These notes refer to the National Health Service Reform and Health Care Professions Act 2002 (c.17) which received Royal Assent on 25 June 2002

NATIONAL HEALTH SERVICE REFORM AND HEALTH CARE PROFESSIONS ACT 2002

EXPLANATORY NOTES

INTRODUCTION

1. These explanatory notes relate to the National Health Service Reform and Health Care Professions Act 2002[1] which received Royal Assent on 25 June 2002. They have been prepared by the Department of Health in order to assist the reader in understanding the Act. They do not form part of the Act and have not been endorsed by Parliament.

2. The notes are to be read in conjunction with the Act. They are not, and are not meant to be, a comprehensive description of the Act. So where a section or part of a section does not seem to require any explanation or comment, none is given.

SUMMARY

3. In July 2000 the Government published *The NHS Plan: A plan for investment, A plan for reform*[2], in which was set out a ten-year plan for the reform of the health service in England. Action has since been taken to implement many of the proposals set out in that document. Many of the legislative proposals were given effect through the Health and Social Care Act 2001 ("the HSC Act").

4. In summer 2001, the Government elaborated on key proposals from the NHS Plan in published documents: *Shifting the Balance of Power within the NHS - Securing Delivery*[3] and *Involving Patients and the Public in Healthcare*[4]. This Act takes forward those of the proposals which required primary legislation.

5. In July 2001, the Report of the Bristol Royal Infirmary Inquiry[5] was published. It made a number of recommendations including some requiring legislation. A full Government Response to the Report[6] was published on 17 January 2002. This Act provides for change in relation to two of the areas covered in the Report: the role of the Commission for Health Improvement ("CHI"), and the regulation of the health care professions. Regarding the latter, the Government's proposals were published in August 2001 in the consultation document *Modernising Regulation in the Health Professions*[7].

6. The document *Improving Health in Wales*[8], published by the National Assembly for Wales ("the Assembly") in February 2001, signalled the intention to abolish the existing

---

1 For copies: - postal address: PO Box 29, Norwich, NR3 1GN. Website: http://www.legislation.hmso.gov.uk/acts/acts2002/20020017.htm

2 *For copies: - postal address: PO Box 777, London SE1 6XH. Website address: http://www.doh.gov.uk/nhsplan/default.htm*

3 For copies: - postal address: PO Box 777, London SE1 6XH. Website address: http://www.doh.gov.uk/shiftingthebalance/index.htm

4 For copies: - postal address: PO Box 777, London SE1 6XH. Website: http://www.doh.gov.uk/involvingpatients/index.htm

5 For copies: - postal address: PO Box 29, Norwich, NR3 1GN. Telephone: 0845 7 023474

6 For copies: - postal address: PO Box 29, Norwich, NR3 1GN. Telephone: 0845 7 023474. Website address: http://www.doh.gov.uk/bristolinquiryresponse/index.htm

7 For copies: - postal address: PO Box 777, London SE1 6XH. Website address: http://www.doh.gov.uk/modernisingregulation/index.htm

8 For copies: - telephone: 029 2080 1032. Website address: http://www.wales.nhs.uk/publications/NHSStrategydoc.pdf

five Health Authorities ("HAs") in Wales on 31st March 2003 and extend and develop the role of the existing Local Health Groups which were established in April 1999 as sub-committees of the HAs to implement health improvement and local action plans through effective partnership working with local organisations and the public. The document envisaged the creation of Local Health Boards ("LHBs") to which the Assembly could delegate the functions of HAs in Wales once they had been abolished.

7. The Act provides for amendment of the structural framework of the health service in England and separately in Wales (see below). It provides, in relation to England, for HAs to be renamed as Strategic Health Authorities. It also provides for most of the functions of HAs to be conferred instead on Primary Care Trusts ("PCTs"), and for health service resources to be allocated directly to PCTs by the Secretary of State. Service planning will in future be undertaken by PCTs, with Strategic Health Authorities providing the performance management function for the health services provided within their boundaries.

8. In relation to Wales, the Act provides for the creation, functions and funding of LHBs, in effect extending the current role of Local Health Groups. The Act places a duty on each LHB and each Local Authority in Wales to formulate and implement a 'health and well-being strategy' for the population in the area, and to have regard to the strategy in exercising their functions. The Act also empowers the Assembly to make regulations imposing a duty on LHBs and Local Authorities to co-operate with other persons and organisations in formulating their strategy. These other bodies may include NHS trusts, Community Health Councils ("CHCs"), voluntary bodies and local businesses.

9. The Act provides for new arrangements to strengthen CHI and its independence. CHI was established by the Health Act 1999 ("the Health Act") to carry out independent reviews of the arrangements for monitoring and improving the quality of health care by NHS bodies and other NHS service providers. The Act makes it clear that the definition of 'health care' extends to the patient environment. It provides for CHI to inspect and report on NHS services, and that CHI may recommend to the Secretary of State that special measures should be taken where services are of unacceptably poor quality or there are significant failings in the way a body providing NHS services is being run. The Act enables CHI to discharge certain of its functions in relation to the collection and analysis of data and performance assessment through what will be known as the Office for Information on Health Care Performance. The Act provides for CHI to appoint its own chief executive and requires CHI to make an annual report on the quality of NHS services, which the Secretary of State must lay before Parliament.

10. The Act provides for the creation of an independent 'Patients' Forum' for every NHS trust and PCT in England, to perform an inspection, monitoring and representation role on behalf of patients and the public. Patients' Forums established in respect of PCTs ("PCT Patients' Forums") will have additional functions to provide information and advice to members of the public, to engender and promote the involvement of the public in local decisions that affect their health, and to advise other local bodies on how to involve the public. PCT Patients' Forums will also commission and provide Independent Advocacy Services. The Act establishes the Commission for Patient and Public Involvement in Health ("CPPIH") to report to the Secretary of State on how public and patient involvement mechanisms are working, and to conduct annual reviews of key issues arising from the work of Patients' Forums. CPPIH will set quality standards for and performance manage Patients' Forums and Independent Advocacy Services. The Act also provides for the abolition of CHCs in England and the Association of Community Health Councils for England and Wales ("ACHCEW").

11. In addition, the Act establishes a duty of partnership between NHS bodies and - through the Home Secretary - the prison service, to work together in carrying out their functions as they relate to health services for prisoners. It also makes provision to enable the NHS and the prison service to work together to fulfil their functions more effectively, mirroring the joint working arrangements that already exist, under section 31 of the

Health Act, between NHS bodies and Local Authorities. Under these provisions, prisons and their local NHS partners will - subject to approval by the Secretary of State - be able to pool funding for health services for prisoners, and prisons will be able to make arrangements to delegate health care functions to NHS bodies (and vice versa).

12. The Act creates a Council for the Regulation of Health Care Professionals ("the Council") to oversee the activities of the various regulatory bodies of the health care professions. It provides for the Council to co-ordinate good practice guidelines and other aspects of the regulatory bodies' work, and for it to encourage the regulatory bodies to act in the interests of patients. Specifically, the Council will oversee the General Medical Council; the General Dental Council; the General Optical Council; the General Osteopathic Council; the General Chiropractic Council; the Royal Pharmaceutical Society of Great Britain; the Pharmaceutical Society of Northern Ireland; the Nursing and Midwifery Council and the Health Professions Council[9]. The Act provides for the Council to have the right of appeal in cases determining a practitioner's fitness to practise or examining whether there has been an instance of professional misconduct where it would be desirable for the protection of members of the public.

13. The Act also deals with other aspects of the regulation of health care professionals. It provides for appeal cases in relation to 'fitness to practise' issues to be transferred from the Judicial Committee of the Privy Council to the High Court (and its Scottish and Northern Irish equivalents) in respect of those professions where this is not already the case. This will bring consistency in these procedures across all the professions. A further provision extends the powers conferred by section 60 of the Health Act (which deals with the modification of legislation governing the regulation of health care professions) to bring those powers in respect of the pharmacy profession more into line with the other health care professions.

THE ACT

14. The Act is in three parts:

Part 1 makes changes to the way the National Health Service (NHS) is managed and funded, including the renaming of HAs as Strategic Health Authorities, the distribution and allocation of functions between Strategic Health Authorities and PCTs and the allocation of funding in England. For Wales, it deals with the establishment and funding of LHBs and a duty to devise health and well-being strategies. Part 1 also extends the role of CHI, reforms the structures for patient and public involvement in the NHS, and provides for joint working between NHS bodies and the prison service.

Part 2 covers the regulation of the health care professions: the establishment and functions of the Council for the Regulation of Health Care Professionals; the transfer of some 'fitness to practise' appeals from the Privy Council to the High Court; and a modification of the powers conferred by section 60 of the Health Act as it affects the regulation of the pharmacy profession.

Part 3 deals with various miscellaneous and supplementary provisions.

15. Part 1 is concerned with the NHS. It changes the structure of the health service in both England and Wales and the way in which it is funded. It changes the ways in which patients and the public are involved in the management of the NHS in England and the ways in which the NHS works with the prison service. It extends the role of CHI. *Sections 1* to *5* relate to the structural change in England. *Section 1* changes the name of HAs in England to Strategic Health Authorities. Many functions of HAs will, as part of these changes, be re-allocated to PCTs who will become the lead NHS organisation in assessing need, planning and securing all health services and improving

---

9 The Nursing and Midwifery Council and the Health Professions Council are bodies set up by orders made in the Health Act and succeed the UK Central Council for Nursing, Midwifery and Health Visiting and the Council for Professions Supplementary to Medicine

health. Provision is made to give the Secretary of State power to make regulations containing requirements to carry out consultation before making an order relating to Strategic Health Authorities. *Section 2* places upon the Secretary of State a duty to create PCTs for all areas of England, and makes provision to allow for PCTs which straddle Strategic Health Authority boundaries. *Section 2* also removes the existing option for the Assembly to establish PCTs in Wales which has never been exercised and which is to be replaced in this Act by a power to establish LHBs (see*section 6*). *Section 3* makes further provision to underpin this changed role by creating a power for the Secretary of State to delegate his own health functions directly to PCTs.

16. *Section 4* contains amendments relating to Personal Medical Services ("PMS"); Personal Dental Services ("PDS") and Local Pharmaceutical Services ("LPS") to take account of the replacement of HAs by Strategic Health Authorities and also the transfer of certain PMS, PDS and LPS functions from HAs to PCTs.

17. *Section 5* addresses a further consequence of the devolution of functions to PCTs by providing for the responsibility of recognising Local Representative Committees ("LRCs") in England to become a PCT function.

18. *Section 6* allows for the establishment of LHBs in Wales to exercise health functions as directed by the Assembly.

