These notes refer to the Health and Social Care Act 2001 (c.15) which received Royal Assent on 11 May 2001

HEALTH AND SOCIAL CARE ACT 2001

EXPLANATORY NOTES

COMMENTARY ON SECTIONS

Part 1: National Health Service

Health Service Funding

Section 1: Determination of allotments to and resource limits for Health Authorities and Primary Care Trusts

20. *Section 1* changes the way in which resources are allocated between Health Authorities ("HAs") by the Secretary of State and between Primary Care Trusts ("PCTs") by HAs.

21. When distributing the resource and cash limited elements the Secretary of State and the National Assembly for Wales (for HAs) and HAs (for PCTs) may take into account how much is being spent on the non-resource and non-cash limited family practitioner services. Those who are spending more than their fair share on these services may get a smaller increase for their other services. Conversely if they are spending less than their fair share they can be given a larger increase. This monetary device will have the effect of supporting action taken to increase the number of GPs in under-doctored areas.

22. *Section 1* provides for changes to the way in which unified allocations – which are cash limited – are made to HAs and PCTs. This provision will allow the Secretary of State and the National Assembly for Wales and HAs to take account of general Part 2 expenditure (non cash limited expenditure on family health services) when making decisions about unified allocations. In the first instance the intention is to take into account only the general Part 2 expenditure on general medical services (GMSNCL). It is envisaged that the power will be exercised so as to make larger increases in the unified allocations of areas which are " under- doctored" than if GMSNCL was not taken into account; and to make smaller increases in the unified allocations of areas which are "over-doctored" than if GMSNCL was not taken into account. It will also provide a financial mechanism for regulating the number of doctors in a Health Authority area (the abolition of the Medical Practices Committee – see *sections 14 and 15* - will mean that HAs will become responsible for declaring GP vacancies).

23. The Department has asked the Advisory Committee on Resource Allocation to devise a new funding formula for GMSNCL expenditure. Using this new formula in conjunction with the existing formula for HA and PCT unified allocations will allow the Department to determine targets, or "fair shares" of available resources for an area covering both unified allocations and GMSNCL. But changes to funding will only be made to unified allocations. Health Authority and Primary Care Trust unified allocations will move towards this overall target level over time (e.g. if the Health Authority is over target it will receive lower funding growth than if it was under target). While these changes will see resources for under doctored areas grow more quickly than the resources for over doctored areas, they will not lead to the cash limiting of Part 2 general expenditure or change the entitlement of primary care practitioners.

24. The statutory provision dealing with the public funding of Health Authorities is section 97 of the National Health Service Act 1977 (the "1977 Act"). Health Authorities are paid money in each year by the Secretary of State under section 97(1) and (3). Section 97(1) concerns the remuneration of persons providing services under Part 2 of the 1977 Act (for example, General Medical Practitioners). Unless such remuneration is excepted from section 97(1), it is not cash limited. The Secretary of State is under a duty to pay each Health Authority the cost of such remuneration, and cannot impose a ceiling on such expenditure (defined as "general Part 2 expenditure" in paragraph 1 of Schedule 12A to the 1977 Act). Section 97(3) provides that the Secretary of State must pay to each Health Authority money not exceeding the amount allotted to it by the Secretary of State. This amount is allotted towards meeting an Authority's "main expenditure" (defined in paragraph 2 of Schedule 12A to the 1977 Act). In the case of a Health Authority this includes all expenditure attributable to the performance of their functions in relation to the provision of hospital-based and community health services, all their administrative costs, the costs of drugs attributed to them by the Secretary of State and certain other expenditure. The amount allotted constitutes a limit on the cash which may be spent by the Authority.

25. Health Authorities are under similar obligations to provide funds to Primary Care Trusts. Each Primary Care Trust is established for an area contained within the area of a Health Authority. Under section 97C, each year the Health Authority must pay each of its Primary Care Trusts (a) the cost of general Part 2 expenditure incurred by the trust and (b) money not exceeding the amount allotted by the Authority for that year towards meeting main expenditure. As with the allotments to Health Authorities, the amount allotted to each Primary Care Trust covers all expenditure attributable to the performance of their functions in relation to the provision of hospital-based and community health services, all their administrative costs and the costs of drugs attributed to them by the Secretary of State. The amount allotted constitutes a limit on the cash which may be spent by the Authority.

26. *Subsection (2)* inserts a new subsection (3AA) into section 97 of the 1977 Act. This allows the Secretary of State to take account of expenditure attributable to the remuneration paid to Part 2 practitioners in the Health Authority area in determining the amount to be allotted to the Health Authority. Subsection (4) inserts a new subsection (1A) into section 97C of the 1977 Act. This allows a Health Authority to take account of the distribution within their area of expenditure attributable to the remuneration paid to Part 2 practitioners in determining the amount to be allotted to each of its Primary Care Trusts.

27. The Government Resources and Accounts Act 2000 inserts two new sections into the 1977 Act (sections 97AA and 97E). These new sections provide for the setting of resource limits for every Health Authority and Primary Care Trust in addition to cash limits. Section 97AA concerns resource limits for Health Authorities; section 97E concerns resource limits for Primary Care Trusts. Section 97AA(2) provides for general Part 2 expenditure to be excluded from the resource limit.

28. *Subsection (3)* inserts a new subsection (2A) into section 97AA of the 1977 Act. This allows the Secretary of State to take account of general Part 2 expenditure in setting the resource limits for Health Authorities, mirroring the new subsection (3AA) of section 97 which allows the Secretary of State to take account of general Part 2 expenditure in determining the amount to be allotted to a Health Authority.

29. *Subsection (5)* inserts a new subsection (2A) of section 97E into the 1977 Act. This allows a Health Authority to take account of the distribution within their area of general Part II expenditure in setting the resource limits for its Primary Care Trusts, mirroring the new subsection (1A) of section 97C which allows the Health Authority to take account of the distribution within their area of general Part 2 expenditure in determining the amount to be allotted to each of its Primary Care Trusts.

Section 2: Payments relating to past performance

30. *Section 2* amends the existing provisions of section 97 of the 1977 Act which enable the Secretary of State and the National Assembly for Wales to increase the initial allocation each of them makes to a Health Authority, where that Authority has satisfied certain conditions. This enables the Secretary of State to make payments to Health Authorities based on their past performance. The existing section 97(3C) provides that the Secretary of State may make such increases where a Health Authority has in any preceding year satisfied objectives which have been notified to Health Authorities in advance.

31. The new subsection (3C) enables the Secretary of State and the National Assembly for Wales to increase an Authority's allocation not only where it has satisfied objectives, but also where it has performed well against performance criteria. The Secretary of State must notify the Authority of such criteria in advance, although he might not notify them in advance of the exact method by which performance will be measured. This would enable the Secretary of State to make additional payments to Health Authorities on the basis of their performance relative to other Authorities (against criteria notified to them in advance) in addition to them meeting particular objectives. For example, he may need to wait until he knows how well NHS bodies have performed against specific measures in the previous year before he is able to finalise the best method of measuring their performance in the coming year. However, the Secretary of State would need to inform Authorities in advance of the criteria against which their performance would be measured if he intended to make additional payments to Authorities on this basis.

32. Under the existing section 97(3C), the Secretary of State and the National Assembly for Wales can only make increases to Health Authority allocations based on performance in preceding financial years. The new subsection (3C) enables the Secretary of State to make such increases on the basis of performance over a period which has been notified to the Authority in advance, whether it consists of, or any part of, a preceding year or any part of the current financial year.

