and technical in nature. However, the Department has already taken the position that regulations that can create exceptions to these groups should be subject to the affirmative procedure (clause 14(2), inserting section 14Z31(3)). In recognition of the potential impact of the power being sought, the affirmative procedure should be applied to the power in clause 14(4). This would also provide Parliament with the opportunity to consider the appropriateness of the regulations at the point in time at which the Secretary of State intends to exercise the power, prior to the regulations being made into law.

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[6] DPM, para. 144

[7] *Ibid.*

[8] See House of Lords Delegated Powers and Regulatory Reform Committee (DPRRC) (2019-21), *1st Report*, HL Paper 3, paras. 8, 11; DPRRC (2019-21), *9th Report*, HL Paper 42, paras. 12, 13

Clause 68 - Procurement regulations

Overview of the clause		
The Bill intends to pave the way for a new healthcare services procurement regime. Clause 68 inserts a new section 12ZB into the 2006 Act, which provides a power under which Ministers may create such a regime. The aim, according to the EN and DPM, is to develop a new procurement regime for the NHS and public health procurement, informed by public consultation, to reduce bureaucracy for commissioners and providers alike, and reduce the need for competitive tendering where it adds limited or no value.[9] However, in clause 68, Parliament is in effect being asked to approve a skeleton part of a Bill that will enable the new healthcare services procurement regime to be established almost entirely by regulations.		
Summary of sub-sections relevant to concerns raised in this clause		
Clause(s)	**What the provision does**	**Applicable parliamentary procedure**
Clause 68 (newly inserted section 12ZB(1))	Provides that the Secretary of State may make regulations that make provision in relation to the procurement by relevant authorities of health care services for the purposes of the health service in England and other goods or services that are procured together with those health care services	Negative (by virtue of section 272(4) of the 2006 Act)
Clause 68 (newly inserted section 12ZB(2))	Provides that regulations made under the newly inserted section 12ZB may make provision in relation to general objectives of procurement and the procurement processes	
Clause 68 (newly inserted section 12ZB(3))	Provides that regulations made under the newly inserted section 12ZB may make provision for the purposes of ensuring transparency or fairness, verifying compliance, or managing conflicts of interests	
Clause 68 (newly inserted section 12ZB(4))	Provides that NHS England may publish guidance about compliance with requirements imposed by regulations made under the newly inserted section 12ZB	None
Clause 68 (newly inserted section 12ZB(5))	Provides that a relevant authority must have regard to guidance published under the newly inserted section 12ZB	
Clause 68 (newly inserted section 12ZB(6))	Provides that NHS England must obtain the approval of the Secretary of State before publishing guidance under the newly inserted section 12ZB	
Clause 68 (newly inserted section 12ZB(7))	Provides the meaning of 'health care service' and 'relevant authority' for the purposes of the newly inserted section 12ZB	

[9] EN, para. 114, 115; DPM, para. 460

Government position

The Department acknowledges that the new health care services procurement regime is to be introduced by regulations. It provides three main arguments for taking the power to do so:

- "*Initial consultation has been carried out on the content of the regime by NHS England, but it has not yet been possible to fully analyse the results of that consultation and to follow up with the sector on a more developed proposal*";[10]
- "*A Cabinet Office procurement Bill will most likely follow this Bill through passage, which may alter existing legal procurement frameworks*";[11]
- "*Outlining the regime in regulations rather than in primary legislation allows for flexibility in the regime in the future*".[12]

In arguing for the proposed parliamentary procedure, the Department states:

- "*… the negative procedure is suitable for these regulations in line with the majority of the other regulation-making powers in [the 2006 Act] as it continues to ensure transparency but also provides flexibility to amend the regulations speedily if necessary*";[13]
- "*… the regulation-making power could technically be used to amend primary legislation. However, the only current intended consequential amendments would be to secondary (the Public Contracts Regulations 2015) and it is thought that any amendments to primary would be very minor, making the negative procedure still sufficient*";[14]
- "*a Cabinet Office procurement Bill will most likely follow this Bill through passage. It is possible that the interaction between that Bill and this one may require some amendments to be made to the procurement regulation-making power in this Bill, which could include a reconsideration of the applicable procedure*".[15]

Analysis

The power in Clause 68 gives rise to three main concerns:

1. Parliament is in effect being asked to approve a skeleton part of a Bill that will enable the new healthcare services procurement regime to be established almost entirely by regulations.

The DPRRC[16] and the Constitution Committee[17] have emphasised that skeleton Bills, or skeleton parts of Bills, inhibit parliamentary scrutiny, and that it is difficult to envisage any circumstances in which their use is acceptable. These Committees have said that the government must provide an exceptional justification for a skeleton approach.

The government's justification in terms of 'flexibility' presents a false dichotomy, by suggesting that the only alternative to the approach it is taking is to set out every detail of the regulatory regime in primary legislation. Such arguments do not explain why it would not be possible to have more details of the proposed new regime provided for on the face of the Bill, which can be debated now, combined with more focused delegated powers to fill in the detail subsequently by regulations.