19. *Sections 7* to *10* change the way in which NHS bodies are funded, as a consequence of the devolution of functions from HAs to PCTs in England and the creation of LHBs in Wales. *Section 7* provides for the funding of Strategic Health Authorities and *section 8* provides for PCTs to be funded directly by the Secretary of State rather than by HAs. It also gives power to make payments based on performance direct to PCTs rather than through the HA. *Section 9* provides for the funding of LHBs. *Section 10* makes further provision relating to the expenditure of NHS organisations.

20. *Sections 11* to *14* clarify the extent of the duty of quality on NHS bodies and extend the role of CHI. As a result of the Act's provisions, CHI will be able to inspect NHS bodies, service providers, and bodies providing NHS services on their behalf and recommend to the Secretary of State that special measures are taken where services are of unacceptably poor quality or there are significant failings in the way a body providing NHS services is being run. The Act enables certain of CHI's functions to be carried out by what will be known as the Office for Information on Health Care Performance.

21. *Sections 15* to *22* complete the new arrangements to reform public and patient involvement in the NHS started in the HSC Act. *Sections 15* to *19* establish statutory Patients' Forums, one for every PCT and every NHS trust in England, and set out provisions for their functions and operation. These bodies are intended to ensure that patients' views are taken into account by those delivering NHS services. PCT Patients' Forums will, in addition, promote wider community involvement in local health decisions and commission and provide Independent Advocacy Services. *Section 20* establishes CPPIH which will have a role at national level in terms of issuing guidance and training on involvement issues, and advising the Secretary of State and other bodies, facilitating the co-ordination of Patients' Forum activities and setting and monitoring quality standards for Patients' Forums and providers of Independent Advocacy Services. *Section 21* provides for a referral process by overview and scrutiny committees to the Secretary of State for Health and to the Assembly. In the light of these new provisions *section 22* abolishes CHCs in England only, but not in Wales. It also abolishes ACHCEW, and ensures that the Assembly may continue to exercise the power to establish a new body to advise and assist CHCs in Wales.

22. *Section 23* mirrors for the prison service the arrangements set out in section 31 of the Health Act for the NHS to work jointly with other bodies.

23. *Section 24* introduces a duty on each LHB, once created, and each Local Authority in Wales to formulate health and well-being strategies in Wales.

24. Part 2 of the Act concerns the regulation of the health care professions. *Sections 25* to *29* deal with the establishment of the Council and set out its duties and functions. The purpose of the Council is to co-ordinate the work of the regulatory bodies, formulate principles of good regulation, encourage regulatory bodies to conform to these principles and act in the interests of patients and the public.

25. *Sections 30* to *34* make changes to some 'fitness to practise' appeals procedures, moving them from the Judicial Committee of the Privy Council to the High Court (or its Scottish and Northern Irish equivalents). They also bring greater consistency to the route taken by appeals against registration decisions. The professions affected by the changes in these sections are medical practitioners; dentists; opticians; osteopaths and chiropractors.

26. *Section 35* extends the powers conferred by section 60 of the Health Act (which deals with the modification of legislation governing the regulation of health care professions) to bring those powers in respect of pharmacy more into line with those for other professions.

27. Part 3 of this Act includes a number of miscellaneous and supplementary provisions.

28. Annex A to this document sets out the existing legal framework for the NHS prior to implementation of this Act. Annex B sets out the effects of the Act in relation to Wales only.

COMMENTARY ON SECTIONS

Part 1 – National Health Service, etc.

NHS bodies and their functions: England

Section 1: English Health Authorities: change of name

29. *Section 1* renames HAs in England as Strategic Health Authorities and places a duty on the Secretary of State to create, for the whole of England, Strategic Health Authorities.

30. The section retains the existing duty to create HAs to cover Wales. As a result of devolution arrangements, this latter duty is a function of the Assembly. For the sake of consistency with the National Health Service Act 1977 ("the 1977 Act") and to avoid confusion, the reference to the Secretary of State is preserved in respect of Wales instead of adding express reference to the Assembly.

31. *Subsection (2)* substitutes a new section 8 of the 1977 Act (which currently provides for the establishment of HAs for the whole of England and Wales) to take account of the renaming of HAs in England as Strategic Health Authorities. Provision is made in *subsection (5)* of the new *section 8* to give the Secretary of State power to make regulations containing requirements as to consultation that must be complied with before he makes an order under this section which relates to a Strategic Health Authority. Consultation requirements contained in regulations under *section 8(5)* are in addition to any other consultation requirements that apply.

32. *Subsection (3)* introduces*Schedule 1* which makes a series of further amendments to existing legislation to take account of the change of name of English HAs.

Section 2: Primary Care Trusts

33. *Section 2* replaces the existing power of the Secretary of State to establish PCTs in section 16A of the 1977 Act with a duty on him to establish PCTs to cover all areas of England. At present, many areas of England are covered by PCTs. However, in order for the new role of PCTs envisaged under the Act to be effective, it is essential that there is comprehensive coverage across the whole of England. The section also removes the

existing option of creating PCTs for Wales, where alternative arrangements for LHBs are being developed – see *section 6*.

34. Following consultation, it became clear that in a small number of cases PCT areas would cross the boundaries of the new Strategic Health Authorities. Although previous legislation did not specifically prohibit this, there was an underlying assumption that all PCTs would in fact fall within the area of a single HA (or in future, Strategic Health Authorities). *Subsection (4)* provides for PCTs which cross the boundaries of Strategic Health Authorities and amends Schedule 5A of the 1977 Act

i) to allow any Strategic Health Authority in whose area the PCT is established to meet preparatory costs

ii) to allow any Strategic Health Authority to make available premises and other facilities during the preparatory period

iii) to provide for the PCTs annual financial and other reports to be sent to all Strategic Health Authorities in whose area the PCT is established.

35. *Subsection (5)* introduces *Schedule 2*, which contains amendments to NHS and other legislation to re-allocate certain functions of HAs to PCTs. Under present arrangements, PCTs provide or secure the provision of a limited range of services, including primary, community care and social care services. HAs are responsible for medical lists and other family health services such as dentists, pharmacists and opticians. The main effect of *Schedule 2* will be to confer directly on PCTs responsibility for all family health services such as dentists, pharmacists and opticians, currently conferred on HAs. The Schedule also contains other miscellaneous amendments relating to the reallocation of functions.

Section 3: Directions: distribution of functions

36. *Section 3* amends section 16D of the 1977 Act to enable the Secretary of State to delegate directly to PCTs the exercise of any functions which are conferred on him by health legislation, for example, the duty to provide hospital accommodation under section 3 of the 1977 Act. These delegated functions are in addition to those directly conferred under *Schedule 2*. Under the existing section 16D, the Secretary of State can only delegate his functions directly to HAs and Special Health Authorities[10]. Further delegation to PCTs has to be carried out by HAs under section 17A of the 1977 Act and is limited to certain functions (described in section 17A(2) as "delegable"). Certain other functions – described in section 17A(3) as "excepted" – cannot currently be delegated beyond HA level. *Section 3* simplifies this system.

37. *Subsection (3)* removes the concepts of "delegable" and "excepted" functions in the existing section 17A of the 1977 Act and inserts a new section 17A. This allows Strategic Health Authorities to direct PCTs, any part of whose area falls within their area, to exercise specified functions of theirs (except, in certain circumstances, functions relating to PMS or PDS where there is a need to maintain a distinction between commissioners and providers). The Secretary of State may direct Strategic Health Authorities to delegate specified functions to PCTs to be exercised by them alone or jointly with either other PCTs or the Strategic Health Authority.

38. *Subsection (4)* enables a Strategic Health Authority to direct a PCT about the exercise of any of its functions whether delegated to it by the Strategic Health Authority or not. *Subsection (5)* makes amendments to section 18 of the 1977 Act consequential on the new section 17A inserted by *subsection (3)*.

---

10 See Annex A, paragraphs 204-209 for more information about Special Health Authorities

Section 4: Personal medical services, personal dental services and local pharmaceutical services

39. *Section 4* contains amendments relating to PMS, PDS and LPS to take account of the replacement of HAs by Strategic Health Authorities and also the transfer of certain PMS, PDS and LPS functions from HAs to PCTs.

40. *Subsection (1)* amends section 9 of the National Health Service (Primary Care) Act 1997 (the Primary Care Act) to remove the restriction on the Secretary of State in England from directing a Strategic Health Authority or Special Health Authority to exercise functions relating to PMS and PDS pilot schemes on his behalf. *Subsection (2)* amends section 36 of the HSC Act to remove the same restrictions as regards functions relating to LPS pilot schemes.

41. *Subsection (3)* introduces *Schedule 3* which makes amendments to the Primary Care Act and other primary legislation related to the provision of PMS and PDS. These amendments are to take account of the creation of Strategic Health Authorities and the transfer of certain PMS and PDS functions to PCTs.

42. The Government's intention is to devolve PMS and PDS functions from the Secretary of State and HAs to PCTs wherever this is practicable. Where the PCT is providing PMS or PDS, rather than commissioning it, it is not considered possible to devolve certain functions to the PCT. This is because the Primary Care Act requires a distinction to be maintained between commissioner and provider.

43. For this reason, PMS and PDS functions currently undertaken by the HA under the 1997 Act will be transferred to Strategic Health Authorities. Where the PCT is the commissioner, the HA's functions will be devolved to the PCT through secondary legislation. Where the PCT is the provider, Strategic Health Authorities will retain the legal exercise of these functions and their accountability, but in practice much of the work will be carried out by PCTs acting as agents on behalf of Strategic Health Authorities. This will be made clear in guidance.

44. *Paragraph 2* of*Schedule 3* therefore provides for all functions in relation to both PMS and PDS pilot schemes in England to be carried out by Strategic Health Authorities. This would include, for example, developing and consulting on proposals and implementing schemes approved by the Secretary of State, but exclude those functions associated with the preparation and maintenance of PMS and PDS 'services lists' (see below).

45. *Paragraph 3* amends section 8ZA of the Primary Care Act (inserted by section 26(2) of the HSC Act) so that responsibility for 'services lists', comprising practitioners who may perform PMS or PDS under pilot schemes, will be transferred from HAs to PCTs. In future, PCTs will be responsible for the preparation and maintenance of these lists, including making decisions, for example, on a doctor's or dentist's application for inclusion in the list and whether there are grounds for removal from it. (PCTs will also be responsible for the preparation and maintenance of the main medical and supplementary lists.)

46. *Paragraph 4* amends section 8A of the Primary Care Act (inserted by section 6(1) of the Health Act) which prevents a HA from delegating certain functions to the PCT where the PCT itself is providing, rather than commissioning, PMS or PDS by applying the same restriction on Strategic Health Authorities. This is because the Primary Care Act requires a distinction to be maintained between the commissioner and provider.