33. *Section 2(3)* amends section 97(3D), which provides that a Health Authority is notified of an objective, if the objective is specified or referred to in a notice given to Health Authorities by the Secretary of State. The amendment means that the Secretary of State may specify or refer to objectives, criteria or periods in a notice given to an individual Health Authority, rather than a notice to all Authorities.

34. It is intended that the NHS Performance Fund will be allocated according to a traffic light system to underpin a system of earned autonomy. "Green" organisations will have access to their share of the National Performance Fund as of right. "Yellow" Health Authorities, NHS trusts and Primary Care Groups/Trusts will be required to agree plans, signed off by the regional office, setting out how they will use their share of the fund. "Red" organisations will have their share of the fund held by the new Modernisation Agency. They will get their fair share of extra funds but the Agency will oversee spending.

Section 3: Supplementary payments to NHS trusts and Primary Care Trusts

35. *Section 3* enables the Secretary of State and the National Assembly for Wales to make payments direct to NHS trusts and Primary Care Trusts, outside the existing arrangements for funding such bodies. In particular it enables payments to be made to NHS trusts other than under NHS contracts and to Primary Care Trusts other than under NHS contracts or the provisions of section 97C of the 1977 Act (Health Authority allocations to Primary Care Trusts). This will facilitate direct payments to NHS trusts and Primary Care Trusts.

36. These supplementary payments may be made through Health Authorities rather than direct to trusts. Under section 16C of the 1977 Act (as inserted by section 12 of the Health Act 1999), the Secretary of State may direct Health Authorities to exercise his powers under the new paragraph 5A of Schedule 3 to the 1990 Act (NHS trusts) and/or

section 97C(5A) of the 1977 Act (Primary Care Trusts). The Secretary of State would be able to control how Health Authorities made these supplementary payments to trusts by giving directions under section 17 of the 1977 Act.

37. Under current arrangements, the Secretary of State for Health makes allocations to Health Authorities under section 97 of the 1977 Act. He can direct that particular sums must be applied for the purpose of making payments to NHS trusts, but such payments are then made under "service level agreements" (i.e. NHS contracts). In relation to Primary Care Trusts, if the Secretary of State attaches conditions as to how sums are to be spent when allocating an amount to a Health Authority, the Health Authority can attach those conditions when allocating part of that amount to a Primary Care Trust (see section 97C(5) of the 1977 Act).

38. These existing arrangements may not be appropriate for supplementary payments to NHS trusts and Primary Care Trusts, for example where the Secretary of State wishes to make payments to trusts specifically for rewarding their staff performance and/or improving facilities. The section is intended to provide for a more efficient resource allocation route to NHS trusts and Primary Care Trusts for such supplementary payments, that will exist alongside income from NHS contracts or in the case of Primary Care Trusts, Health Authority allocations.

Section 4: Public-Private Partnerships

39. This section will insert a new section 96C into the 1977 Act to provide for the Secretary of State and the National Assembly for Wales to participate in public-private partnerships with companies that provide facilities or services to persons or bodies carrying out NHS functions. As with various other powers of the Secretary of State under the 1977 Act, these new powers could be delegated to Health Authorities, and through them to Primary Care Trusts, and to Special Health Authorities. The intended first use of this new power is the establishment of NHS LIFT (NHS Local Improvement Finance Trust) which will be set up to invest in primary care premises.

40. Subsection (1) of the new section 96C provides for the Secretary of State to form or participate in forming companies to provide facilities or services to:

— any person or body providing services, or exercising functions, under the 1977 Act;

— NHS trusts (which exercise functions under the NHS and Community Care Act 1990).

41. Subsection (2) provides that the Secretary of State may invest in companies providing such facilities or services or provide loans or guarantees or make other financial provision.

42. Subsection (3) provides that the powers are exercisable irrespective of whether the company also provides facilities or services to other persons or bodies or to persons or bodies, for example pharmacists, whose activities are not solely confined to the NHS.

43. Subsection (5) makes it clear that the inclusion of section 96C is without prejudice to any other powers of the Secretary of State.

Section 5: Income Generation

44. The purpose of this section is to enable the Secretary of State and the National Assembly for Wales and other NHS bodies exercising "income generation" powers under section 7 of the Health and Medicines Act 1988 to form, invest in and otherwise make financial provision in relation to companies. Section 7 of the 1988 Act confers powers under which the Secretary of State and the National Assembly for Wales may carry out a wide range of commercial activities, such as the supply of goods and services and the exploitation of intellectual property, in order to increase the funds available for

improving the health service . This is subject to the proviso that such activities do not interfere with the performance of any duties under the 1977 Act or operate to the disadvantage of patients. The Secretary of State may authorise bodies established under the 1977 Act to exercise these powers subject to any directions he might give. NHS trusts are given the same income generation powers by virtue of paragraph 15 of Schedule 2 to the NHS and Community Care Act 1990.

45. Subsection (7A) would be inserted into section 7 of the 1988 Act so as to provide for the formation of, investment in and making of financial provision in relation to companies where that was calculated to facilitate, or be conducive, or incidental to, the exercise of income generation powers.

46. Subsection (7B) defines "companies" and makes clear that the inclusion of the new subsection would be without prejudice to any other powers of the Secretary of State.

Terms of employment of health service employees

Section 6: Terms and conditions of employment by certain health service bodies

47. This section provides for the Secretary of State and the National Assembly for Wales to make regulations and give directions to certain health service bodies about the terms and conditions on which they employ staff and generally in connection with matters concerning the employment of staff. The NHS Plan makes a commitment to modernisation of the NHS pay system to deliver better, fairer awards for staff. This new power is designed to ensure that NHS bodies implement changes to terms and conditions of staff approved by the Secretary of State.

48. *Subsection (1)* amends paragraph 10(1) of Schedule 5 to the 1977 Act to provide for Health Authorities and Special Health Authorities to pay their officers such remuneration and allowances, and employ them on such other terms and conditions, as they may determine subject to any regulations made or directions given by the Secretary of State or the National Assembly for Wales. Paragraph 10(1) is also amended to provide for regulations or directions to make provision with respect to any matter connected with the employment of an Authority's officers. *Subsection (2)* replaces paragraphs 8 and 11(2) of Schedule 5A to the 1977 Act to the effect that Primary Care Trusts may pay their officers such remuneration and allowances, and employ them on such other terms and conditions, as they think fit but subject to regulations or directions by the Secretary of State or the National Assembly for Wales about those matters or otherwise in connection with the employment of such officers . Before making any such regulations the Secretary of State or the National Assembly for Wales are required to consult representative bodies. *Subsection (3)* makes similar provision in relation to NHS trusts.

Scrutiny of Health Service provision, Patient and Public involvement and Independent Advocacy – Background

49. The Government believes that patients and the public should have a much greater role in the development and operation of the NHS. Chapter 10 of the NHS Plan set out the Government's proposals for enhancing patient and public influence and for introducing local democratic scrutiny of the NHS through local authority overview and scrutiny committees.