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[10] DPM, para. 463(a)(i)
[11] *Ibid.*, para. 463(a)(ii)
[12] *Ibid.*, para. 463(b)(i)
[13] *Ibid.*, para. 465
[14] *Ibid.*, para. 466
[15] *Ibid.*, para. 467
[16] For example, DPRRC (2019-21), *19th Report*, HL Paper 109, paras. 15, 16, 28(a), 50, 51; DPRRC (2019-21), *22nd Report*, HL Paper 118, paras. 41, 45
[17] For example, House of Lords Constitution Committee (2017-19), *16th Report*, HL Paper 225, para. 58

The relevant consultation has not yet been fully analysed. However, Parliament is still being asked now to approve delegated powers that can be used to establish the new regime at some point in the future at the Secretary of State's discretion, without any substantive information on what this regime might entail. The consultation is welcome, but consultations should not be presented as a substitute for parliamentary scrutiny.[18] Indeed, the fact that detailed analysis of results from a consultation is required to inform a fully-developed proposal for the new regime indicates that that regime is sufficiently important to warrant a higher level of parliamentary scrutiny.[19]

2. Regulations made under the power in clause 68 are subject only to the negative procedure.

In clause 68, Parliament is being asked to approve powers the exercise of which is subject to the negative procedure. That is, the new health care services procurement regime can be made into law without requiring parliamentary approval.

None of the government's arguments for the negative procedure is conclusive:

- There is a strong presumption that powers that *can* be exercised to amend primary legislation should be subject to the affirmative procedure, notwithstanding assurances that any amendments to Acts of Parliament made by the exercise of such powers would be minor.[20]
- The government's reliance on the negative procedure as the 'default' procedure in the 2006 Act is insufficient and unconvincing: the 2006 Act also contains provisions that are subject to the affirmative procedure.[21]
- The possible implications of the forthcoming procurement Bill for clause 68 are not relevant: it is the Health and Care Bill, not an unpublished future Bill, that Parliament is currently being asked to scrutinise.

Regulations made under clause 68 should thus be subject to a more stringent scrutiny procedure.

The affirmative procedure, for example, would provide Parliament with an opportunity to debate the substance of the new regime, with the requisite information, at the point in time that the Secretary of State decides to exercise the power, and before the new regime could be enacted into law. The nature of the clause 68 power would be enough to justify this on its own; but an additional factor is that MPs expressed interest in the procurement regime during the Bill's Second Reading debate, [22] and the subject-matter has also attracted significant extra-parliamentary interest,[23] potentially warranting further opportunities for parliamentary scrutiny and debate at the time the powers are exercised.

3. Statutory guidance made under the power in clause 68 is not subject to any parliamentary procedure, even though "*regard must be had*" to the guidance, and the guidance forms part of a package with the prospective procurement regulations.

Statutory guidance to which "*regard must be had*" should be subject to a parliamentary procedure.[24] The rationale for this standard, as stated by the DPRRC, is that *"[a]lthough a duty to have regard to*

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[18] For example, DPRRC (2019-21), *19th Report*, HL Paper 109, paras. 44, 45; DPRRC (2019-21), *37th Report*, HL Paper 258, para. 7(a)
[19] DPRRC (2019-21), *19th Report*, HL Paper 109, paras. 44, 45, 48
[20] For example, DPRRC (2019-21), *1st Report*, HL Paper 3, paras. 8, 11; DPRRC (2019-21), *9th Report*, HL Paper 42, paras. 12, 13
[21] The *National Health Service Act 2006* ('2006 Act'), section 272(6)
[22] For example, House of Commons, *Hansard*, 14 July 2021, vol. 699, cols. 436, 440, 441, 462, 467, 472
[23] For example, British Medical Association, *BMA briefing - Health and Care Bill, Second reading*, 14 July 2021 [accessed on 02 September 2021: https://www.bma.org.uk/media/4328/bma-briefing-on-health-and-care-bill-second-reading-july-2021.pdf]; The King's Fund, *Briefing on the Health and Care Bill: House of Commons Second Reading*, 12 July 2021 [accessed on 02 September 2021: https://www.kingsfund.org.uk/sites/default/files/2021-07/health-care-bill-house-commons-second-reading.pdf]
[24] For example, DPRRC (2019-21), *7th Report*, HL Paper 28, para. 15; DPRRC (2019-21), *17th Report*, HL Paper 98, para. 10; DPRRC (2019-21), *37th Report*, HL Paper 258, paras. 7(c), 7(d), 8, 9

statutory guidance does not imply a duty to follow it in any or all respects, we have in recent years observed that a person or body that is required by statute to have regard to guidance will normally be expected to follow it and will in practice normally do so unless there are cogent reasons for not doing so".[25]

Where guidance will form part of a package with delegated legislation to which it relates, the same parliamentary procedure as applies to the delegated legislation should also apply to the guidance.[26]