47. *Paragraphs 5*, *6*, *9* and*10* make amendments to the Primary Care Act to take account of responsibility for the preparation and maintenance of General Medical Services medical lists (the medical and supplementary lists) being transferred to PCTs. Sections 12 and 13 of and Schedule 1 to the Primary Care Act make provision for the removal from and subsequent readmission to the GMS medical list of a GMS doctor moving to or returning from working under PMS pilot arrangements.

48. *Paragraphs 7*, *8* and*16* make similar provision in relation to such schemes under any permanent arrangements for PMS and PDS which are made following the pilot schemes.

49. *Paragraphs 11*, *12*, *13* and*17* make amendments to a range of primary legislation to take account of and provide consistency with the provisions of this Schedule that transfer PMS and PDS functions from HAs to Strategic Health Authorities.

50. *Paragraph 14* removes the restriction on the delegation by a HA to a PCT of certain functions relating to the permanent arrangements for PMS/PDS contained in section 28EE(1) of the 1977 Act (as inserted by section 6(2) of the Health Act).

Section 5: Local Representative Committees

51. Section 5 amends sections 44 and 45 of the 1977 Act consequential on the renaming of HAs as Strategic Health Authorities in England and the devolution of functions to PCTs. Sections 44 and 45 of the 1977 Act currently provide for the recognition by HAs of LRCs formed by family health service practitioners providing GMS, General Dental Services (GDS), Pharmaceutical or General Ophthalmic Services. Doctors and dentists working in PMS or PDS may also opt to be represented by the appropriate LRC. These sections also provide for the HA to attribute funding to these LRCs from payments which would otherwise be payable to the practitioners themselves. These sections currently require that such LRCs must always be co-terminous only with the relevant HA. Section 5 removes the need for LRCs to conform to the boundaries of a single PCT and instead provides for LRCs to establish themselves at the level of one whole PCT area or more; profession by profession, area by area. It also removes the longstanding requirement that LRCs need HA approval to delegate any of their business to a sub-committee of their own members.

NHS bodies and their functions: Wales

Section 6: Local Health Boards

52. *Section 6* enables the Assembly to create statutory bodies to be known as LHBs to exercise health functions as directed by the Assembly.

53. *Subsection (1)* inserts three new sections into the 1977 Act, sections 16BA, 16BB and 16BC. The new section 16BA empowers the Assembly to establish LHBs with a view to their exercising the functions of former HAs and also any other functions of the Assembly relating to the health service. It also introduces a new Schedule 5B in the 1977 Act (as set out in *Schedule 4*). Schedule 5B makes provision for the content of orders establishing LHBs, the status, constitution and membership of LHBs and other matters. In particular, under paragraph 5 of the Schedule, the chairman is to be a board member and appointed by the Assembly; this also applies to a vice-Chairman who can be appointed if the Assembly so wishes. *Paragraph 13* enables the LHB to do whatever it considers necessary in order to exercise its functions. *Paragraph 17* enables the Assembly to make regulations for the LHB to produce reports, audit and publish accounts, and publish other such documents as required.

54. The new section 16BB empowers the Assembly to direct LHBs to carry out specified HA functions, which have previously been transferred to the Assembly under Section 27 of the Government of Wales Act 1998. The Assembly may also direct a LHB to exercise, in relation to its area, other health service related functions of the Assembly. The Assembly may direct LHBs about the exercise of functions, which it has directed LHBs to exercise. The Assembly can, if it considers appropriate, confer different powers and functions upon different LHBs and change these as it determines necessary.

55. The new section 16BC enables the Assembly to give directions for an LHB's functions to be exercised on it's behalf by another LHB, a Special Health Authority or jointly

with a number of other health bodies, or by any committee, sub-committee or officer of the relevant LHB or health body.

56. *Subsection (3)* applies to orders, regulations and directions made in respect of LHBs the general powers relating to orders, regulations and directions provided by Section 126 of the 1977 Act.

57. *Subsection (4)* extends section 1 of the National Health Service (Private Finance) Act 1997 to LHBs so that they may enter into externally financed development agreements.

Financial arrangements: England and Wales

Sections 7, 8 and 9: funding of Strategic Health Authorities, Health Authorities, Primary Care Trusts and Local Health Boards

58. The statutory provision dealing with the public funding of HAs is section 97 of the 1977 Act. HAs are paid money in each year by the Secretary of State under sections 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 HA 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 HA money not exceeding the amount allotted to it by the Secretary of State. This amount is allotted towards meeting an HA's "main expenditure" (defined in paragraph 2 of Schedule 12A to the 1977 Act.) In the case of an HA 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 HA.

59. The Health Act inserts new provisions into the 1977 Act which provide for the establishment and operation of PCTs. Under section 97C, each year the HA must pay each of its PCTs (a) the cost of general Part 2 expenditure incurred by the trust (defined in paragraph 4 of Schedule 12A to the 1977 Act) and (b) money not exceeding the amount allotted by the Authority for that year towards meeting the trust's main expenditure (defined in paragraph 5 of Schedule 12A to the 1977 Act). Provisions associated with PCTs have not been commenced in Wales.

60. The Government Resources and Accounts Act 2000 inserted two new sections into the 1977 Act (sections 97AA and 97E). These new sections provide for the setting of resource limits for every HA and PCT in addition to cash limits. Section 97AA concerns resource limits for HAs; section 97E concerns resource limits for PCTs. Section 97AA(2) provides for general Part 2 expenditure to be excluded from the resource limit.

61. The HSC Act inserts four new subsections into the 1977 Act (sections 97(3AA), 97AA(2A), 97C(1A) and 97E(2A)). These subsections provide that in determining amounts to be allotted towards main expenditure, the Secretary of State may take into account the level of a HA's general Part 2 expenditure; and HAs may take into account the level of their PCTs' general Part 2 expenditure.

62. An element of performance funding was introduced by the Health Act. Subsections (3C) to (3F) of section 97 of the 1977 Act, inserted by section 8 of the Health Act and amended by section 2 of the HSC Act, provide for the Secretary of State to increase the allotments made to a HA if they have, over a period notified to the HA, satisfied objectives notified as objectives to be met by the HA, or performed well against criteria notified to them as criteria relevant to their satisfactory performance of functions. The additional sums may be subject to conditions. If those conditions are not met the Secretary of State may reduce the HA's allotment, in the current year or following years.

Section 7: Funding of Strategic Health Authorities and Health Authorities

63. *Section 7(2)* inserts a new subsection into section 97 of the 1977 Act to provide for the funding of Strategic Health Authorities. It mirrors the existing provision for the funding of Special Health Authorities.

64. *Sections 7(3)*, *7(4)* and*7(5)*relate to performance payments and add Strategic Health Authorities to the existing provisions of section 97.

65. *Sections 7(6)*, *7(7)(a)* and *7(9)* add Strategic Health Authorities to the existing provisions of section 97 for the funding of HAs. They cover respectively: the variation of allotments in the course of a year; the earmarking of allotments for a particular purpose, and the payment of capital charges; and the keeping of records. *Section 7(7)(c)* omits the existing provision concerning sums paid by PCTs to HAs in respect of capital charges. The revised section 97C(8)(b) inserted by *section 8* provides for PCTs to pay these sums direct to the Secretary of State.

Section 8: Funding of Primary Care Trusts

66. *Section 8* provides for PCTs to be funded direct by the Secretary of State. It replaces the existing section 97C under which PCTs are funded by HAs. The provisions in the new section 97C (1), (2), (7), (8) and (9) mirror the existing provisions in section 97 for the funding of HAs by the Secretary of State. They cover respectively: the funding of PCTs; taking account of general Part 2 expenditure in determining amounts to be allotted towards main expenditure; the variation of allotments in the course of a year; the earmarking of allotments for a particular purpose, and the payment of capital charges; and the keeping of records.

67. Section 97C (3) to (6) mirrors existing provisions for HAs, to allow performance payments direct to PCTs. The provision allows the Secretary of State to increase the allotments made to a PCT if they have, over a period notified to the PCT, satisfied objectives notified as objectives to be met, or performed well against criteria notified to them as criteria relevant to their satisfactory performance of functions. The additional sums may be subject to conditions. If those conditions are not met the Secretary of State may reduce the PCT's allotment, in the current year or following years.

Section 9: Funding of Local Health Boards

68. *Section 9(1)* provides for LHBs to be funded directly by the Assembly. The provisions in the new section 97F (1), (2), (7), (8) and (9) mirror the existing provisions in section 97 for the funding of HAs. They cover respectively: the funding of LHBs; taking account of general Part 2 expenditure in determining amounts to be allotted towards main expenditure; the variation of allotments in the course of a year; the earmarking of allotments for a particular purpose, and the payment of capital charges; and the keeping of records.

69. Section 97F (3) to (6) is a new provision to allow performance payments direct to LHBs. The provision allows the Assembly to increase the allotments made to a LHB if they have, over a period notified to the LHB, satisfied objectives notified as objectives to be met, or performed well against criteria notified to them as criteria relevant to their satisfactory performance of functions. The additional sums may be subject to conditions. If those conditions are not met the Assembly may reduce the LHB's allotment, in the current year or following years.

70. Section 97G is a new provision which specifies the financial duties of LHBs. It places a duty on LHBs not to spend more than the sum of the amount allotted to them by the Assembly (the cash limit) and any other receipts. It enables the Assembly to give directions to LHBs to ensure they comply with their financial duty. These provisions mirror those in respect of HAs in section 97A of the 1977 Act.

71. Section 97H extends the setting of resource limits to LHBs.

Section 10: Expenditure of NHS bodies

72. Currently HA expenditure distinguishes between "main expenditure" which is subject to resource and cash limits, and Part 2 (Family Health Services) expenditure which is not. Part 2 services include pharmaceutical services. However certain elements of pharmaceutical services, including the cost of drugs dispensed, form part of a HA's main expenditure. The cost initially falls on the HAs where the drugs are dispensed. For the purpose of HA resource and cash limits it is then apportioned between the HAs where it was prescribed (by GPs or others). Schedule 12A to the 1977 Act gives effect to this process. It is intended that in future the expenditure of PCTs be treated in the same way as HA expenditure is currently.

73. *Sections 10(3)* to *10(10*) amend Schedule 12A to the 1977 Act (expenditure of HAs and PCTs). *Section 10(5)* amends the definition of PCT general Part 2 expenditure, so that it mirrors the definition of HAs' general Part 2 expenditure within Schedule 12A. *Sections 10(6)* and*10(7)* redefine the main expenditure of PCTs, so that the definition matches that of HA main expenditure within Schedule 12A. *Section 10(8)* enables the Secretary of State to apportion remuneration referable to the cost of drugs between PCTs. This replaces the existing arrangement, which gave HAs the power to apportion the cost of drugs between PCTs.

74. *Section 10(4)* relates to paragraph 3 of Schedule 12A. The Assembly is substituted for the Secretary of State, which allows Wales to preserve its existing position until HAs are abolished.