50. *Sections 7 – 12* make provision for this strengthened patient and public consultation and involvement in the operation of the NHS. Local authority overview and scrutiny committees will scrutinise the NHS including decisions on NHS reorganisations and service change. Independent complaint advocacy services will be provided across the country to assist patients in making complaints about health services. NHS bodies will have a statutory duty to make arrangements with a view to securing that the public are involved in and consulted on the planning of NHS services and decisions affecting the operation of those services.

51. The new arrangements are to be complemented by a new non-statutory arrangement, Patient Advocacy and Liaison Services (PALS). PALs will be new trust-based services able to assist and support patients. They will be able to provide information and resolve problems and difficulties. It is intended that they will be situated in or near main reception areas of hospitals and act as a welcoming point for patients and carers. The PALS will also advise patients on how to access independent advocacy to support their complaints.

Local Authority Scrutiny of Health Service Provision

Section 7: Functions of overview and scrutiny committees

52. This section provides for local authority overview and scrutiny committees to exercise new functions in relation to the NHS and NHS bodies. In particular, it enables such a committee to review and scrutinise the operation of the health service in its area.

53. Local authority overview and scrutiny committees (OSCs) are to be established under section 21 of the Local Government Act 2000. These committees are part of the arrangements for local authorities under Part II of that Act. Under these arrangements, local authorities may establish an executive to perform particular functions and to implement the plans and policies approved by the authority. The executive may take one of four forms –

- an elected mayor and cabinet executive consisting of 2 or more councillors;
- a council leader and cabinet executive consisting of 2 or more councillors;
- an elected mayor and an officer of the authority appointed as the council manager;
- such other form as may be prescribed in regulations made by the Secretary of State.

54. An overview and scrutiny committee is a committee of the authority made up of councillors who are not members of the executive. The committee's functions are to review and scrutinise the decisions and other actions of the executive or the authority itself, and to make reports or recommendations to the authority or executive with respect to the discharge of functions by the executive or authority. In addition, the committee may make reports and recommendations to the authority or executive on matters which affect the authority's area or its inhabitants.

55. *Subsection (1)* confers on some of these committees the additional functions of reviewing and scrutinising health service matters and making reports and recommendations to NHS bodies on such matters. These functions will not be conferred on all overview and scrutiny committees; the provisions only apply to committees of county councils, county borough councils in Wales, unitary authorities and London borough councils (see *subsection (2)*). These are the authorities that also hold responsibility for social services. District Councils will be able to contribute to the scrutiny of the NHS through joint arrangements with the authorities set out above (see s*ection 8*).

56. The detail of how the committees are to operate and the matters which they may review and scrutinise are to be set out in regulations under *subsection (3)*. HAs would be required to consult OSCs on major service changes and Chief Executives of local NHS bodies will be required to attend OSC meetings at least twice a year. It is intended that overview and scrutiny committee functions will include referring contested proposals for major service changes to the Secretary of State on the grounds of process and merit. A new Independent Reconfiguration Panel is being established to advise the Secretary of State on proposals referred to him in this way and its membership will include clinicians, patient representatives and NHS managers.

57. OSCs will scrutinise not only health services, but also social care services provided or commissioned by NHS bodies exercising local authority functions under arrangements

under section 31 of the Health Act 1999 (*see subsection (5)*). OSCs may scrutinise local authority social services under the existing provisions of the Local Government Act 2000.

Section 8: Joint overview and scrutiny committees etc

58. This section allows the Secretary of State (or, in relation to Wales, the National Assembly for Wales) to make regulations which provide for joint overview and scrutiny committees of two or more local authorities; it allows for a number of different options. It enables the Secretary of State and the Assembly to make regulations providing for local authorities to form joint OSCs, for a local authority to delegate the NHS functions of their OSC to an OSC of another local authority, and for district council OSC members to be co-opted on to county council OSCs as voting members.

59. *Subsection (2)(a)* allows for two or more authorities, which can include district councils, to form a single overview and scrutiny committee to scrutinise health organisations. Where a district council joins with a county council, the scrutiny is the county council's responsibility, and the county council will therefore remain in the lead. These joint arrangements may also include local authorities operating "alternative arrangements" under regulations under section 32 of the Local Government Act 2000. "Alternative arrangements" do not involve the creation of an executive for the authority, but they will provide for the establishment of a committee to undertake scrutiny functions similar to those carried out by an overview and scrutiny committee under section 21 of the Local Government Act 2000.

60. *Subsection (2)(b)* provides for two or more authorities whose OSCs have responsibility to scrutinise the NHS to give the lead to one OSC so that it exercises the others' functions in relation to health scrutiny. Under this provision, a county council and district council could arrange for the district OSC to undertake the county council OSC's responsibility of scrutinising health services in the district. This approach may be appropriate where a localised service is being considered, for example a particular PCT.

61. *Subsection (2)(c)* provides for a county council to co-opt one or more district council OSC members onto its own OSC; the county council may also co-opt district council OSC members when that county is part of a joint scheme with another OSC.

62. *Subsection (3)* allows regulations relating to the joint arrangements to set out the circumstances and conditions under which joint schemes can be established. District council involvement in the joint scheme arrangements will be set out in regulations; the lead will always be with local social services authorities. Regulations and directions may also under *subsection (4)* provide for the circumstances where authorities will be required to put in place joint scheme arrangements.

63. The regulations that relate to the normal arrangements for scrutiny and review of the NHS by OSCs will also apply to the scrutiny and review of the NHS where there is a joint scheme in operation.

Section 9: Overview and scrutiny committees: exempt information

64. As local authority committees, overview and scrutiny committees are subject to section 100A of the Local Government Act 1972, which provides that councils and their committees must be open to the public except to the extent that they must be excluded under section 100A(2) (where certain confidential information may be disclosed) or may be excluded under section 100A(4) (exclusion by resolution of the council or committee, if certain "exempt information" may be disclosed). The categories of exempt information are set out in Schedule 12A to the 1972 Act. *Section 9(2)* of, and *Schedule 1* to, the Act extend the categories of exempt information, where an overview and scrutiny committee is dealing with NHS matters. As with the categories of exempt

information in the 1972 Act, the Secretary of State may add to, or remove provisions or otherwise amend the list by making an order (s*ection 9(4) and (5)*).

Section 10: Application to the City of London

65. The Local Government Act 2000 does not provide for the Common Council of the City of London (the local authority for the City) to establish an overview and scrutiny committee. This section makes it possible for the Common Council of the City of London to set up a committee which mirrors the functions of the overview and scrutiny committees in relation to the scrutiny of the NHS. *Subsection (2)* applies sections 7(3) to (5) and 8 and 9 and Schedule 1 to the committee that is set up. *Subsection (3)* of *section 10* applies the provisions of section 21 of the Local Government Act 2000 (overview and scrutiny committees) to a scrutiny committee established by the Common Council, with modifications to reflect the fact that the Common Council will not have an executive under Part 2 of that Act.

Public involvement and consultation

Section 11: Public involvement and consultation.

66. *Section 11* confers on each Health Authority, Primary Care Trust and NHS trust a new statutory duty to make arrangements with the aim of involving patients and the public in the planning and decision making processes of that body, in so far as they affect the operation of the health services for which the body is responsible. In relation to Health Authorities, this would cover both the hospital and community health services for which they are responsible and the family health services provided by practitioners in their area.

Independent advocacy services

Section 12: Independent advocacy services

67. *Section 12* imposes a new duty on the Secretary of State to arrange independent advocacy services for people who wish to complain about the service they or someone they care for has received from the NHS. Advocacy is to be independent, so far as practicable, by being provided by a person or body other than the person or body against which the complaint is being made, or the person or body investigation or adjudicating the complaint (see *subsection (5)*).