Clause 87 - Power to transfer functions between bodies

Overview of the clause		
Clause 87 confers powers on the Secretary of State to transfer functions between specified health and care sector arm's length bodies (ALBs). Clause 89 provides for the scope of the powers in clause 87.		
Summary of sub-sections relevant to concerns raised in this clause		
Clause(s)	**What the provision does**	**Applicable parliamentary procedure**
Clause 86	Defines 'relevant bodies' to mean Health Education England, the Health and Social Care Information Centre, the Health Research Authority, the Human Fertilisation and Embryology Authority, the Human Tissue Authority, and NHS England	
Clause 87(1)	Provides that the Secretary of State may by regulations transfer functions between the relevant bodies in clause 86	Affirmative (clause 131(3)(b)).
Clause 87(2)	Provides that regulations under clause 87 may be made only if the Secretary of State considers that they serve the purpose of improving the exercise of public functions, having regard to efficiency, effectiveness, economy, and securing appropriate accountability to Ministers	
Clause 87(3)	Provides that regulations made under clause 87 may not transfer a function of NHS England if the Secretary of State considers that to do so would make NHS England redundant	
Clause 87(4)	Provides that through regulations made under clause 87, by virtue of clause 131(1)(a), the Secretary of State may modify the functions, constitution or funding of relevant bodies, and abolish a relevant body if it has become redundant as a consequence of the transfer of functions	
Clause 89(1)	Provides that references to modifying the functions of a body (clause 87(4)) include conferring a function on the body, abolishing	

[25] DPRRC (2019-21), 37th *Report*, HL Paper 258, para. 8
[26] DPRRC (2019-21), 7th *Report*, HL Paper 28, para. 16

	a function of the body, changing the purpose or objective for which the body exercises a function, and changing the conditions under which the body exercises a function	
Clause 89(2)	Provides that references to the constitutional arrangements of a body (clause 87(4)) include matters relating to the name of the body, the chair of the body (including qualifications and procedures for appointment and functions), members of the body (including the number of members, qualifications and procedures for appointment and functions), staff of the body exercising functions on its behalf (including qualifications and procedures for appointment and functions), the body's powers to employ staff, governing procedures and arrangements (including the role and membership of committees and sub-committees), and reports and accounts	
Clause 89(3)	Provides that references to modifying the funding arrangements of a body (clause 87(4)) include modifying the extent to which it is funded by a Minister and conferring power on the body to charge fees for the exercise of a function (and to determine their amount)	
Clause 89(4)	Provides that regulations made under clause 87 may repeal and re-enact (but may not create) a power to make subordinate legislation, a power of forcible entry, search or seizure, a power to compel the giving of evidence, or a criminal offence	
Clause 89(5)	Provides that provisions which may be made by regulations under clause 87 may be made by repealing, revoking, or amending provisions made by or under an Act of Parliament, whenever passed or made, and this includes those provisions made by the Devolved Administration legislatures. Powers in clause 87 are therefore 'Henry VIII powers'.	
Clause 92	Provides for consultation requirements before the making of regulations under clause 87	
Clause 131(1)(a)	Provides that a power to make regulations under any provision of this Bill includes the power to make consequential, supplementary, incidental, transitional or saving provision	

Government position

The Department makes several arguments for taking the powers in clauses 87 and 89, namely:

- *"The current process for making changes to improve the ALB landscape is unsatisfactory in a system where the NHS is ever changing: the current balance of powers prohibits the Department from responding to or pre-empting these changes";*[27]
- *"Using primary legislation each time a function was to be moved would be very time-consuming, as would setting up any new ALBs";*[28]
- *"In many cases, it would be a small change between one ALB and another ALB's functions, which would not warrant a new piece of primary legislation";*[29]
- *"The power to abolish functions may only be used if it is consequential, supplemental or incidental to / upon a transfer (for example if a transfer created an overlap of functions exercised by the same body)";*[30]
- *"There are no immediate plans to change or transfer functions of the bodies in the system but the utility of having such flexibility in the future is key to why it is included in this Bill";*[31]
- *"There is precedent for powers of the type proposed by this clause in the Public Bodies Act 2011. However, the powers in the Public Bodies Act 2011 went substantially further than the provisions in this Bill, in that they allowed for the abolition of bodies (without a transfer of their functions elsewhere) and applied to a wider range of bodies".*[32]

The Department recognises that these are wide powers and highlights four main ways that the powers are contained:[33]

- the limited number of 'relevant bodies' to which they apply (clause 86);
- the test which must be fulfilled before the powers can be exercised (clause 87(2));
- the consultation requirements (clause 92); and
- the fact that the regulations are subject to the affirmative procedure (clause 131(3)(b)).

Analysis

There are four principal concerns about the power in clause 87:

1. The government is correct that there are comparable powers, and precedent, in the Public Bodies Act 2011 ('the 2011 Act'), which also applies to a wider range of bodies than the power in clause 87 of this Bill. However, there are limitations to the powers in the 2011 Act that have not been applied in clause 87.

With respect to public bodies, sections 1 to 5 of the 2011 Act confer on Ministers powers to abolish, merge, modify constitutional arrangements, modify funding arrangements, and modify or transfer functions. The exercise of these powers is subject to a strengthened scrutiny procedure. The process begins with a consultation requirement. A draft Public Bodies Order (PBO) may then not be laid before both Houses (with an explanatory document) until 12 weeks have passed from the start of the