75. *Section 10(9)* defines general Part 2 expenditure and main expenditure (main expenditure being cash-limited and general Part 2 services expenditure not being cash limited) and replicates for LHBs the existing position as currently applies to HAs in Wales.

Quality

Section 11: Duty of Quality

76. *Section 11* amends section 18 of the Health Act to clarify that the duty of NHS bodies as referred to in that section to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which they provide, includes arrangements relating to the environment in which health care services are provided.

Section 12: Further functions of the Commission for Health Improvement

77. *Section 12* makes changes to CHI's functions as set out in section 20 of the Health Act.

78. *Subsections (2)* and *(3)* extend CHI's functions to allow for its review activity to extend to any aspect of health care and in particular to the collection and analysis of data and performance assessment of the NHS.

79. *Subsections (3)* and *(4)* provide that CHI must publish at least a summary of each report it makes in the exercise of its functions.

80. *Subsection (5)* provides that the Audit Commission must consult CHI on its programme of Value for Money studies in relation to the NHS as part of better co-ordination of regulation of the NHS.

Section 13: Commission for Health Improvement: inspections and investigations

81. *Subsection (1)* amends section 20 of the Health Act to allow CHI to carry out inspections of NHS bodies, service providers and persons who provide or are to provide health care for which NHS bodies or service providers have responsibility. CHI currently reviews arrangements for clinical governance in NHS organisations and carries out

investigations into the health care provided by such organisations and reviews of particular types of health care provided by the NHS.

82. The subsection also amends section 20 to provide that if, after carrying out an inspection or investigation, CHI is of the view that the health care for which the NHS body or service provider has responsibility is of unacceptably poor quality or there are significant failings in the way the body or service provider is being run, CHI must make a report of its view to the Secretary of State. As a result of the devolution arrangements set out in the Government of Wales Act 1998 and the National Assembly for Wales (Transfer of Functions) Order 1999 (SI 1999/672), if the body or service provider operates in Wales, CHI must make a report of its view to the Assembly rather than the Secretary of State. The report may recommend that the Secretary of State or the Assembly (in case of bodies or service providers operating in Wales) takes special measures in relation to the body or service provider in question with a view to improving the health care for which it is responsible, or the way the body or service provider is being run. Such measures could include the use by the Secretary of State of his powers of intervention under sections 84A and 84B of the 1977 Act as inserted by section 13 of the HSC Act .

83. *Subsection (2)* amends section 23 of the Health Act. Section 23 of the Act makes provision for the Secretary of State to make regulations setting out CHI's powers to obtain entry to NHS premises and to access information and documents. Certain providers of services to NHS patients do not work from premises owned or controlled by the NHS. This amendment will enable the regulations made by the Secretary of State under section 23 also to cover entry to any premises owned or controlled by a service provider or to other premises which are used for any purpose connected with the provision of NHS services. Such premises include those owned or controlled by NHS service providers such as general practitioners, pharmacists, dentists, optometrists, and by independent and voluntary sector providers who provide services to NHS patients under arrangements with NHS bodies. The subsection also provides for confidential information to be disclosed to CHI when it carries out investigations in relation to Special Health Authorities or other bodies which may be prescribed in regulations under section 20(1)(e), and not only where it carries out investigations in relation to the bodies specified in 20(1)(c) (HAs, PCTs and NHS trusts).

Section 14: Commission for Health Improvement: constitution

84. This section (by means of amendment to Schedule 2 to the Health Act) allows the Secretary of State and the Assembly to direct a Special Health Authority to exercise their functions in relation to appointing the chairman and members of CHI *(subsection (2))*; removes the requirement that the Secretary of State, after consultation with the Assembly, consents to the appointment of CHI's Chief Executive; removes the Secretary of State's direction-making powers in respect of the terms under which CHI employs people *(subsection (3));* and provides for CHI to produce an annual report about the quality of NHS services (in addition to the annual report on its own work) *(subsection (5)).* CHI is required to make this report to the Assembly and the Secretary of State.

85. *Subsection (4)* provides that certain of CHI's functions in relation to the collection and analysis of data and performance assessment may be carried out by what will be known as the Office for Information on Health Care Performance.

86. Currently, CHI may arrange for any of its functions to be discharged by any committee, sub-committee, member or employee of CHI. *Subsection (4)* also provides that CHI may arrange for the discharge of any of its functions by any other person.

Patient and public involvement

Section 15: Establishment of Patients' Forums

87. The NHS Plan set out the new arrangements for involving patients and the public, in the way the NHS is run. Central to this are Patients' Forums. They will be independent bodies established for each PCT and NHS trust in England, with members drawn from voluntary sector organisations representing patients and/or carers and from individual patients. Their main role will be to provide direct input from patients to NHS trusts and PCTs on the range and operation of local NHS services. The members of Patients' Forums will be appointed by CPPIH.

88. *Section 15* requires the Secretary of State to establish a Patients' Forum for each PCT and NHS trust in England and sets out their functions. These include monitoring and reviewing the services for which the trust is responsible, obtaining and reporting the views of patients and their carers to their trust, and making available to patients and carers advice and information about those services provided or arranged by the trust.

89. *Subsection (2)(e)* provides that in circumstances set out in regulations, the

    Patients' Forum can take on responsibility for arranging or providing services to assist patients. This could include Patient Advice and Liaison Services ("PALS") where the trust PALS was proved not to be performing satisfactorily.

90. *Subsection 2(f)* provides that the Secretary of State may by regulations confer additional functions on Patients' Forums.

91. *Subsection (4)* provides a Patients' Forum with the right to refer matters of which it becomes aware in the course of exercising its functions to the relevant overview and scrutiny committee and/or to CPPIH where it feels this is appropriate. *Subsection (5)* makes it clear that this does not restrict the power of a Patients' Forum to make representations or referrals to any other persons or bodies as it thinks fit.

92. *Subsection (8)(b)* makes clear that the services to which a Patients' Forum's functions relate include those of a trust exercising health related functions of a Local Authority under arrangements with the Local Authority pursuant to section 31 of the Health Act (eg. social care services).

Section 16: Additional functions of PCT Patients' Forums

93. *Section 16* provides for Patients' Forums established for PCTs to have additional functions.

94. *Section 16(1)(a)* gives PCT Forums the specific function of providing independent advocacy services. Section 16 (5) amends section 19A of the 1977 Act (as inserted by the HSC Act) to enable the Secretary of State to direct a PCT Patients' Forum to discharge his function of arranging for the provision of independent advocacy services. The combined effect of these two subsections is to enable PCT Forums to both provide or commission independent complaints advocacy. Subsection 16(5) also prevents PCT Patients' Forums from commissioning independent advocacy services from themselves. *Section 16(1)(b)* and *(3)(b)* give PCT Patients' Forums the responsibility of providing advice to patients and carers about the local complaints process and to the public on how they can get involved more generally. *Section 16(1)(c)* provides for PCT Patients' Forums to make representations to local bodies, in particular overview and scrutiny committees, on the views of members of the local public about matters that affect their health.

95. *Section 16(3)* provides for PCT Patients' Forums to promote the involvement of local people in local decision making processes. It also gives PCT Patients' Forums the role of advising Strategic Health Authorities, PCTs, NHS trusts, other public bodies and others providing services to the public on how to encourage such involvement,

including how the NHS bodies might carry out their duty to involve the public under section 11 of the HSC Act; and of monitoring how successful these bodies are at achieving such involvement.

Section 17: Entry and Inspection of Premises

96. *Section 17* gives the Secretary of State power to make regulations requiring Strategic Health Authorities, HAs, PCTs, LHBs, NHS trusts, Local Authorities, providers of family health services (e.g. GPs, pharmacists, dentists and opticians), as well as others who own or control premises where family health services are provided, to allow authorised members of Patients' Forums to inspect premises owned or controlled by them. The requirement to allow access may be limited to the cases and circumstances set out in regulations and subject to any limitations or conditions specified in those regulations.

Section 18: Annual reports

97. *Section 18* requires Patients' Forums to produce annual reports of their activities after the end of the financial year, to be submitted to the Patients' Forum's trust, the Secretary of State, CPPIH and the relevant overview and scrutiny committee and Strategic Health Authority. The Patients' Forum must include in the report a section that shows how it obtained the views of patients during the year.

Section 19: Supplementary

98. *Section 19* enables the Secretary of State to make further provision in regulations for Patients' Forums, in particular concerning funding, accounts, membership and appointments, committees and proceedings, payments for members, premises and staff, reports, the provision of information to or by Patients' Forums and the referral of matters to overview and scrutiny committees.

99. It is the Government's intention that Patients' Forums will receive their money via CPPIH. As such, the Patients' Forums' accounts will form part of the accounts of the CPPIH. *Subsection (2)(j)* provides for this.

100. As regards membership, the regulations must provide for members of the Patients' Forum to include representatives of local patient or carer voluntary sector groups, as well as patients of the trust. *Subsection (4)* provides that the PCT Patients' Forum must also include in its membership at least one member of each Patients' Forums of the NHS trusts that provide services in the PCT area. In addition, it provides that the CPPIH may include representatives of appropriate local community interest groups which represent the local public in matters relating to their health as members of the PCT Patients' Forum.

101. *Subsection (5)* provides that the regulations may include similar requirements about public access to meetings and information of Patients' Forums as now apply to CHCs and overview and scrutiny committees (with appropriate modifications to account for the different role and constitution).

102. *Subsection (6)* provides that correspondence from Patients' Forums is to be added to the list of bodies exempt from subsections (1)(b) and (2) of section 134 of the Mental Health Act 1983, which provide for the withholding of postal packets to and from persons held under that Act.

Section 20: The Commission for Patient and Public Involvement in Health

103. *Section 20,, subsection (1)* establishes an independent body corporate, to be known as CPPIH.

104. *Subsections (2)(a)* and *(2)(b)* provide for CPPIH to advise the Secretary of State, and such other bodies as the Secretary of State may prescribe in regulations, about the

arrangements that are in place for the involvement and consultation of patients and the public in matters relating to the health service in England; and on arrangements for the provision of independent advocacy services (to be provided under section 19A of the 1977 Act).

105. *Subsection 2(c)* provides for CPPIH to report to and advise the Secretary of State, and such other bodies as the Secretary of State may prescribe in regulations, on the views of organisations representing patients and their carers, including Patients' Forums, on such arrangements (for example, how effectively they are operating).

106. *Subsection (2)(d*) provides for CPPIH to facilitate the co-ordination of Patients' Forums activities and to provide advice and assistance to Patients' Forums including staff for PCT Patients' Forums. It is intended that CPPIH will, through the staff provided to PCT Patients' Forums, provide administrative support to NHS trust Patients' Forums.