68. PALS will play an important role in informing patients of the availability of independent advocacy services and how to access them. However PALS will not control access to independent advocacy, and patients will be able to access them directly. Independent advocacy services in each area could be commissioned and/or provided by the local authority (under section 2 of the Local Government Act 2000) or by other persons or bodies.

69. Under *subsection (2)* independent advocacy services will be made available when a complaint is being made using the hospitals complaints procedures or when complaining to the Health Service Commissioner for England or Health Service Commissioner for Wales. The Secretary of State may by regulations extend the scope of the procedures covered by the advocacy service. A possible extension could be complaints made to one of the regulating professional bodies (e.g. General Medical Council), or which give rise to disciplinary proceedings against a member of staff. *Subsection (4)* allows the Secretary of State to further extend these arrangements as he sees necessary to provide assistance to individuals in connection with complaints about health services.

Intervention powers

Section 13: Intervention orders

70. Management of the NHS will move to a system of earned autonomy. Good performance will be rewarded and failure tackled swiftly and effectively. *Section 2* provides for the performance payments that will help underpin this new system. *Section 13* provides for new intervention powers to provide a sanction against the most serious and persistent failures. Early identification of poor performance through performance management and the new Traffic light system, backed up by support from the NHS Executive Regional Office and the Modernisation Agency should mean that performance can be improved in most cases without resorting to formal intervention orders.

71. The purpose of this section is to enable the Secretary of State to intervene in an NHS body (Health Authorities, Special Health Authorities, Primary Care Trusts and NHS trusts) where he has concerns about the management of that body, its ability to perform its functions adequately (for example, to deliver health care to the required standard) or where there has been a one off catastrophe . This new power will complement the performance fund in delivering the NHS Plan commitment to drive up performance in the NHS.

72. *Section 13* inserts new sections 84A and 84B into the 1977 Act. Section 84A enables the Secretary of State to make an intervention order in respect of a Health Authority, Special Health Authority, NHS trust or Primary Care Trust. *Subsection (1)* sets out the test that must be satisfied before he may intervene using such an order. The test would enable the Secretary of State to intervene if he was satisfied, for example, that an NHS trust was failing to provide health services to an adequate standard. The Secretary of State would however not be restricted to intervening where there was a failure to provide adequate health services; he might also intervene where the body concerned is not being properly administered or managed. The Secretary of State must also be satisfied that the form of intervention provided for under these new provisions is appropriate; for example, he may be satisfied that temporarily replacing the board of an NHS trust, is the appropriate way to ensure that the body's performance is substantially improved.

73. Section 84B sets out the effect of an intervention order and the different forms the intervention may take. The first form of intervention (*subsections (2) and (3)*) is that members of the body concerned (i.e. the members of Health Authorities, Special Health Authorities and Primary Care Trusts, and the Chairman and directors of NHS trusts) may be suspended or removed from office, and new individuals appointed in their place. The members of a body are responsible for how that body is managed; by replacing existing members with the new members, it will enable changes to be made in the way an individual body is managed. Under these provisions, the Secretary of State has a wide range of options: he may remove all the members, or only some; he may suspend members from all their board duties, or only in respect of some duties.

74. The second form of intervention (*subsection (5)*) will enable the Secretary of State to require an NHS body to make arrangements for some other person or body to perform that NHS body's functions. Alternative expressions of interest will be selected from an approved list. Although the functions were performed by that other person or body, the NHS body would remain legally responsible for that functions – for example, an NHS trust would retain overall responsibility for managing its hospital and providing services. The Secretary of State may also direct how functions are to be performed so as to achieve particular objectives. These two forms of intervention may be combined (see section 84A(3)).

75. Sections 84B(7) and (8) provide that the Secretary of State's intervention order may disapply or modify any legislative provision relating to the membership or procedure of the body subject to intervention. The purpose is to ensure that the intervention can operate effectively where the Secretary of State removes or suspends board members, and substitutes replacements. The replacements need not be the same number as those

replaced. The nature of intervention is that it must be prompt and that the Secretary of State must be able to adapt the intervention to the particular local circumstances; it may not be practicable or appropriate to find an identical number of replacements. If the number of members is different, the existing rules which govern the number of members the body must have, or about the numbers of members which must be present at the meetings of the body, may be inconsistent with the new membership arrangements implemented by an intervention order. In addition, as the method of appointing those replacements and the length of time they remain in office are to be determined by the intervention order, the rules about appointment of members and tenure of office may require modification. The Secretary of State will only be able to disapply or modify provisions about membership or procedure, and will be able to do so only where he considers that it is appropriate (for example, in order to ensure the intervention order operates effectively). The provision for disapplying or modifying provisions will be limited to the particular body concerned and to the period during which the intervention order is in force.

76. Section 84B(9) allows the Secretary of State to include in the order supplementary directions to give full effect to an intervention. He may wish to make more specific directions about how the intervention should work. For example, he may wish to ensure that the body makes staff or other assistance available to the replacement members or the third party to which functions have been delegated. These directions are akin to the directions which the Secretary of State may give to NHS bodies under section 17 of the 1977 Act.

77. *Section 20(2)* provides that intervention orders under these provisions are not statutory instruments.

Abolition of Medical Practices Committee and National Health Service Tribunal

Section 14: Abolition of Medical Practices Committee

78. *Section 14* abolishes the Medical Practices Committee ("MPC"). (*Section 15* transfers the function of declaring GP vacancies to Health Authorities). This section should be considered alongside *section 1*, which provides for Health Authority allocations to be determined with reference to both their general allocations and Part 2 general expenditure in their area. This is intended to provide a new resource based method of control over the distribution of GPs and is intended to ensure that Health Authorities with a shortage of GPs will now be given sufficient allocations to attract more GPs. The result of this is intended to be a more equitable distribution of GPs.

79. The MPC is constituted under sections 7 and 34 of the 1977 Act. Its main function is to control the distribution of the general practitioner workforce in England and Wales. Essentially it controls the numbers of general medical practitioners wishing to provide GMS in Health Authority areas. This function will be taken on by Health Authorities , so *Section 14* provides for the abolition of the MPC. Sections 7 and 34 of the 1977 Act are therefore repealed in Schedule 6 to the Act.

80. *Subsection (2)* provides for the transfer to the Secretary of State of all property, rights and liabilities relating to the MPC including certification regarding the sale of medical practices. This includes certification relating to the sale of goodwill.

Section 15: Vacancies for medical practitioners

81. *Section 15* provides for regulations enabling Health Authorities to determine the existence, and filling, of vacancies in their area for GPs under GMS and requiring them to undertake consultation before making their determinations.

82. *Subsection (3)* provides for a right of appeal against a decision of a Health Authority as to how a vacancy is to be filled to the Family Health Services Appeal Authority. The existing right of appeal is to the Secretary of State.

83. *Section 15* alongside s*ection 1* provides for a new method of controlling the distribution of GPs. Health Authorities will have the power to declare vacancies under GMS, but GMS expenditure within the Health Authority area will be taken into account when determining the allocation of funds to that Health Authority. This is expected to lead to a more equitable distribution of GPs and health resources.