[27] DPM, para. 544
[28] *Ibid.*, para. 553
[29] *Ibid.*, para. 549
[30] *Ibid.*, para. 556
[31] *Ibid.*, para. 553
[32] *Ibid.*, para. 554
[33] *Ibid.*, para. 543

consultation. Within 30 days after the draft PBO is laid, either House can resolve - or a committee charged with reporting on the draft can recommend - that the 'enhanced affirmative' procedure be used. If no such resolution or recommendation is made - and the draft PBO thus remains subject to the regular affirmative procedure - after 40 days (from the date on which the draft was laid) a motion to approve the draft can be moved. If the 'enhanced affirmative' procedure is triggered, this extends to 60 days (from the date on which the draft was laid) the period before a motion to approve the draft PBO can be moved. The Minister must have regard to any representations, resolutions and/or recommendations made during this period. After the expiry of the 60-day period, the draft PBO can be debated, or the Minister may choose to lay a revised draft PBO with a statement summarising the changes. This revised draft is then subject to the affirmative procedure.[34] In addition to this strengthened scrutiny procedure in the 2011 Act, schedules to which these powers apply are sunsetted.[35]

Comparable limitations have not been applied to clause 87 of the Health and Care Bill. The Secretary of State can exercise the power conferred by clause 87 subject to the affirmative procedure and indefinitely. As to why the power is not sunsetted the Department states that *"[t]here are no immediate plans to change or transfer functions of the bodies in the system but the utility of having such flexibility in the future is key to why it is included in this Bill"*.[36] It is debatable whether this is adequate justification for taking a non-sunsetted power of this width. Moreover, the difference in limitations placed on the power in clause 87, in contrast to the powers in the 2011 Act, undermines the use of the 2011 Act as a precedent.

2. The test that the Secretary of State must fulfil before the power in Clause 87 can be exercised is not clear and proportionate.

During passage of the Public Bodies Bill, there were strong concerns levelled at some of its provisions – provisions that have been emulated in clauses 87 of the Health and Care Bill and not cogently justified by the Department.

In its reporting on the Bill in 2010-11, the DPRRC was critical of a test that required Ministers to have regard to efficiency, effectiveness, economy, and securing appropriate accountability in order to be able to exercise the powers. As stated by the DPRRC, *"[t]his does not limit the purpose for which the power may be exercised; it merely specifies factors to be taken into account"*.[37] Powers to transfer, modify or abolish functions were deemed the widest powers in the Bill,[38] and *"[i]f these expansive powers are to be delegated by Parliament to Ministers, it is important that, as a minimum, the general purposes for which Parliament expects the powers to be used should be set out on the face of the Bill, and this is not currently the case"*.[39] Regarding powers to modify constitutional arrangements, the DPRRC highlighted that *"[t]hese are matters which can be of considerable interest or even controversy when bills establishing such bodies and offices are considered in Parliament"*.[40]

The provision criticised by the DPRRC[41] made it onto the statute book, in the 2011 Act. However, this fact alone is insufficient justification for a repetition: powers conferred by a Bill and the degree of parliamentary scrutiny applied to their exercise should be considered on their own merits.[42] It is therefore concerning that the test for the exercise of the clause 87 power in the current Bill, which

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[34] The *Public Bodies Act 2011* ('2011 Act'), section 11; for more information see, Fox, R. & Blackwell, J. (2014), *The Devil is in the Detail: Parliament and Delegated Legislation,* (London: Hansard Society), pp. 91-108, 232
[35] 2011 Act, section 12
[36] DPM, para. 553
[37] DPRRC (2010-11), *5th Report*, HL Paper 57, para. 19. See also, DPRRC (2010-11), *6th Report*, HL Paper 62, para. 22
[38] DPRRC (2010-11), *5th Report*, HL Paper 57, para. 16
[39] DPRRC (2010-11), *11th Report*, HL Paper 108, para. 12
[40] DPRRC (2010-11), *5th Report,* HL Paper 57, para. 14
[41] For example, DPRRC (2010-11), *5th Report,* HL Paper 57, para. 19; DPRRC (2010-11), *6th Report,* HL Paper 62, para. 22
[42] For example, DPRRC (2019-21), *5th Report*, HL Paper 24, para. 4; DPRRC (2019-21), *37th Report,* HL Paper 258, para. 7(b)

the Department relies on as a limitation to the power,[43] is a replica of the one in the 2011 Act.[44] Furthermore, powers that provide for Ministers to be able to 'improve' something may be considered as giving them unacceptably wide discretion. As the DPRRC has in a previous report been "*[c]onscious that one person's improvement is another person's vandalism*", a clearer, more focused and proportionate test is required for the exercise of the power conferred by clause 87 of this Health and Care Bill.[45]

3. There is no requirement on the Secretary of State to lay, together with the regulations, a report on the consultation which must be conducted before the clause 87 power may be used.

Consultation requirements imposed on the exercise of the power in clause 87 are welcome, but consultations should not be presented as a substitute for parliamentary scrutiny.[46] The Department has also not justified why the Bill places no requirement on the Secretary of State to lay a report about the consultation together with the instrument before Parliament.[47]

4. The scope of the power in clause 87 is wider than the intended use put forward by the Department in the Delegated Powers Memorandum (DPM).

The Department's statement in the DPM that the exercise of the power in clause 87 "*[i]n many cases… would be a small change between one ALB and another ALB's functions*"[48] is not reflected on the face of the Bill. The exercise of the power is not limited to "*a small change*". Indeed, the Department's statement that such a small change would take place in "*many*" cases suggests that it envisages that there might be cases where a transfer of functions between relevant bodies and any consequential changes would be something larger. Powers are traditionally judged not on how the government says that it will exercise them, but on their actual scope and how they are *capable* of being used. Government policy can change, and it is therefore important that powers are considered on the basis of what they will in fact allow, rather than what it is said they will be used for.[49] Furthermore, one Minister's use of a power may be very different from another's. This principle holds equally for different governments of different political complexions.