107. *Subsection (2)(e)* provides for CPPIH to give advice and assistance to providers of independent advocacy services. This could be, for example, in the form of guidance or training.

108. *Subsection (2)(f)* specifies that CPPIH will set quality standards for (i) the activities of Patients' Forums and (ii) the provision of independent advocacy services. It will also monitor how effectively these standards are met and make recommendations to them about how to improve their performance against those standards.

109. *Subsection (2)(g)* enables the Secretary of State in regulations to prescribe other functions for CPPIH.

110. *Subsection (3)* specifies CPPIH's function to promote public involvement in decisions and consultations on matters affecting the health of the population. It will do this at a national level whilst PCT Patients' Forums will do so at a local level. The bodies making decisions and carrying out consultations to which *subsection (3)* relates are described in *subsection (4)*, namely health service bodies but also other public bodies and others providing services to the public. *Subsection (5)* also confers on CPPIH a function of reviewing the annual reports of Patients' Forums and making any recommendations or reports to the Secretary of State and others that it thinks are necessary on matters arising from the annual reports.

111. *Subsections (6)* and *(7)* place a duty on CPPIH to report to those it considers appropriate matters of concern about patient safety and welfare, where these are not being dealt with satisfactorily. An example might be that if it were made aware, as a result of the monitoring of a trust by a Patients' Forum, of a unit within a trust with a particularly high mortality rate, it might then report its concerns to, for example, a body such as CHI, the National Patients Safety Agency, the National Care Standards Commission or the police.

112. *Subsection (8)* allows CPPIH to make charges as it sees fit for the provision of its advice or other services. It is envisaged that in practice CPPIH will want to use this power to recover reasonable costs incurred in providing its services, but there may also be opportunities for CPPIH to supplement its income in this way, for example by charging for advice provided to private hospitals. Regulations may be made to set limits on this - for example, it is not intended that CPPIH would charge for the advice it provides to the Secretary of State or for the routine guidance and training materials it provides to Patients' Forums and providers of independent advocacy services.

113. *Subsection (9)* gives the Secretary of State power by regulations to make further provision about CPPIH and*subsection (10)* provides by way of example that those regulations may make provision about the information that should be made available to CPPIH by Strategic Health Authorities, Special Health Authorities, NHS trusts, PCTs, Patients' Forums or providers of independent advocacy services.

114. *Subsection (11)* gives effect to *Schedule 6*. *Schedule 6* makes provision about constitution, membership, the payment of allowances, appointment of staff, the delegation of functions, arrangements for assistance with functions, payments and loans, accounting and auditing arrangements, reporting and the miscellaneous amendments needed in relation to other legislation. It also provides for the Secretary of State to delegate his function of appointing the chair of CPPIH to a Special Health Authority. In practice, this will be the NHS Appointments Commission.

Section 21: Overview and scrutiny committees

115. This section provides for a referral process by overview and scrutiny committees to the Secretary of State for Health and the Assembly in relation to their health scrutiny activities under section 21 of the Local Government Act 2000. Further details about the circumstances in which referrals may be made and the nature of the referrals may be set out in regulations made under section 7 of HSC Act – functions of overview and scrutiny committees.

Section 22: Abolition of Community Health Councils in England

116. *Subsections (1)* and *(2)* provide for the abolition of CHCs in England.

117. Paragraph 5 of Schedule 7 to the 1977 Act provides that the Secretary of State may by regulations provide for the establishment of a body to advise and assist CHCs. The National Health Service (Association of Community Health Councils) Regulations (S.I.1977/874), made under that paragraph, established ACHCEW. *Subsection (3)* provides for the abolition of that body, but *subsection (4)* ensures that the Assembly may continue to exercise the power in paragraph 5 and establish a new body to advise and assist CHCs in Wales.

118. *Subsection (5)* provides for the transfer of rights and liabilities and, in the case of ACHCEW property, of members and former members of CHCs and members and former members of CHCs which were members of ACHCEW. Any such transfer must be to a person listed in *subsection (6)*. In the case of the Association a transfer may also be made to the Assembly. Under *subsection (7)*, transfers from ACHCEW require consultation with the Assembly.

Section 23: Joint working with the prison service

119. This section make provision for the NHS and the prison service to work together to fulfil their functions more effectively. It will enable regulations to be made to enable them to pool their resources and to delegate functions and resources from one party to another. It also introduces an explicit duty of co-operation between the NHS and the prison service to secure and maintain the health of prisoners. Responsibility for the health of prisoners is shared between the prison service and the NHS. Following publication in 1999 of the report *The Future Organisation of Prison Health Care*[11], a formal partnership has already been established between the prison service and the NHS with the aim of ensuring that prisoners have access to health services which are as far as possible equivalent to those available to the general population from the NHS.

120. *Section 23* removes existing legal barriers to joint working between the NHS and the prison service. The measures set out in this section are intended to allow NHS bodies and the prison service to agree jointly who is best placed to carry out certain of their functions, and to agree how resources might be used in joint working arrangements. They parallel the provisions that exist to allow closer working between the NHS and Local Authorities under section 31 of the Health Act. This section removes some of these barriers by allowing NHS bodies and the prison service to:

---

11 For copies: postal address: PO Box 777, London SE1 6XH. Website address: http://193.32.28.83/nhsexec/prison.htm

— pool resources, which will mean that the agreed resources contributed to the pool can be used on any of the functions agreed by the partner agencies when the pool is established. This is intended to allow staff from either agency to develop packages of care suited to the needs of prisoners irrespective of whether health or prison service money is used; and

— delegate functions to one another. This will allow, for example, one of the partner bodies to commission or provide all mental health services for a group of prisoners. It is expected that this will improve the integration of the services commissioned or provided.

121. These joint working arrangements need to be able to respond to local needs and will not necessarily be appropriate in all areas, or for all prisoners. The powers are therefore discretionary, not mandatory.

122. *Subsection (1)* introduces an explicit duty of co-operation between the NHS and the prison service to secure and maintain the health of prisoners, making clear the intention that NHS bodies and the prison service are expected to work together.

123. *Subsection (2)* provides for the Secretary of State in relation to England and the Assembly in relation to Wales to make regulations setting out the details of the joint working arrangements. These arrangements can only be used if doing so leads to an improvement in the way in which the bodies' functions are exercised, which might, for example, include better outcomes for service users. *Subsection (3)* sets out examples of the new operational working arrangements.

124. *Subsection (3)(a)* enables the creation of pooled budgets made up of contributions from the NHS and the prison service. The resources contributed by each body will lose their identity as health or prison service money, and will be used to carry out the functions agreed by the partner agencies when the pool is established. The pool will be able to fund both health and prison service activity as set out in regulations.

125. *Subsections (3)(b)* and *(3)(c)* allow both NHS bodies and the prison service to delegate some of their functions to the other partner. These functions will be prescribed in regulations. In relation to health services for prisoners, the effect of these subsections will be to allow in particular:

— the prison service to delegate specified commissioning functions to NHS commissioning bodies, and vice versa; and

— the prison service to delegate specified provider functions to NHS bodies and vice versa.

126. *Subsections (3)(d)* to *(3)(f)* provide for practical arrangements to support the exercise of these provisions for budget pooling and delegation**.**

127. *Subsection (4)* makes it clear that, where an NHS body or the prison service delegates its functions under the arrangements in this section, that body will remain liable for the exercise of those functions.

Section 24: Health and well-being strategies in Wales

128. *Section 24* is intended to give effect to the Assembly's commitment to ensure joint working in the development and implementation of local strategies for health and well-being.

129. *Subsection (1)* places a duty on each newly created LHB and each Local Authority in Wales to formulate and implement a health and well-being strategy for the area. (LHBs and Local Authorities will be co-terminous).

130. *Subsection (3)* requires the LHBs and Local Authorities to have regard to their strategy in the exercise of their functions.

131. *Subsection (4)* empowers the Assembly, by regulations, to set the time period to which the strategy will apply. Under *subsections (5)* and *(6)* further provision about such strategies may be made by the Assembly by regulations. Such regulations may in particular require LHBs and Local Authorities to co-operate with other prescribed bodies such as NHS trusts, voluntary bodies and local businesses in formulating their strategy (*subsection (6)(a))* The regulations may also cover such issues as steps to be taken before formulation of the strategy (*subsection (6)(b))* and measures to avoid duplication between health and well-being strategies and other strategies prescribed in the regulations *(subsection (6)(g))*. This might include, for example, the Community Care Plan under section 46 of the National Health Service and Community Care Act 1990 (the 1990 Act).

Part 2: Health care professions

The Council for the Regulation of Health Care Professionals

Sections 25 to 29: The Council for the Regulation of Health Care Professionals

132. Parliament has established statutory frameworks for a number of health care professions within which the professions regulate themselves. For the most part there are separate enactments for each professional group (doctors; dentists; nurses, midwives and health visitors; opticians; pharmacists; osteopaths; chiropractors and the twelve professions coming within the remit of the Health Professions Council). Each of these groups has its own regulatory body operating within its own legal framework:

- The General Medical Council – Medical Act 1983
- The General Dental Council – Dentists Act 1984
- The Nursing and Midwifery Council – Nursing and Midwifery Order 2001
- The General Optical Council – Opticians Act 1989
- The Royal Pharmaceutical Society of Great Britain – Pharmacy Act 1954, Medicines Act 1968 (and in Northern Ireland, The Pharmaceutical Society of Northern Ireland – Pharmacy (Northern Ireland) Order 1976
- The General Osteopaths Council – Osteopaths Act 1993
- The General Chiropractic Council – Chiropractors Act 1994
- The Health Professions Council – Health Professions Order 2001

133. The different enactments make provisions which, with very few exceptions, could until recently only be changed by means of primary legislation. Section 60 and Schedule 3 of the Health Act, therefore provided a framework within which Her Majesty by Order in Council can modify the enactments affecting professional regulation and regulate any other health care profession.

Section 25: The Council for the Regulation of Health Care Professionals

134. *Section 25* provides for the establishment of a Council for the Regulation of Health Care Professionals ("the Council"). It gives the Council the functions of promoting the interests of patients and other members of the public in the way that the existing (and any future) statutory regulatory bodies carry out their work, and promoting co-operation between them.

135. *Subsection (3)* lists the bodies within the Council's remit. The bodies referred to in *subsection (3)(h)* have now been abolished and replaced from 1st April 2002 by 2

successor bodies – the Nursing and Midwifery Council and the Health Professions Council – which are therefore brought within the remit of the Council by *subsection (3)(i)*. *Subsection (3)(j)* provides that if in future other health care professions are regulated by a new body set up by an Order under section 60 of the Act, they would also be covered by the Council.

136. *Schedule 7* makes more detailed provisions about the constitution of the Council. The constitution given to the Council is designed to enable it to operate independently from the Government, amongst other standard provisions.