Section 16: Abolition of NHS Tribunal

84. *Sections 20 to 26* introduce a new system whereby all practitioners working in family health services will be required to be on the list of a Health Authority and for decisions about the removal and suspension of such practitioners from these lists to be taken by Health Authorities. The aim is that this will lead to faster and more effective decisions being taken where there are doubts about the ability of a practitioner to practise. Consequentially, the NHS Tribunal will no longer be needed. *Section 16* provides for the NHS Tribunal to be abolished. Sections 46 to 49E of, and Schedule 9 to the 1977 Act (which relate to its constitution and functions) are repealed in Schedule 6 to this Act.

General and personal medical services, general dental services, general ophthalmic services and pharmaceutical services

Section 17: Remuneration of General Medical Practitioners

85. *Section 17* ends the requirement under section 29(4) of the 1977 Act that the remuneration paid to GPs must not, except in special circumstances, consist wholly or mainly of a salary which has no reference to the number of patients to whom the GP has undertaken to provide services under General Medical Services ("GMS").

Section 18: Out of hours medical services

86. GPs undertake 24 hour responsibility for patients. GPs may discharge this in a number of ways: by providing the service personally; in a rota with other practices; by joining a GP co-operative; by employing a commercial deputising service established for the purpose of providing an out-of-hours service for GPs; or a combination of two or more of these.

87. *Section 18* provides powers to regulate the provision of out-of-hours services. The body to be regulated is any person or persons providing out-of-hours cover to GPs that will have to be accredited by a Health Authority. Accreditation is intended to ensure the delivery of out-of-hours GP patient care to consistent high quality standards. This was recommended in the independent Report *Raising Standards for Patients, New Partnerships in Out of Hours Care* which considered how consistent high quality services could be made available across the country. Concern had also been expressed by the Health Services Commissioner (the "Ombudsman") about the quality and responsiveness of out-of-hours services provided in some areas.

88. Regulations may specify those who are to be accredited under the regulations, the procedure for applying for accreditation, any conditions with which accredited bodies must comply and the transfer of liability from the GP to the out of hours service provider. They may also provide for the withdrawal or suspension of approval by Health Authorities as well as the criteria to be used in making decisions under the regulations.

89. Once this section has come into force, existing powers under the 1977 Act and the 1997 Act will be used to effect consequential changes to the Terms and Conditions of Service for GPs and to the Directions for the Implementation of Personal Medical Services to ensure that GPs use only accredited providers of out-of-hours services.

Section 19: Enhanced criminal record certificates

90. Health Authorities are currently required by Part 2 of the 1977 Act to maintain lists of all practitioners who undertake to provide general medical services (GMS), general dental

services (GDS), general ophthalmic services (GOS) and pharmaceutical services (PhS) in their area. *Sections 24* and *26* of this Act extend this list system to cover those who assist in the provision of these primary care services (e.g. deputies or locums) as well as those practitioners performing personal medical services (PMS) or personal dental services (PDS). To remain on a list, or be admitted to it, the intention is that persons will have to declare any criminal convictions, bindings-over following a criminal conviction and cautions. In requiring a practitioner to declare his criminal conviction, Health Authorities will need to take steps to verify the information that they are given. The Home Office's new Criminal Records Bureau (CRB) set up under Part 5 of the Police Act 1977 will assist in the provision of criminal record checks.

91. The policy is that Health Authorities should have the fullest possible report from the CRB to ensure maximum protection for the public. Health Authorities can already be provided with standard criminal conviction or criminal record certificates under section 112 and 113 of the Police Act 1977. *Section 19* amends the Police Act 1997 to also enable Health Authorities to have access to enhanced criminal record certificates under section 115 of that Act. These are certificates, which will involve an extra layer of checking with local police records. Such enhanced disclosures are presently required for posts involving significant contact with children and vulnerable adults.

92. *Subsection (2)* of this section amends the Police Act 1977 to provide that section 115 certificates may be made available for those practitioners identified in new *subsections (6C), (6D)* and *(6E)*.

93. *Subsection (3)* of the section inserts *subsections (6C), (6D) and (6E)* into section 115 of the Police Act 1977. New *subsection (6C)* covers those practitioners included or seeking inclusion in the main GMS, GDS, GOS or PhS lists. *Subsection (6D)* covers directors of bodies corporate included or seeking inclusion in a main GDS or GOS list, members of limited liability partnerships included or seeking inclusion in a GOS list and a member of the body of persons controlling a body corporate included or seeking inclusion in a PhS list.

94. New *subsection (6E)* covers individuals included or seeking inclusion in a supplementary list (of, for example, deputies or locums) or services list (of those who may perform Personal Medical Services/Personal Dental Services). It also covers individuals seeking inclusion in service lists of people providing Local Pharmaceutical Services, should such lists be established by virtue of regulations made under s*ection 41* of this Act.

Section 20: Medical, dental, ophthalmic and pharmaceutical lists etc.

95. As indicated in the notes on s*ection 19*, Health Authorities are already required by Part 2 of the 1977 Act to maintain lists of all practitioners who provide GMS, GDS, GOS and PhS in their area. These are known respectively as the medical, dental, ophthalmic and pharmaceutical lists. *Section 20* provides new powers for Health Authorities to refuse a practitioner admission to the appropriate list on the grounds of unsuitability, prejudice to efficiency or because of previous fraudulent behaviour.

96. *Subsection (2)* amends section 29A of the 1977 Act to provide for regulations requiring practitioners already included in the medical list to provide the Health Authority information of a prescribed description as well as criminal conviction or criminal record certificates under sections 112, 113 or 115 of the Police Act 1977.

97. *Subsection (3)(a)* amends section 29B of the 1977 Act to provide for regulations specifying when Health Authorities may, or must, refuse an application from a medical practitioner to fill a vacancy: for example, because the applicant is considered to be unsuitable to work in the provision of general medical services, because it is considered that the applicant's inclusion in the list would be prejudicial to the efficiency of the service or because of the risk of the applicant's fraudulent behaviour. It further allows regulations to be made specifying the information which an applicant must provide

(or arrange to be provided) in support of the application, including the supply of a certificate provided under sections 112, 113 or 115 of the Police Act 1997. Regulations may provide for the disclosure by Health Authorities to prescribed persons of specified information about persons applying for inclusion in the medical list as well as refusals of such applications.

98. *Subsection (3)(b)* provides for the regulations to specify when a Health Authority may defer a decision to nominate or approve a medical practitioner for appointment to fill a vacancy.

99. *Subsection (3)(c)* provides for a right of appeal, by re-determination, to the Family Health Services Appeal Authority (FHSAA) against a decision by a Health Authority under its discretionary powers.

100. *Subsections (4), (5), (6) and (7)* provide for similar regulatory powers in respect of practitioners included, or applying for inclusion in, dental, ophthalmic, pharmaceutical and dispensing doctor lists.

Section 21: Conditional inclusion in medical, dental, ophthalmic and pharmaceutical lists

101. *Section 21* inserts new section 43ZA into the 1977 Act. *Subsection (1)* of the new section provides powers to make regulations providing for a person's inclusion in a GMS, GDS, GOS or PhS list to be subject to conditions determined by the Health Authority; for the Health Authority to vary the conditions or impose new ones and for the consequences of a practitioner failing to comply with a condition, which could include removal from a list.

102. *Subsection (2)* requires that the imposition of conditions must relate to preventing any prejudice to the efficiency of the service or preventing any fraudulent acts.