Clause 120 – International healthcare arrangements

Overview of the clause		
This clause amends the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019 (HEEASAA) to enable the government to implement healthcare agreements with countries outside the European Economic Area and Switzerland.[50]		
Summary of sub-sections relevant to concerns raised in this clause		
Clause(s)	What the provision does	Applicable parliamentary procedure
Clauses 120(3) and 120(4)	Omits the power to make healthcare payments in the current section 1 HEEASAA and the power to make regulations in	

[43] DPM, para. 555
[44] 2011 Act, section 8
[45] DPRRC (2019-21), *13th Report*, HL Paper 69, para. 9
[46] For example, DPRRC (2019-21), *19th Report*, HL Paper 109, paras. 44, 45; DPRRC (2019-21), *37th Report*, HL Paper 258, para. 7(a)
[47] For an example of such a requirement see the *Health Act* 1999, schedule 3 para. 9(2)
[48] DPM, para. 549
[49] For example, DPRRC (2019-21), *1st Report*, HL Paper 3, para. 15(c); DPRRC (2019-21), *4th Report,* HL Paper 17, paras. 2, 40; DPRRC (2019-21), *5th Report*, HL Paper 24, paras. 7, 13; DPRRC (2019-21), *13th Report,* HL Paper 69, para. 19; DPRRC (2019-21), *19th Report,* HL Paper 109, para. 26; DPRRC (2019-21), *24th Report*, HL Paper 130, paras. 10(c), 12(c), 15, 19, 28
[50] EN, para. 921

	relation to healthcare and healthcare agreements in the current section 2 HEAASAA. Replaces them with a new healthcare agreements and payments section (newly inserted section 2)	
Clause 120(4) (newly inserted section 2(1))	Provides that the Secretary of State may by regulations make provision for the purpose of giving effect to a healthcare agreement (including provision about payments)	Negative (by virtue of section 7(5) HEEASAA)
Clause 120(4) (newly inserted section 2(2))	Provides that the Secretary of State may by regulations make provision authorising the Secretary of State to make a payment (otherwise than under a healthcare agreement) in respect of healthcare provided in a relevant country or territory, but only where the Secretary of State considers that exceptional circumstances justify the payment	Negative (by virtue of section 7(5) HEEASAA)
Clause 120(4) (newly inserted section 2(3))	Provides that 'relevant country or territory' in section 2(2) means a country or territory, outside the United Kingdom, in respect of which there is a healthcare agreement	
Clause 120(4) (newly inserted sections 2(4), 2(5) and 2(6))	Regulations under the newly inserted section 2 may include provisions about administrative arrangements, may confer functions on a public authority (including discretions) and may provide for the delegation of functions to a public authority. The Secretary of State may give directions to a person about the exercise of any functions exercisable by the person under such regulations.	
Clause 120(5)	Provides that 'healthcare agreement' means an agreement or other commitment between the United Kingdom and either a country or territory outside the United Kingdom or an international organisation, concerning healthcare provided anywhere in the world	
Clauses 120(1) and 120(6)	Changes the short title of the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019 to Healthcare (International Arrangements) Act 2019	

Government position

The main arguments made by the Department for these proposed amendments are that the Secretary of State does not have the necessary powers to implement reciprocal healthcare agreements with countries outside the European Economic Area and Switzerland,[51] and that the proposed powers are not as wide as those provided in the HEEASAA, as:

[51] DPM, para. 649

- the clause removes the broad payment power in section 1 HEEASAA and replaces it with a narrower power to make regulations to make provisions for healthcare payments (newly inserted section 2(1) and (2));[52] and
- the substituted section 2 removes the existing section 2 power to make regulations to establish detailed unilateral healthcare schemes (current section 2(1)(a) and (b) of HEEASAA).[53]

The Department also states that "*as is evidenced by the Healthcare (European Economic Area and Switzerland Arrangements) (EU Exit) Regulations 2019 (the HEEASAA Regulations), these regulations are by their nature technical, operational and detailed and so better suited to secondary legislation*",[54] and that "*[t]he regulations are unlikely to contain policy issues that require in depth Parliamentary debate and consideration*".[55]

Regarding the parliamentary procedure, the Department states that "*as with the current section 2 power, the negative procedure affords the appropriate level of scrutiny in the case of regulations under clause 120 which substitutes section 2*".[56]

Analysis

There are three main concerns about the powers in clause 120:

1. Clause 120 would see a further departure from the constitutional convention on the means of implementing international agreements in domestic law.