137. *Paragraph 4* sets out the membership of the Council which will consist of one appointee each from the regulatory bodies and the relevant authorities in Scotland, Wales and Northern Ireland; and a number appointed by the Secretary of State (but see paragraph 5 of the Schedule). The combined number of members appointed by the Secretary of State and the devolved administrations will exceed the number of regulatory body members by one. Some of the members appointed by the regulatory bodies might also come from Scotland, Wales and Northern Ireland.

138. *Paragraph 4* also deals with the appointment of the Chairman. The Secretary of State will appoint the first chairman, in order to allow the new body to begin establishing itself more rapidly, for example by finding premises. Similar arrangements have been made in the past on the establishment of other new bodies. Subsequent chairmen will be appointed by the Council from among their own number.

139. *Paragraph 5* allows the Secretary of State to delegate his power of appointment of members to a Special Health Authority. The Government gave a commitment in the Commons that this power would be delegated to the NHS Appointments Commission. The intention is for the NHS Appointments Commission to appoint two kinds of members; a small number who will speak for the interests of health care providers and a larger number who will speak for the interests of patients and the wider public.

140. *Paragraph 6* provides for the Secretary of State to make regulations providing for the appointment of the chairman and other members of the Council. The intention is that these should ensure the independence of the Council from Government, for example in the provision they make for tenure of office and removal from office.

141. *Paragraphs, 7-13, 16, 17 and 18* are routine provisions relating to the establishment of a new public body which provide the Council with the necessary legal structure for its effective operation including the power to take its own decisions about its internal procedures and to appoint staff.

142. *Paragraph 14* makes provisions for the financing of the Council. It is the intention that the Council's work should be financed out of money provided by Parliament and paid to it by the Secretary of State. The paragraph also allows for the future possibility that money provided by Parliament might be loaned to the Council, and that authorities in Scotland, Wales and Northern Ireland might, if they so decide, provide grants or loans to the Council.

143. *Paragraphs 14(7)* and*14(8)*give the Secretary of State, and, if they make grants or loans, the Assembly, Scottish Ministers or the Department of Health, Social Services and Public Safety in Northern Ireland, a power to direct the Council on the application of grants and loans. Such directions might relate, for example, to the way the Council secures value for money in its expenditure. The Council will be financed by monies voted by Parliament for the Health Vote, and the Secretary of State and the Department of Health's Accounting Officer are therefore accountable to Parliament for this. These sub-paragraphs therefore allow the Secretary of State to fulfil his financial responsibilities to Parliament. They do not confer a wider power on him to direct the Council more generally as to how it should exercise its business. He cannot for example direct it to direct a regulatory body using its powers under *section 27*.

144. *Paragraph 15* makes provision for annual accounts and requires that they be laid before (or published) by Parliament, the Scottish Parliament, the Assembly and the Northern Ireland Assembly.

145. *Paragraph 16* provides for the Council to make an annual report to Parliament on its work. This report will also be laid before the devolved assemblies. The Council will be accountable to Parliament rather than to the Secretary of State. The Council will also be accountable to the Scottish Parliament and the Northern Ireland Assembly in so far as its activities relate to devolved matters.

146. *Paragraph 19* provides that if the Council holds a meeting in Northern Ireland, it will be open to the public on the same basis as District Council meetings are there at present. This is mirrored for Great Britain by *paragraph 21*, which applies the provisions of the Public Bodies (Admission to Meetings) Act 1960, to the Council.

147. The effect of *paragraph 20* is that the records of the Council are public records for the purposes of the Public Records Act 1958.

148. The effect of *paragraph 24* is that the Council is a public authority for the purposes of the Freedom of Information Act 2000.

Section 26: Powers and duties of the Council: general

149. *Section 26* sets out the powers and duties to be exercised by the Council in carrying out the functions given to it by *section 25*. The Council is given the power to do what is necessary or expedient in carrying out its functions. It can investigate and report on the performance of a regulatory body and make recommendations to a regulatory body about they way the regulatory body performs its functions.

150. *Subsections (3)* and *(4)* provide that the Council may not intervene in the determination of 'fitness to practise' cases or allegations made to regulatory bodies which could become fitness to practise cases. An exception to this rule is provided by *section 28*, which deals with complaints about regulatory bodies. At the conclusion of a fitness to practise case, the Council would only be able to intervene by referring the case to the High Court (or its Scottish or Northern Irish equivalent) if it felt that this was desirable for the protection of members of the public (this is provided for in *section 29(4)*).

151. *Subsection (5)* limits the range of the functions of the Royal Pharmaceutical Society of Great Britain in which the Council can take an interest to those which have to do with professional regulation. This reflects the unique nature of the Royal Pharmaceutical Society of Great Britain, which is the professional body for pharmacists as well as their regulator. *Subsection (6)* reflects the parallel situation in Northern Ireland with the Pharmaceutical Society of Northern Ireland.

152. *Subsection (9)* amends section 60(1) of the Health Act, to include the Council within the scope of this section so that the Council's legal framework, like that of the regulatory bodies themselves, can be updated if changed circumstances call for this in the future.

153. In particular, this subsection would allow an Order under section 60 of the Health Act to modify the Council's functions, powers and duties, to modify the list of regulatory bodies which fall within the scope of the Council and to alter the range of functions of a particular regulatory body which were covered.

154. The power to modify the legal framework of professional self-regulation under section 60 of the Health Act is circumscribed by paragraphs 7 and 8 of Schedule 3 to the Health Act, which provide for example that existing regulatory bodies cannot be abolished, have a lay majority imposed on them or have any of the key functions of a regulator (which are defined in paragraph 8) taken away from them. In addition, *subsection (10)* further restricts the provision which a future section 60 Order can make. *Subsection (10)* provides that a future section 60 Order cannot give the Secretary of

State more powers of direction over the Council. This is intended as a safeguard to the Council's independence from Government.

Section 27: Regulatory bodies and the Council

155. *Section 27* provides underpinning powers for the Council and duties on the regulatory bodies, in order to ensure that the Council can do its work effectively.

156. *Subsection (2)* provides the Council with a reserve power to direct a regulatory body to make rules for a particular purpose. One situation in which it is envisaged that this power might be used is where the Council felt that consistency between the fitness to practise rules of all regulators was essential for the protection of members of the public.

157. *Subsection (3)* limits the effect of this section to the more important types of rules which regulatory bodies can make, those where the rule-making powers created in their different enactments require the permission of the Privy Council before they come into force (or in the case of the Pharmaceutical Society of Northern Ireland, require the permission of the Department of Health, Social Services and Public Safety in Northern Ireland). These mostly have to do with the maintenance of the professional register and fitness to practise issues.

158. *Subsections (4)* to *(10)* (read in conjunction with *section 38(3) and (4)*) provide for control over the Council's use of directions by stating that if a direction is made, it does not come into force until both Houses of Parliament (or, in the case of the Pharmaceutical Society of Northern Ireland, the Northern Ireland Assembly) have approved an Order laid before them setting a date for it to come into force.

159. *Subsection (11)* places a regulatory body under a duty to comply with directions which have come into force. If a regulator refused to comply with a direction made under this section, it would be open to the Council to seek, by way of judicial review, an appropriate declaration or order from the Court.

160. *Subsection (12)* ensures that a regulatory body is not in breach of the obligation to comply under *subsection (11)* merely because a court has interpreted the rules (made to comply with a direction) in a manner which means that the rules did not in fact give effect to that direction.

161. *Subsections (13)* and *(14)* require the Secretary of State to make regulations concerning the procedure to make a direction and providing that such regulations must include provision that a direction may only be made after consultation with the regulatory body in question.

Section 28: Complaints about regulatory bodies

162. This section provides for the Secretary of State to set up in regulations a complaints scheme under which the Council would acquire powers to investigate complaints about the regulatory bodies. The intention is that this should be used as a power to investigate maladministration, not a means of overturning the decisions of 'fitness to practise' committees. These regulations are to be made by the affirmative resolution procedure.

Section 29: Reference of disciplinary cases by Council to court

163. *Section 29* gives the Council the power to refer a fitness to practise decision by a regulatory body to the High Court where this seems to it to be desirable for the protection of the public. It is envisaged that the Council would do this in extreme cases where the public interest in having a clearly perverse decision reviewed by a Court outweighs the public interest in the independent operation of self-regulation. Where such a case was referred to the High Court, the Court would have the power to substitute its own decision for the one referred to it, or if it preferred to refer the case back to the regulatory body for re-hearing. Existing Court Rules protect the rights

of the professional whose case was being heard by ensuring that he or she becomes a "respondent" in the appeal, that is, has a right to be represented at the appeal hearing.

Appeals

Sections 30 to 34: Appeals

164. A professional has a right of appeal against the decisions of regulatory bodies on fitness to practise cases. Under current law, some professions appeal to the Judicial Committee of the Privy Council, and some appeal to the High Court. The purpose of these sections is to introduce consistency across the professions. The main effect of these five sections is to redirect appeals from doctors, dentists, opticians, osteopaths and chiropractors to the High Court.

165. In addition to dealing with appeals against fitness to practise decisions, these sections bring consistency to the route taken by appeals against registration decisions. At present the Osteopaths Act 1993, the Chiropractors Act 1994, the Medical Act 1983 and the Opticians Act 1989 provide for an appeal from decisions to remove registration on grounds of fraud or error to the Judicial Committee of the Privy Council. These sections move this appeal to, in England and Wales, and in Northern Ireland, a county court and in Scotland to a sheriff court.

166. The Osteopaths Act 1993 and the Chiropractors Act 1994 currently provide for an appeal on points of law from decisions to refuse registration on more general grounds (section 29 of each Act) to a county court or the High Court at the appellant's choice. These sections remove this option to appeal to the High Court and restrict such appeals to a county court. At the same time the basis of appeal is widened so that it can be on issues of fact and law, rather than solely on points of law as currently.

Section 30: Medical practitioners

167. *Section 30* amends the Medical Act 1983. *Subsection (2)* provides for appeals against decisions in 'fitness to practise' cases to be directed to the High Court or Court of Session in Scotland. The relevant court is dependent on the address which the appellant has (or would have if he was registered) as his registered address with the regulatory body. If an appellant's registered address is outside the United Kingdom the appeal will be to the High Court in England and Wales. This subsection also provides for appeals on decisions to remove registration on grounds of fraud or error to be directed to a county court, or in Scotland, to the sheriff. This subsection also sets out the appeal court's order making powers.

168. *Subsection (3)* deals with consequential amendments to the Medical Act 1983.

Section 31: Dentists

169. *Section 31* amends the Dentists Act 1984. *Subsection (2)* provides for appeals against decisions in 'fitness to practise' cases to be directed to the High Court or in Scotland, the Court of Session. The relevant court is dependent on the address which the appellant has as his registered address with the regulatory body. If an appellant's registered address is outside the United Kingdom, the appeal will be to the High Court in England and Wales. This subsection also sets out the appeal court's order making powers.