103. *Subsection (4)(a*) provides that if the regulations provide for a practitioner's removal from a list for breach of condition, the regulations may also prevent the practitioner from withdrawing from the list whilst the Health Authority are investigating in order to see whether there are grounds for removal, or after the Health Authority have made the decision to remove the practitioner but before they have given effect to that decision. *Subsection (4)(b*) requires the regulations to include provision for a practitioner to be given notice of any allegations against him; for him to put his case at a hearing before a Health Authority makes a decision , and for him to be informed of a Health Authority's decision, the reasons for it and his right of appeal.

104. *Subsection (5*) requires the regulations to provide for a right of appeal to the FHSAA against a Health Authority's decision to impose conditions, to vary a condition, to vary terms of service or to remove a person from a list for a breach of a condition. The regulations may provide for a Health Authority decision not to have effect until the FHSAA has determined the appeal (and must do so in relation to a decision to remove the person from a list).

105. *Subsection (7*) provides that regulations may provide for a Health Authority to notify prescribed persons or persons of prescribed descriptions of any decisions they make to conditionally include practitioners in a list or remove such persons from a list for breach of condition. They may also supply any related information.

Section 22: Dental Corporations

106. *Section 22* enables Health Authorities to make arrangements with dental corporate bodies to provide GDS as well as with individual dental practitioners.

107. *Subsection (2)* amends section 35 of the 1977 Act to make provision for Health Authorities to arrange for the provision of GDS by dental corporations as well as dental practitioners. *Subsection (2)(c)* introduces the definition of 'dental corporation'

as a body corporate which carries on the business of dentistry within the meaning of section 40 of the Dentists Act 1984 (i.e. to receive payments for providing dental treatment).

108. *Subsection (3)* amends section 36 of the 1977 Act which enables regulations to be made about the delivery of GDS. *Subsection (3)(a)* provides for such regulations to empower Health Authorities to include dental corporations in their list of those undertaking to provide GDS. *Subsection (3)(b)* confers a right on dental corporations to be included in that list subject to certain conditions. *Subsection (3)(d)* provides for the removal of dental corporations from the Health Authority list in the event that the body never provides, or ceases to provide, GDS in that area.

Section 23: Declaration of financial interests, gifts, etc.

109. *Section 23* introduces new arrangements requiring practitioners providing family health services to declare their financial interests and any gifts or benefits they receive. The aim is to be broadly consistent with other NHS workers. Doctors, and other NHS employees, in the hospital sector are required to agree to local standards of business conduct that normally oblige them to refuse all gifts from patients except those gifts which are of low intrinsic value such as diaries or chocolates.

110. *Subsection (2)* amends section 29 of the 1977 Act to provide that regulations may require practitioners providing general medical services to declare any financial interests, gifts above a prescribed value or other benefits that they may receive in connection with the provision of NHS services. Such regulations will be subject to consultation.

111. *Subsections (3), (4) and (5)* provide for similar regulatory powers requiring persons and organisations providing general dental services, general ophthalmic services and pharmaceutical services to declare any gifts or other benefits that they may receive in connection with the provision of NHS services. Such regulations will also be subject to consultation.

Section 24: Supplementary lists

112. *Section 24* amends the 1977 Act to extend the existing Health Authority list systems to embrace all people who assist in the provision of family health services (i.e. otherwise than as principals in their own right).

113. This section inserts new section 43D into the 1977 Act. *Subsection (1)* of that section provides powers to make regulations providing for the preparation and publication by each Health Authority of lists covering practitioners (locums, deputies, or employees) assisting in the provision of GMS, GDS, GOS and PhS. *Subsection (2)* of the new section provides that such a list is to be referred to as a "supplementary list".

114. New section 43D(3) sets out provisions which (among others) may be included in the regulations about supplementary lists.

115. Paragraph (a) provides powers to prescribe the Health Authority to which an application for inclusion in a supplementary list should be made.

116. Under paragraph (b), the regulations may make provision about the procedure for applying for inclusion in a list. This may include details of the information to be supplied to the Health Authority, either directly by or by arrangement with an applicant, in order for that Authority to assess the applicant's suitability.

117. Paragraph (c) enables provision to be made about the grounds on which a Health Authority may or must refuse an application for inclusion in a list. This includes reasons of unsuitability or other grounds. For example, regulations might require a Health Authority to refuse entry to a list where the applicant has a conviction for murder. Regulations might also require a Health Authority to have regard to, but not be bound

by previous decisions by other Health Authorities concerning the applicant's inclusion or otherwise in their lists. The Health Authority would, however, be bound by national disqualification decisions issued by the FHSAA (see section 25). Provision may be made under paragraph (e) as to the grounds on which a Health Authority may, or must suspend or remove a person from a supplementary list and the procedure for doing so.

118. Provisions may be made under paragraph (f) about payments to be made to or in respect of suspended practitioners. Applicants for inclusion in a list and practitioners already included may, under paragraph (g), be required to supply the Health Authority with criminal conviction or criminal record certificates. Paragraph (h) provides that regulations may make provision to prevent a person withdrawing from a Health Authority supplementary list (for example, during any period a practitioner is under investigation which might result in removal or during any period awaiting removal from a list). Under paragraph (k), regulations may provide for the disclosure by Health Authorities to prescribed persons or persons of prescribed descriptions of specified information about applicants applying for inclusion in a supplementary list as well as refusals of such applications and suspensions and removals from lists.

119. Section 43D(4) provides for regulations to make provision for a person's inclusion in a list to be subject to conditions determined by the Health Authority. The Health Authority may vary these conditions or impose different ones. The regulations will also set out the consequences of a person failing to comply with a condition, which could include removal from the list. They may also provide for the Health Authority to review their decisions to conditionally include a person in the list. Section 43D(5) requires that the imposition of conditions must relate to preventing any prejudice to the efficiency of the service or preventing any fraudulent act.

120. Section 43D(6) allows provision to be made about supplementary lists which corresponds to provision which may be made about principal lists under sections 49F to 49N (which are inserted by s*ection 25*).

121. Section 43D(7) requires that, if regulations make provision for a Health Authority to suspend or remove a practitioner from a supplementary list, the regulations must also include provision for a practitioner to be given notice of any allegation against him; for him to put his case at a hearing before the Health Authority makes a decision; and for him to be informed of the Health Authority's decision, the reasons for it and any right of appeal.

122. Section 43D(8) provides that if regulations provide for the removal of a person from a supplementary list, or for refusal to include him in one (other than a compulsory removal or refusal) they must also provide for an appeal, by re-determination, to the FHSAA against the Health Authority's decision to do so.

123. If the regulations make provision under section 43D(4), they must also provide for an appeal, by re-determination, to the FHSAA against any Health Authority decision to impose conditions on a person's inclusion in a supplementary list; to vary a condition, to remove a person from a list for failing to comply with a condition or any review of an earlier decision.

124. Section 43D(10) provides for regulations requiring that practitioners on one of the main lists may not employ or engage a person to assist them in the provision of the respective family health service, unless that person is included in one of the main lists, a supplementary list, or a services list established under s*ection 26* or a similar list in respect of local pharmaceutical services. However, by virtue of section 43D(11), regulations need not require the two people concerned to be on lists held by the same Health Authority, but they may require that someone must be on a relevant list held by an English Health Authority if they are to be engaged to assist in providing services in England, and on a Welsh Health Authority's list to be engaged in Wales. The intention is to help those, such as locum doctors, who work across Health Authority boundaries by normally requiring them to join just one, rather than several, supplementary lists.