The Department may be correct to state that the Secretary of State lacks the necessary powers to implement reciprocal healthcare agreements with countries outside the European Economic Area and Switzerland. However, this does not mean that there is currently no way to implement such agreements: they could be implemented by primary legislation, with its attendant scrutiny. Indeed, as the Constitution Committee has noted in a previous report, and the DPRRC has restated,[57] it is "*a long-standing convention of the constitution … that outside the exceptional case of making provision for EU law, international legal agreements that make changes to UK law are given domestic force by an Act of Parliament*".[58]

The Department fails to make a case for departing from this convention. It points to the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019 and the Regulations made under it as a precedent, but undermines this position by stating that "[t]*he exact arrangements which will be provided for under any future reciprocal healthcare agreements is a matter for negotiations*".[59] In any case, with respect to the then-Bill in 2018-19, the government justified the taking of the relevant powers partly in terms of the need for speed and flexibility in the extraordinary circumstances of the EU withdrawal process;[60] and Parliament did not accept the provisions in the original Bill that the powers should be geographically and temporally unlimited: they ended up sunsetted (in relation to sections 2(1)(a) and 2(1)(b) HEEASAA) and confined to the EEA and Switzerland. The government also sought in connection with the 2018-19 Bill to argue that delegated legislation was an appropriate means of implementing international healthcare agreements partly because such

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[52] *Ibid.*, para. 661
[53] *Ibid.*, para. 658
[54] *Ibid.*, para. 660
[55] *Ibid.*, para. 664
[56] *Ibid.*, para. 662
[57] DPRRC (2021–22), *2nd Report,* HL Paper 13, para. 32. See also DPRRC (2019–21), *8th Report,* HL Paper 40, para. 5
[58] House of Lords Constitution Committee (2019–21), *5th Report,* HL Paper 55, para. 4
[59] DPM, para. 655
[60] Department of Health and Social Care, *Memorandum Concerning the Delegated Powers in the Healthcare (International Arrangements) Bill,* 29 October 2018, para. 25

agreements would also be subject to parliamentary scrutiny under the pre-ratification requirements of the Constitutional Reform and Governance Act 2010 (CRAG Act); but the DPRRC has taken the view that, even if the CRAG Act process were to make for adequate treaty scrutiny, its existence has no bearing on the appropriateness or otherwise of the taking of delegated powers.[61]

2. Clear and proportionate criteria for what constitutes 'exceptional circumstances' have not been provided.

Regarding the Secretary of State's power to make healthcare payments, the Department highlights that the proposed amendments remove the Secretary of State's existing broad payment power and power to establish unilateral healthcare schemes with Switzerland and countries inside the European Economic Area.

As they were originally proposed in the then-Healthcare (International Arrangements) Bill, the scope of these powers was a concern for the DPRRC, given their potential to be used for providing and funding healthcare throughout the world. As stated by the DPRRC, "*[u]nder the powers in clause 2(1)(a) and (b) of the Bill, the Secretary of State could fund the entire cost of mental health provision in, say, the state of Arizona as well as the cost of all hip replacements in, say, Australia. If this might appear fanciful, we assess powers by how they are capable of being used, not by how governments say that they propose to use them. The fact that the powers could be used in these ways suggests that they are too widely drawn*".[62]

As currently proposed, the new power in the current Bill for the Secretary of State to make regulations authorising the Secretary of State to make healthcare payments broadens the scope once again to funding healthcare throughout the world. However, it is also limited in two fundamental ways. Firstly, the healthcare that warrants the payment must be in a country or territory, outside the United Kingdom, in respect of which there is a healthcare agreement and the healthcare falls outside the scope of that agreement. Secondly, the Secretary of State must consider that 'exceptional circumstances' justify the payment.[63] Given that a key limitation on this proposed power is that the Secretary of State must consider there to be 'exceptional circumstances', a clear and proportionate test should be provided on the face of the Bill for what qualifies as an 'exceptional circumstance'.

3. Existing safeguards in the current section 2 HEEASAA are to be removed and the Department has not addressed some of the original concerns levelled at the Healthcare (International Arrangements) Bill.

The DPRRC expressed strong concerns when reporting on the then-Healthcare (International Arrangements) Bill, which became the Healthcare (European Economic Area and Switzerland Arrangements) Bill. A major concession by the government in the passage of that Bill through Parliament, given the width of the powers that are conferred, was to sunset the regulation-making powers in clause 2(1)(a) and clause 2(1)(b), so that they are exercisable only for a five-year period after the UK's withdrawal from the EU.[64] The Department has not acknowledged that this sunsetting provision will be removed by the proposals in the current Bill.[65] It has also not acknowledged that the proposal will also remove the current section 2(2) HEEASAA that specifies that regulations under subsection (1) may *only* do one or more of the things listed.

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[61] DPRRC (2019–21), *8th Report*, HL Paper 40, para. 13
[62] DPRRC (2017–19), *47th Report*, HL Paper 289, para. 3. See also DPRRC (2017–19), *39th Report*, HL Paper 226, para. 11
[63] Bill, clause 120(4)
[64] DPRRC (2017-19), *50th Report*, HL Paper 336, Appendix 1
[65] Bill, clause 120(4)

Furthermore, in making these proposed amendments to the HEEASAA, some of the original concerns raised by the DPRRC in its reports on the then-Healthcare (International Arrangements) Bill have not been addressed, namely that:

- *"There is no limit to the amount of the payments"*;[66]
- *"There is no limit to the types of healthcare being funded"*;[67]
- *"Regulations made under clause 2 are subject only to the negative procedure"*.[68]