170. *Subsection (3)* amends section 44 of the Dentists Act 1984 to provide for a body corporate to appeal to the High Court (or Court of Session in Scotland) against decisions to withdraw their privilege to practise as a body corporate. The relevant court is dependent on the registered office address of the body corporate.

171. *Subsections (5)* to *(8)* make some consequential changes to the Dentists Act 1984, made necessary by the making of the Dentists Act 1984 (Amendment) Order 2001 ("the 2001 Order") on 11 December 2001. The 2001 Order made provisions for new

requirements for continuing professional development for dentists. Failure to comply with continuing professional development requirements can lead to the dentist's name being erased from the register. The 2001 Order provides for an appeal against erasure to the new Continuing Professional Development Committee and thereafter to the Privy Council. The 2001 Order amends section 29 of the Dentists Act 1984, which the present Act will itself amend. These consequential changes are therefore now necessary to take account of the changes brought about by the 2001 Order. The main effect is to substitute the High Court (and its equivalents throughout the UK) for the Judicial Committee of the Privy Council. The date of coming into force of the relevant provisions of the 2001 Order has not yet been determined, so *subsections (6)* to *(8)* cater for the relevant provisions of the 2001 Order coming into force prior to the coming into force of this section in the Act, or alternatively, for this section in the Act coming into force prior to the relevant provisions in the 2001 Order.

Section 32: Opticians

172. *Section 32* amends section 23 of the Opticians Act 1989. *Subsection (2)* provides for appeals against decisions in 'fitness to practise' cases in respect of individuals or a body corporate, to be directed to the High Court or in Scotland, the Court of Session. For individual appellants the relevant court is dependent on the address which the appellant has as his registered address with the regulatory body. For a body corporate the relevant court is dependent on the registered office address.

173. *New section (1B)* provides for a practitioner or body corporate to appeal against decisions to remove registration on grounds of fraud or error to a county court, or in Scotland to the sheriff.

174. *Subsection (2)* also sets out the appeal court's order making powers.

Section 33: Osteopaths

175. *Section 33* amends the Osteopaths Act 1993. *Subsection (2)* provides for appeals on decisions to remove registration on grounds of fraud or error to be directed to a county court, or in Scotland, to the sheriff. This subsection also provides that time for serving notice of appeal, runs for 28 days after notification of the order to remove is "served" rather than beginning on the date on which the order is made. *Subsection (2)* also sets out the appeal court's order making powers.

176. *Subsections (3)* and *(4)* deal with consequential amendments to sections 22 and 23 of the Osteopaths Act 1993.

177. *Subsection (5)* amends section 29 of the Osteopaths Act 1993 to provide that appeals against refusal of registration on more general grounds are to be to a county court or in Scotland, the sheriff. This removes the previous right of the appellant to choose whether to appeal to a county court or the High Court. This subsection also extends the basis of appeals to issues of fact as well as issues of law and sets out the appeal court's order making powers.

178. *Subsection (6)* provides for appeals against decisions in 'fitness to practise' cases to be directed to the High Court or Court of Session in Scotland. The relevant court is dependent on the address which the appellant has (or would have if he was registered) as his registered address with the regulatory body. If an appellant's registered address is outside the United Kingdom, the appeal will be to the High Court in England and Wales.

Section 34: Chiropractors

179. *Section 34* amends the Chiropractors Act 1994 and makes corresponding provision for chiropractors.

The pharmacy profession

Section 35: Regulation of the profession of pharmacy

180. *Section 35* amends Schedule 3 of the Health Act, and by doing so extends the powers in section 60 of that Act for Her Majesty by Order in Council to modify the regulation of the health professions to bring their scope in respect of the pharmacy profession more into line with that for other professions.

181. Orders under section 60 may be used to modify the statutory regulation of health care professions and to regulate other health care professions which are not yet subject to such regulation. Subject to certain limitations, an Order may repeal or revoke any enactment, amend it, or replace it. One such limitation relates to the Medicines Act 1968, which is one of two main Acts (the other being the Pharmacy Act 1954) which contain provisions relevant to the regulation of the pharmacy profession. At present, an Order may (except for certain associated purposes) only amend sections 80 to 83 of the Medicines Act 1968. Those sections deal with the disciplinary action which may be taken against bodies corporate and certain other persons lawfully conducting retail pharmacy businesses.

182. This section will permit an Order to amend any other provision of the Medicines Act insofar as it relates to the regulation of the profession of pharmacy in Great Britain. This might, for example, include section 79 of the Medicines Act 1968, which restricts the use of "pharmacist" and various other titles to people with particular qualifications. Equivalent provisions for other professions are already within the scope of the order making power.

Part 3: Miscellaneous

Section 36: Amendments of health service legislation in connection with consolidation

183. *Section 36* enables the Secretary of State to amend legislation relating to the health service in England and Wales by order if he thinks that such amendment will assist the consolidation of that legislation. Amendments made under the Order will form part of consolidating legislation. *Section 38(3)* provides for such orders to be subject to affirmative resolution.

Section 38: Regulations and orders

184. *Section 38* makes provision about the making of orders, regulations and directions under the Act. It provides that all orders and regulations (except those under *section 22(5)* – orders making provision for the transfer of rights, liabilities etc. on or after the abolition of a CHC or ACHCEW) shall be exercised by statutory instrument, sets out the parliamentary procedures relating to statutory instruments and how the powers in question may be exercised. All orders and regulations are subject to the negative resolution procedure except for regulations relating to complaints about regulatory bodies (*section 28)*, orders relating to the coming into force of directions under *section 27* and orders made in connection with consolidation of health service legislation (*section 36*). Commencement orders under section 42(3) are not subject to any Parliamentary procedure. *Subsection (10)* provides that except where otherwise stated, directions are to be given by instrument in writing.

Section 39: Supplementary and consequential provision etc

185. *Section 39(1)* and *(2)* enable the Secretary of State by regulations to make such supplementary, incidental or consequential provision, or such transitory, transitional or saving provision, as he considers necessary to give full effect to the Act. This includes power to amend or repeal any enactment, instrument or document. This would enable

regulations to be made, for instance, to ensure a smooth transition from HAs to Strategic Health Authorities in England.

186. *Subsection (3)* provides that such regulations may also be made by the Assembly in respect of devolved matters.

Section 40: Wales

187. *Section 40* provides that in the National Assembly for Wales (Transfer of Functions) Order 1999 any reference to an Act amended by this Act is to be treated as a reference to that Act as amended.

Section 41: Financial Provisions

188. *Section 41* provides for expenditure relating to the Act to be paid out of money provided by Parliament.

Section 42: Short title, interpretation, commencement and extent

189. *Section 42* gives the short title of the Act and makes provisions for commencement and extent. It provides that all sections of the Act will be brought into force by order made by statutory instrument except *sections 38 to 41* and those conferring order or regulation-making powers on the Secretary of State which will come into force on Royal Assent. *Subsections (2)* and *(4)* also contain definitions of certain terms used in the Act.

Note on drafting assumptions

190. There are a number of points at which this Act amends provisions of the 1977 Act which have already been amended by the Health Act or the HSC Act. Not all of the relevant amendments, however, have yet been brought into force. For the purposes of this Act, the following method of dealing with such amended provisions has been adopted:

191. Where it is known that the amendment **will not** have been brought into force before this Act receives Royal Assent, then this Act amends the amending provision in the HSC Act and the Health Act. This applies, for example, in the case of the amendments to section 10 of the Health Act in *paragraph 68* of *Schedule 2* and the amendments to section 40 and Schedule 3 to the HSC Act in *paragraphs 78* and *81* of *Schedule 2*.

192. Where it is known that the amendment **will** have been brought into force before this Act receives Royal Assent, then this Act amends the 1977 Act as amended. This applies, for example, in the case of the amendments to section 97 of the 1977 Act (as amended by sections 1 and 2 of the HSC Act) made by *section 7* of the Act.

193. Where, at the time of drafting, it was not yet clear whether the amendments would have been brought into force before this Act receives Royal Assent, then this Act also amends the 1977 Act as amended rather than the amending provision. This applies, for example, in the case of the amendments to section 29B of the 1977 Act (as amended by section 15 of the HSC Act) made by *paragraph 5* of *Schedule 2* to the Act. In these cases, where the relevant amendments have not in fact been brought into force at Royal Assent, commencement orders for the two sets of amending provisions will be arranged so that any amendments made by the earlier Act which are further amended by this Act are brought into force before those further amendments. These further amendments should then be taken as applying to the text of the 1977 Act as it stood at the date of their commencement.

COMMENCEMENT

194. *Section 42* makes standard provision for commencement. Some technical provisions of the Act and the powers to make regulations under it will come into force on Royal Assent. The substantive provisions of the Act will come into force on such a day, or days, as the relevant authority may determine.

HANSARD REFERENCES

The following table sets out the dates and Hansard references for each stage of this Act's passage through Parliament.

Stage	***Date***	***Hansard Reference***
House of Commons		
Introduction	8 November 2001	Vol 374, col 380
Second Reading	20 November 2001	Vol 375, col 198-289
Committee	27 and 29 November 2001	Standing Committee A
	4, 6, 11, 13 December 2001	
Report and Third Reading	15 January 2002	Vol 378, col 174-266
House of Lords		
Introduction	16 January 2002	Vol 630, col 1114
Second Reading	31 January 2002	Vol 631, col 351-434
Committee	14 March 2002	Vol 632, col 973-1042
18 March 2002	Vol 632, col 1101-1228	
21 March 2002	Vol 632, col 1487-1587	
11 April 2002	Vol 633, col 531-672	
Report	29 April 2002	Vol 634, col 461-560
	30 April 2002	Vol 634, col 574-658
Third Reading	16 May 2002	Vol 635, col 427-476
House of Commons		
Commons consideration of Lords amendments	22 May 2002	Vol 386, col 300-353
House of Lords		
Lords consideration of Commons reasons and amendments	13 June 2002	Vol 636 col 402-433
Royal Assent in the Commons	25 June 2002	Vol. 387, col 751
Royal Assent in the Lords	25 June 2002	Vol. 636, col 1191

ANNEX A: OUTLINE OF THE EXISTING LAW RELATING TO THE NHS[12]

195. The following paragraphs provide a brief description of the current legislative framework for the NHS. The legislative framework for the NHS in England and Wales is mostly set out in the 1977 Act. This has been amended quite substantially by various enactments, notably by the 1990 Act, the Health Authorities Act 1995 (the 1995 Act), the Primary Care Act, the Health Act and the HSC Act.