Section 25: Suspension and disqualification of practitioners

125. *Section 25* makes provision for Health Authorities to suspend and remove (including contingent removal) practitioners from the relevant principal family health services list . This will enable Health Authorities to take fast and effective action where concerns arise about a practitioner involved in the provision of these services.

126. New section 49F of the 1977 Act provides powers for a Health Authority to remove practitioners from the relevant principal medical, ophthalmic, dental, pharmaceutical or dispensing doctor list on the grounds of inefficiency, fraud or unsuitability.

127. Section 49G provides powers for a Health Authority in an efficiency or fraud case to contingently remove, rather than remove, a practitioner from a principal list. If a Health Authority makes a contingent removal it must impose conditions on the practitioner with a view to ensuring that the identified risks of "prejudice to the efficiency of the NHS" or preventing further fraud are eliminated. Where a practitioner fails to meet any such conditions, a Health Authority can vary them, impose new ones, or remove the practitioner from the list. For example, a practitioner might be required to submit more detailed information than normal in order to justify claims for fees and allowances. In consequence of its decision to impose conditions, the Authority may vary the individual practitioner's terms of service.

128. Section 49H(1) provides that in a fraud or unsuitability case a Health Authority may take action against a body corporate if the individuals in control of the body corporate themselves meet the criteria for fraud or unsuitability (whether or not they were running the body corporate at the time they first met the criteria) . Section 49H(2) means that a Health Authority may take action against a practitioner in a fraud case, if the fraud was committed by someone providing services on the practitioner's behalf and the practitioner had not taken all reasonable steps to prevent the fraud.

129. Section 49I provides powers for a Health Authority to suspend a practitioner from their list whilst considering whether that person should be removed or contingently removed or while it waits for a decision affecting the practitioner of a Court or a professional regulatory body anywhere in the world. In deciding whether to suspend a practitioner, a Health Authority must be satisfied that it is necessary to do so for the protection of members of the public or is otherwise in the public interest. If a Health Authority suspends a practitioner, it must specify the period of suspension. This may not exceed a maximum period of six months, except in certain cases. One is a case falling within prescribed circumstances. Regulations could, for example, prescribe that such circumstances would include where there is an ongoing criminal investigation, fraud investigation, or an investigation by the professional regulatory body. The Health Authority may also refer the matter to the FHSAA to determine whether the suspension should continue exceptionally for longer than six months. *Subsections (9)* and *(10)* provide that the Secretary of State may make regulations about payments to suspended practitioners. These regulations may include provision about the amount of the payments or the method of calculating the amount, to be determined by the Secretary of State or someone appointed by the Secretary of State.

130. Section 49J provides that, if a Health Authority decides to remove a practitioner from a list, they may also suspend that person pending any appeal to the FHSAA, if they are satisfied that it is necessary to do so for the protection of members of the public or is otherwise in the public interest.

131. Section 49K provides that while a practitioner is suspended, he shall be treated as though he were not on the list, even though his name was still on it.

132. Section 49L provides for a Health Authority to review any decision to contingently remove or suspend a practitioner. A Health Authority will be obliged to review a decision if requested in writing to do so by the practitioner. Following a review a Health Authority may confirm the suspension or contingent removal, end a suspension

it has made, or in the case of contingent removal vary the conditions, impose different conditions, remove all conditions or remove the practitioner from a list.

133. Section 49M provides practitioners with a right of appeal, by re-determination, to the FHSAA against any decision the Health Authority may make to remove or contingently remove them from a list, or any decision on a review of a contingent removal by the Health Authority. In addition, a practitioner can appeal to the FHSAA against any further decision to vary or change the conditions imposed on the practitioner pursuant to a contingent removal. An appeal must be lodged in writing to the FHSAA within 28 days of notice of the decision. The FHSAA may make any decision which could have been made by the Health Authority. If the FHSAA decides to remove the practitioner contingently, the Health Authority and the practitioner may each apply to the FHSAA for the conditions imposed on the practitioner to be varied, for different conditions to be imposed or for the contingent removal to be revoked. The Health Authority may remove the practitioner from their list if they determine that he has failed to comply with a condition. A Health Authority decision to remove or contingently remove a practitioner from a list may not take effect until the specified time to lodge an appeal with the FHSAA has passed and no appeal has been lodged, or if an appeal is lodged, until the FHSAA has disposed of the appeal.

134. Section 49N provides for a "national disqualification". A decision by a Health Authority would be 'local' and would remove a practitioner from the list covering its area. *Subsection (1)* provides for the FHSAA to make a decision to nationally disqualify a practitioner from the principal, supplementary and services lists of all Health Authorities or any of these as specified by the FHSAA. *Subsection (3)* provides that the FHSAA may also impose a national disqualification on a practitioner if it dismisses an appeal against a Health Authority's refusal to include that practitioner in a list (or in the case of a medical list, a refusal to nominate or approve that practitioner for inclusion). *Subsection (4)* provides that a Health Authority may apply to the FHSAA for national disqualification to be imposed on a person after removal from, or a refusal to admit to any of its lists (i.e. principal lists, supplementary lists, and services lists). The Health Authority would be required to apply for such disqualification within three months from the date of removal or their refusal. *Subsection (6)* provides that no Health Authority may subsequently include a person upon whom a national disqualification has been imposed in such a list, or if already included in a list, requires the Health Authority to remove the person from it. *Subsection (7)* provides for the FHSAA to review a national disqualification at any time. Following a review the FHSAA may confirm or revoke the disqualification. Subject to *subsection (9)* a person may not request such a review until at least two years from the date of the original national disqualification, or in the case of repeat applications, at least one year from the date of the last decision. *Subsection (9)* provides that, in prescribed circumstances, a person may request a review either before or after these time limits.

135. New section 49O provides for regulations requiring a Health Authority to notify prescribed persons or persons of prescribed descriptions of any decision they make under this group of sections: for example, to suspend, remove or contingently remove a practitioner from a list. They may also supply any related information.

136. In addition, section 49P provides for regulations stating the circumstances in which a practitioner whom a Health Authority are investigating in order to see whether there are grounds for removal, contingent removal or suspension, or in relation to whom a decision to remove or contingently remove has not yet taken effect, or who has been suspended pending an appeal to the FHSAA, may not withdraw from a list.

137. Section 49Q provides for regulations prescribing the procedure to be followed by Health Authorities in making a decision to suspend, remove or contingently remove a practitioner. *Subsection (2)* requires the regulations to include provision for a practitioner to be given notice of any allegation against him; for him to put his case at

a hearing before a Health Authority makes a decision, and for him to be informed of a Health Authority's decision, the reasons for it and his right of appeal.

138. Section 49R is intended to provide a mechanism for preventing a practitioner who has been disqualified from a health board list by a NHS tribunal in Scotland or similarly from an equivalent list in Northern Ireland from being included on any list in England and Wales. Specifically, it enables the Secretary of State to make provisions in regulations to recognise the decisions of Scottish and Northern Irish tribunals in England and Wales.

Personal medical services and personal dental services

Section 26: PMS and PDS lists

139. *Section 26* introduces new arrangements further extending the Health Authority list system to include those practitioners who may perform personal medical services "PMS" and personal dental services "PDS". These arrangements are substantially identical to those relating to supplementary lists.