Clause 125 - Advertising of less healthy food and drink

Overview of the clause		
An intention of the Bill is to reduce children's exposure to the advertising of less healthy food and drink products on TV and online.[69] Clause 125 inserts schedule 16 into the Bill, and schedule 16 amends the Communications Act 2003 ('the 2003 Act') to restrict the advertising of certain food and drink products. Paragraphs that contain delegated powers are paragraph 1 (watershed prohibition as it relates to television programme services), paragraph 2 (watershed prohibition as it relates to on-demand programme services) and paragraph 3 (prohibition of paid-for advertising of less healthy food and drink online). The paragraphs propose to impose prohibitions for advertisements for identifiable 'less healthy' food or drink products. Prohibitions imposed by the respective paragraphs do not apply in relation to advertisements included as a result of arrangements made by or on behalf of a person who is, at the time when the arrangements are made, a 'food or drink SME'.		
Summary of sub-sections relevant to concerns raised in this clause		
Paragraph(s)	**What the provision does**	**Applicable parliamentary procedure**
Paragraphs 1, 2 and 3 (newly inserted sections 321A(2)(b), 368FA(3) and 368Z14(4))	Enables the Secretary of State, by regulations following a duty to consult (newly inserted sections 321A(3), 368FA(4), and 368Z14(5) respectively), to provide for further exemptions from the prohibition imposed by the respective sections	Negative (by virtue of section 402(2) of the 2003 Act)
Paragraphs 1, 2 and 3 (newly inserted sections 321A(4)(c), 368FA(5)(c)(i) and 368Z14(6)(e)(i))	Provides that a food or drink product is 'less healthy' if it falls within a description specified in regulations made by the Secretary of State, and it is 'less healthy' in accordance with the 'relevant guidance'. The 'relevant guidance' is specified in newly inserted sections 321A(4)(d), 368FA(5)(d) and 368Z14(6)(f) respectively.	Negative (by virtue of section 402(2) of the 2003 Act)
Paragraphs 1, 2 and 3 (newly inserted sections 321A(6),	Provides that the Secretary of State may by regulations amend the respective newly inserted sections to change the meaning of 'the relevant guidance'. These are 'Henry VIII powers'.	Affirmative (newly inserted sections 321A(7), 368FA(8) and 368Z14(9))

[66] DPRRC (2017–19), *39th Report*, HL Paper 226, para. 10; DPRRC (2017–19), *47th Report*, HL Paper 289, para. 3
[67] *Ibid.*
[68] DPRRC (2017–19), *39th Report*, HL Paper 226, para. 13; DPRRC (2017–19), *47th Report*, HL Paper 289, para. 15
[69] EN, para. 184

368FA(7) and 368Z14(8))		
Paragraphs 1, 2 and 3 (newly inserted sections 321A(4)(e), 368FA(5)(e) and 368Z14(6)(g))	Provides that 'food or drink SME' means a small or medium enterprise, within the meaning given by regulations made by the Secretary of State, of a description specified in the regulations	Negative (by virtue of section 402(2) of the 2003 Act)
Paragraph 3 (newly inserted section 368Z14(6)(h))	Provides that 'services connected to regulated radio services' has the meaning given by regulations made by the Secretary of State	Negative (by virtue of section 402(2) of the 2003 Act)
Paragraph 3 (newly inserted section 368Z20)	Provides that the Secretary of State may by regulations amend the newly inserted Part 4C to extend prohibition. The provision which may be made by such regulations include incidental, supplemental, consequential, and transitional provision repealing, revoking, or amending provision made by or under primary legislation whenever passed or made. This is a 'Henry VIII power'. The Secretary of State has a duty to consult prior to exercising this power.	Affirmative (newly inserted section 368Z20(5))

Government position

The Department argues in support of these powers and the applicable parliamentary procedure in terms of six main points:

- The negative procedure, where applied, enables regulations to be brought into force quickly.[70]
- The powers allow for changes to take account of the evolving nature of the policy and future changes in food standards.[71]
- The nature of the regulations is technical or administrative.[72]
- There are unlikely to be policy issues that would merit the use of parliamentary time for debates.[73]
- These regulations should not give rise to any controversial issues.[74]
- For some of the powers, there will be a duty to consult prior to making regulations.[75]

[70] DPM, paras. 733, 740, 756
[71] *Ibid.*, paras. 730, 738, 753
[72] *Ibid.*, paras. 732, 744, 762
[73] *Ibid.*
[74] *Ibid.*, paras. 730, 743, 761
[75] *Ibid.*, paras. 730, 738, 753

Analysis

The powers in schedule 16, under clause 125, give rise to two main concerns:

1. The exercise of some of these powers is subject only to the negative procedure, when they may warrant a more stringent scrutiny procedure

Among the powers in schedule 16, the affirmative procedure is triggered only for the exercise of those which amend primary legislation. However, there are powers conferred on the Secretary of State to make regulations to specify that a food or drink product is 'less healthy', provide for exemptions from the prohibition for advertisements, specify the meaning of a small or medium enterprise, and specify the meaning of services connected to regulated radio services. These are all subject to the negative procedure, despite their potential to be used to reshape prohibition on advertisements of less healthy food and drink – the primary aim of this clause and schedule.