140. *Subsection (1)* inserts new section 28DA into the 1977 Act. *Subsection (1)* of that section provides powers to make regulations providing for the preparation and publication by each Health Authority of lists of medical and dental practitioners who may perform PMS and PDS. *Subsection (2)* of the new section provides that such a list is to be referred to as a "services list".

141. Section 28DA(3) sets out provisions which (among others) may be included in regulations about services lists.

142. Paragraph (a) provides powers to prescribe the Health Authority to which an application for inclusion in a services list should be made.

143. Under paragraph (b), the regulations may make provision for the procedure for applying for inclusion in a list. This may include details of the information to be supplied to the Health Authority, either directly by or arranged by an applicant, in order for that Authority to assess the applicant's suitability.

144. Paragraph (c) enables provision to be made about the grounds on which a Health Authority may or must refuse an application for inclusion in a list. This includes reasons of unsuitability or on other grounds. For example, regulations might require a Health Authority to refuse entry to a list where the applicant has a conviction for murder. Regulations might also require a Health Authority to have regard to, but not be bound by, previous decisions by other Health Authorities concerning the applicant's inclusion or otherwise in their lists. The Health Authority would, however, be bound by national disqualification decisions issued by the FHSAA (see *Section 25*). Provision may be made under paragraph (e) as to the grounds on which a Health Authority may, or must, suspend or remove a person from a services list and the procedure for doing so.

145. Provision may be made under paragraph (f) about payments to be made to or in respect of suspended practitioners. Applicants for inclusion in a list and practitioners already included, may, under paragraph (g), be required to supply the Health Authority with criminal conviction or criminal record certificates. Paragraph (h) provides that regulations may make provision to prevent a person withdrawing from a Health Authority services list (for example, during any period a practitioner is under investigation which might result in removal or during any period awaiting removal from a list). Under paragraph (k), regulations may provide for the disclosure by Health Authorities to prescribed persons or persons of prescribed descriptions of specified information about applicants applying for inclusion in a services list as well as refusals of such applications and suspensions and removals of practitioners from a services list.

146. Section 28DA(4) provides for regulations to make provision for a person's inclusion in a list to be subject to conditions determined by the Health Authority. The Health

Authority may vary these conditions or impose different ones. The regulations will also set out the consequences of a practitioner failing to comply with a condition, which could include removal from the list. They may also provide for the Health Authority to review their decisions to conditionally include a person in the list. Section 28DA(5) requires that the imposition of conditions must relate to preventing any prejudice to the efficiency of the service or preventing any fraudulent act.

147. Regulations under section 28DA(6) may require that no person may perform PMS or PDS unless they are included in either a medical or dental list, a supplementary list or a services list.

148. Section 28DA(7) allows provision to be made about services lists which corresponds to provision which may be made about principal lists under sections 49F to 49N (which are inserted by *section 25*).

149. Section 28DA(8) requires that, if the regulations make provision for a Health Authority to suspend or remove a practitioner from a services list, the regulations must also include provision for a practitioner to be given notice of any allegation against him; for him to put his case at a hearing before the Health Authority makes a decision; and for him to be informed of the Health Authority's decision, the reasons for it and any right of appeal.

150. Section 28DA(9) provides that any regulations providing for the removal of a person from a services list or a refusal to include him in one (other than a compulsory removal or refusal) must also provide for an appeal, by re-determination, to the FHSAA against the Health Authority's decision.

151. If the regulations make provision under section 28DA(4), they must also provide for an appeal, by re-determination, to the FHSAA against any Health Authority decision to impose conditions on a person's inclusion in a services list; to vary a condition, to remove a person from a list for failing to comply with a condition or any review of an earlier decision.

152. *Subsection (2)* inserts a new section 8ZA into the National Health Service (Primary Care) Act 1997 introducing similar provisions in relation to PMS and PDS pilot schemes.

The Family Health Services Appeal Authority

Section 27: The Family Health Services Appeal Authority

153. The NHS Plan set out the Government's intention to abolish the NHS Tribunal and to devolve the power to suspend or remove practitioners from a Health Authority list to Health Authorities. Practitioners will have a right of appeal to the Family Health Services Appeal Authority (FHSAA) against any decision to remove them a list. *Section 16* of this Act abolishes the NHS Tribunal. The intention is to rationalise the functions carried out by the existing Family Health Services Appeal Authority and the NHS Tribunal into one body. In effect the Family Health Services Appeal Authority created by the Act will take over the functions of the Tribunal, adapted to take account of the new powers of Health Authorities to suspend or remove practitioners. The existing Family Health Services Appeal Authority is a Special Health Authority. *Section 27* provides for the creation of the new Authority as an independent body.

154. *Subsection (1)* of *section 27* inserts a new section 49S into the 1977 Act which sets up the Family Health Services Appeal Authority (FHSAA). *Subsection* (*2)* of the new section provides for the Authority to be constituted in accordance with new Schedule 9A. *Subsection (3)* provides for the functions of the FHSAA to be conferred on it by the 1977 Act or by any other enactment. *Subsection (4)* provides a power for the Secretary of State to direct the FHSAA to exercise any of his functions relating to the determination of appeals (for example, such functions currently exercised by the existing Family Health Services Appeal Authority). *Subsection (5)* provides that

such directions must be given by regulations or in writing. *Subsection (6)* permits the Secretary of State to make available to the FHSAA any facilities (or premises) provided by him or a Special Health Authority or NHS trust as well as the services of any staff employed by him or by a Special Health Authority or NHS trust.

155. *Subsection (4)* (of*section 27*) inserts Schedule 9A into the 1977 Act. Paragraphs 1 to 6 set out the constitution and membership of the FHSAA. The FHSAA will consist of a President, one or more Deputy Presidents, and a number of other members, all to be appointed by the Lord Chancellor on terms to be determined by him. The number of other members will be determined by the Lord Chancellor after consulting the Secretary of State. The membership must include people with a lay background as well as those with relevant professional expertise.

156. Paragraph 7 provides for the FHSAA to determine its own procedure, subject to the requirements of paragraphs 8 to 18 of the Schedule. Paragraph 8 provides that the functions of FHSAA are exercised by panels consisting of one or more members chosen by the President (who may include himself). Paragraph 9 requires that at least one member of a panel (or in the case of a one member panel, that member) must have a seven year legal qualification. Paragraph 10 provides that a three member panel exercising functions under section 49M or 49N of the 1977 Act, as inserted by *section 25*, must comprise one legal member, one professional member and one other.

157. Paragraph 11 requires that where a panel has more than one member, the President shall nominate one of the members to act as chairman; for decisions to be taken by a majority of votes, and if there is a tie for the chairman to have a second vote as a casting vote.

158. The FHSAA will be required to give notice of a panel's decision and the reasons for it to each party to the proceedings; to publish each decision of a panel, and to send a copy of any such decision, and, where appropriate, any information as appears to be relevant, to prescribed persons or persons of prescribed descriptions.

159. Paragraphs 15 to 18 provide for the Lord Chancellor to make rules regarding the composition of the panels and the procedure to be followed. Paragraph 19 provides for the publication of an annual written report about the FHSAA's activities. Paragraph 20 provides that the President must arrange for appropriate training for himself and the other members of the FHSAA.