In specifying that the affirmative procedure will apply to the use of powers to amend the meaning of 'the relevant guidance', the Department recognises the importance of Parliament being able "… to *debate the implications of any changes to technical guidance that may impact on the food in scope of the policy. The exercise of this power may have important budgetary implications on businesses caught by the restrictions*".[76] However, the Department does not apply the same rationale to all the powers in schedule 16 that "*may impact on the food in scope of the policy*". As the DPRRC has stated previously, while Parliament should not be overburdened with minor matters that are best dealt with in delegated legislation, avoiding taking up parliamentary time unnecessarily is an insufficient justification when dealing with powers that can change major provisions of law.[77] In any case, the subject-matter of clause 125 and schedule 16 was of interest to MPs at the Bill's Second Reading stage,[78] and has also attracted significant extra-parliamentary interest,[79] potentially warranting further opportunities for parliamentary scrutiny and debate at the time the powers are exercised.

If the affirmative procedure is the appropriate level of parliamentary scrutiny for the exercise of a power, an alternative procedure should only be applied for cogent reasons. In this case, allowing regulations to be brought into force quickly is not such a reason.[80]

2. There is no requirement for the Secretary of State to lay a report about a consultation before Parliament together with the instrument.

Consultation requirements imposed on the exercise of certain powers in schedule 16 are welcome, but consultations should not be presented as a substitute for parliamentary scrutiny.[81] If the exercise of the power is sufficiently important to merit extensive consultation, it is also sufficiently important to warrant the higher level of parliamentary scrutiny which the affirmative procedure affords.[82] The Department has also not explained why it is not a requirement for the Secretary of State to lay a report about a consultation before Parliament together with the relevant instrument.[83]

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[76] DPM, paras. 735, 746, 762
[77] DPRRC (2019-21), *14th Report,* HL Paper 74, paras. 10, 14(d)
[78] For example, House of Commons, *Hansard*, 14 July 2021, vol. 699, cols. 438, 442, 445, 452-453, 469
[79] For example, the views of stakeholders summarised in T. Powell, M. Gheera, D. Foster, B. Balogun, L. Conway, *The Health and Care Bill [Bill 140 of 2021-22]*, House of Commons Library Briefing Paper, No. CBP9232, 12 July 2021, pp. 66-69
[80] For example, DPRRC (2019-21), *14th Report,* HL Paper 74, paras. 20-23, 25; DPRRC (2019-21), *19th Report,* HL Paper 109, paras. 36-38
[81] For example, DPRRC (2019-21), *19th Report,* HL Paper 109, paras. 44, 45; DPRRC (2019-21), *37th Report,* HL Paper 258, para. 7(a)
[82] DPRRC (2019-21), *19th Report,* HL Paper 109, paras. 44, 45, 48
[83] For an example of such a requirement see the *Health Act* 1999, schedule 3 para. 9(2)

Glossary

Affirmative procedure: Parliamentary scrutiny procedure under which delegated legislation requires the active approval of the House of Commons and in most cases also the House of Lords. Under the 'draft affirmative' procedure, delegated legislation is laid before Parliament as a draft, and cannot be made into law by the Minister unless and until it has been approved by the House of Commons and in most cases also the House of Lords. Alternatively, delegated legislation may be subject to an 'urgent' 'made affirmative' procedure, whereby it is laid before Parliament after it has been made – signed – into law by the Minister but cannot remain law unless it is approved by the House of Commons and in most cases also the House of Lords within a statutory period – usually 28 or 40 days.

Delegated legislation (also known as secondary or subordinate legislation): Law made by Ministers (and sometimes other authorised individuals and bodies) under delegated powers deriving from Acts of Parliament. Statutory Instruments (SIs) are the most common form of delegated legislation. Orders and Regulations are among the categories of delegated legislation enacted in SIs.

Delegated powers: Powers conferred on Ministers (and sometimes other authorised individuals and bodies) in Acts of Parliament to make delegated legislation

Delegated Powers Memorandum (DPM): The document produced by the relevant government department identifying every delegated power in a bill, its justification, and the parliamentary scrutiny procedure that is proposed for it. The DPM is published when the relevant bill is introduced and is scrutinised by the House of Lords Delegated Powers and Regulatory Reform Committee (DPRRC).

Delegated Powers and Regulatory Reform Committee (DPRRC): Select committee appointed by the House of Lords to examine almost all bills on their introduction to the House in order to determine whether they contain any inappropriate delegation of power or subjects those powers to an inappropriate level of scrutiny.

Henry VIII power: A delegated power that enables Ministers to amend or repeal primary legislation by delegated legislation

Negative procedure: Parliamentary scrutiny procedure under which the measure concerned does not require active parliamentary approval. Under the 'made negative' procedure, a piece of delegated legislation is laid before Parliament after it has been made – signed – into law by the Minister but it may be annulled if a motion to do so – known as a 'prayer' – is passed by either House within 40 days of it being laid before Parliament. A small share of delegated legislation is subject to the 'draft negative' procedure, whereby delegated legislation is laid in draft and cannot be made into law if the draft is disapproved within 40 days.

Statutory Instruments (SIs): The most common form of delegated legislation. The term 'Statutory Instrument' was given to most, but not all, form of delegated legislation made after the Statutory Instruments Act 1946 came into force in 1948.

Strengthened scrutiny procedure: A higher level of parliamentary scrutiny than the affirmative procedure. This is usually reserved for the exercise of significant powers that are conferred on a Minister to amend primary legislation. It involves scrutiny by a designated committee(s) and can include, among other possible required elements, statutory consultation and even a committee veto. Examples include 'enhanced affirmative' and 'super-affirmative' procedures.

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