196. Under the 1977 Act, the NHS is essentially split into two different systems. There is first of all the system which consists primarily in the provision of health care in hospitals. It also covers those services described as "community health services", for example, the services provided by midwives or health visitors in clinics or individuals' homes, and the provision of medical services to pupils in state schools. This is the subject of Part 1 of the 1977 Act. The responsibility for securing the provision of these services to patients rests with the Secretary of State, although under his powers in section 16D (formerly section 13) of the 1977 Act he has delegated most of his functions to HAs. HAs enter into arrangements with bodies known as NHS trusts for the provision by the trusts of hospital and community health services.

197. The other main part of the NHS structure is what might be described as "the NHS in the High Street". This is dealt with under Part 2 of the 1977 Act. The professionals in question are general practitioners (GPs) (i.e. family doctors), general dental practitioners (GDPs), ophthalmic opticians and ophthalmic medical practitioners, and chemists. They respectively provide what are termed GMS (see section 29ff), GDS (see section 35ff), general ophthalmic services (see section 38-40) (GOS) and pharmaceutical services (see sections 41-43). The remainder of Part 2 contains other provisions relevant to the provision of these High Street services, which are sometimes referred to as "family health services".

198. The 1990 Act, the Primary Care Act, the Health Act and the HSC Act introduced a number of changes to these systems of health care although not all of those in the HSC Act are yet in force. Broadly speaking, these changes were as follows:

a) the 1990 Act introduced what is known as the internal market; by creating a divide between the planning and purchase of Part 1 services, on the one hand, and the provision of those services, on the other;

b) the Primary Care Act in effect enabled what were previously Part 2 services to be delivered, not under Part 2, but under a more flexible system within Part 1 of the Act - these changes applied only to doctors and dentists, and not the other family health services practitioners; and

c) the Health Act made a number of changes, but in particular provided for the abolition of GP fund-holding (introduced by the 1990 Act), the establishment of PCTs (a new type of NHS body to both commission and provide NHS care) and new arrangements to improve the quality of NHS services and co-operation between NHS bodies and Local Authorities;

d) the HSC Act also made a number of different changes, but in particular provided for changes to the funding of NHS bodies, Local Authority scrutiny of NHS provision, changes to the system for filling vacancies for GPs, additional lists for Part 2 practitioners, the abolition of the NHS tribunal, the provision of LPS (similar to the Primary Care Act arrangements for PMS/PDS), and the establishment of Care Trusts[13].

---

12 REFERENCES TO HAS IN THIS ANNEX ARE FOR HAS IN BOTH ENGLAND AND WALES. UNDER PROVISIONS IN THIS ACT, HAS IN ENGLAND WILL BE RENAMED AS STRATEGIC HEALTH AUTHORITIES.

13 Care Trusts are designed to bring together health and social care in one local organisation.

199. The two systems, Part 1 and Part 2, are very different. It should be noted that despite the changes introduced by the Primary Care Act the provision of Part 1 services is distinct from the provision of services under Part 2. The changes proposed in this Act will not alter this divide.

200. What follows is a more detailed description of the two systems.

PART 1 SYSTEM: HOSPITAL AND COMMUNITY HEALTH SERVICES

201. The system provided for under Part 1 of the 1977 Act (and Part 2 of the 1990 Act - discussed below) is the system under which all of the NHS, apart from family health services, is provided, including its hospitals. The core duty is laid upon the Secretary of State (1977 Act, section 1) in extremely broad terms, supplemented by the provisions of sections 2 to 5. It is these provisions which define the Secretary of State's overarching responsibilities to provide health services under a comprehensive health service. They are broad powers and thus frequently the legislative source for functions which have in practice, been delegated to health service bodies such as HAs and PCTs.

202. Section 3 sets out those general services which it is the Secretary of State's duty to provide to such extent as he considers necessary to meet all reasonable requirements. Most of the services, which may be described as hospital and community health services, are included under this section.

203. Section 5(1) and (1A) impose duties on the Secretary of State to provide medical and dental services to state school pupils. This is the basis for what is described as the school nursing service.

204. Section 2 confers wide ranging powers for the Secretary of State to provide such services as are appropriate to discharge any duty imposed on him by the Act (including his general duty under section 1), and to do any other thing whatsoever which is calculated to facilitate, or is conducive or incidental to, the discharge of such a duty. Further miscellaneous powers relating to specific matters are conferred by section 5(2) (for example, the conduct and assistance of research and development (section 5(2)(d)).

205. Sections 8 to 18 of the 1977 Act go on to provide for the administration of the NHS. These sections have been substantially amended since 1977, most recently by the Health Act. As amended, they provide for the setting up of HAs (section 8), Special Health Authorities (section 11) and PCTs (section 16A, as inserted by section 2 of the Health Act). HAs, Special Health Authorities and PCTs are independent statutory bodies, although their membership is determined in accordance with regulations (and in the case of Special Health Authorities, the establishment order) and some of the appointments to their membership are made by the Secretary of State. HAs and PCTs are established for territorial purposes. Each HA is established for such area of England and Wales as set out in the establishment order made under section 8; the entire area of England and Wales is covered by HAs. Each PCT is established for the area specified in its establishment order under section 16A(3). Each PCT area is wholly contained within the area of a HA but there is no requirement for total coverage. Some areas of England are covered by PCTs and the rest should be by April 2002; there are no PCTs in Wales, as the relevant provisions of the Health Act have never been brought into force in relation to Wales. Special Health Authorities are established for specific functional purposes - they are established for the purpose of performing any functions of the Secretary of State which he may direct them to perform under section 16C.

206. Legislation allows health service functions to be exercised by health service bodies in one of two ways. Functions are either directly conferred by the primary legislation or the person on whom they are directly conferred (either Secretary of State or a health service body) is permitted to delegate them to another health service body.

207. The Secretary of State may direct a HA or Special Health Authority to exercise his functions. He may also direct a Special Health Authority to exercise the functions of a HA or a PCT. He thus has no power to direct health service bodies other than HAs or Special Health Authorities to exercise his functions (section 16D, formerly 13, of the 1977 Act). A HA may direct a PCT established in their area to exercise its delegable functions (section 17A, inserted by section 12 to the Health Act: section 17A(3) lists the excepted or non-delegable functions). The Secretary of State may direct HAs that delegable HA functions are or are not to be exercisable by PCTs, or are to be exercisable by PCTs to any specified extent (section 17A(4)). The Secretary of State may also give directions to a HA, Special Health Authority or PCT about the exercise of any of their functions (section 17). A HA may also give directions to a PCT about the exercise of any functions which the HA has directed the PCT to exercise (section 17B). These directions may be given by regulations or by instrument in writing (section 18). There is very little further prescription in primary legislation as to what the Secretary of State must do or how he must do it in relation to the provision of that part of the NHS which is not concerned with family health services. It will be seen that this way of providing services is a great deal more flexible than the regulatory system under Part 2.

208. HAs may, in accordance with regulations and any relevant directions, delegate their functions (whether Part 1 or Part 2) to each other, or to committees or others: see section 16 of the 1977 Act (as substituted by paragraph 9 of Schedule 4 to the Health Act). Similar provision is made for PCTs (see section 16B of the 1977 Act as inserted by section 2(1) of the Health Act). Regulations have been made under both provisions.

209. HAs and Special Health Authorities are funded under the provisions of section 97, as substituted by paragraph 47 of Schedule 1 to the 1995 Act and amended by section 36 of the Primary Care Act, by sections 4 and 8 of the Health Act and section 1 of the HSC Act, and by section 2 of the HSC Act. HAs are paid money in each year under section 97(1) and section 97(3). Section 97(1) concerns the remuneration of persons providing Part 2 services and is not cash-limited (in other words the Secretary of State must pay whatever it has cost the HA, and he cannot impose a ceiling on the expenditure). Under section 97(3) a HA is paid money not exceeding the amount allotted to them by the Secretary of State. This amount is allotted towards meeting their "main expenditure" which includes all expenditure attributable to the performance of their Part 1 functions, and all their administrative costs. The money paid in respect of Part 1 services is therefore ultimately cash-limited. To enforce the cash-limits set by the Secretary of State, HAs have various financial duties imposed upon them by section 97A of the 1977 Act (as substituted by paragraph 48 of the 1995 Act and amended by paragraph 23 of Schedule 2 to the Primary Care Act).

210. PCTs are funded by HAs under section 97C of the 1977 Act, as inserted by section 3 of the Health Act and amended by section 3 of the HSC Act and amended by section 1 of the HSC Act. There is a similar distinction between cash-limited and non-cash-limited funding. Section 97C was amended by section 3(3) of the HSC Act so that in addition to HA allotments, the Secretary of State may make supplementary payments direct to PCTs. PCTs are subject to a set of financial duties similar to those for HAs (see section 97D, as inserted by section 3 of the Health Act and amended by section 3 of the HSC Act).

211. Although funding for the remuneration of Part 2 practitioners is largely non cash-limited ("general Part II expenditure"), section 97(3AA) of the 1977 Act, as inserted by section 1(2) of the HSC Act, provides that in determining a HA allotment the Secretary of State may take into account the level of the HA's "general Part II expenditure". Similarly, section 97C(1A), as prospectively inserted by section 1(4) of the HSC Act, provides that in determining PCT allotments, HAs may take into account the distribution within their area of their general Part 2 expenditure.

212. The cash-based system provided by sections 97, 97A, 97C and 97D has now been supplemented by a resource-based system provided for in sections 97AA and 97E, as

inserted by sections 12 and 13 of the Government Resources and Accounts Act 2000 and amended by section 1 of the HSC Act. These provide for the Secretary of State to set an annual limit on the use of resources by each HA and for HAs to set annual limits on the resources used by each of their PCTs.

PART 2 SYSTEM: FAMILY HEALTH SERVICES

213. The system provided for under Part 2 of the Act is quite different. The broad structure of the Part 2 system is similar for doctors, dentists, persons providing ophthalmic services and persons providing pharmaceutical services. This Annex first describes the existing system as it applies to doctors, and then if necessary describes any differences between that system and those relating to other professional groups.

214. Under section 29 of the 1977 Act, it is the duty of each HA in accordance with regulations to arrange as respects their area with medical practitioners to provide "personal medical services" for all persons in the area who wish to take advantage of the arrangements. These services are described as GMS. A principal feature of this system as it operates in practice is that (apart from certain exceptional cases) it is not the HA which itself provides the GMS; instead, it enters into separate statutory arrangements with independent practitioners for the provision of those services. GPs are therefore not (save in the exceptional circumstances referred to above, and which are not currently relevant) employees of the HA; they are independent professionals who undertake to provide GMS in accordance with the body of regulations governing that activity. Those regulations are currently the National Health Service (General Medical Services) Regulations 1992 (S.I. 1992/635) ("the GMS Regulations") as amended.

215. The remainder of section 29, as amended, sets out certain things which must or may appear in the regulations. Section 29 is prospectively amended by section 23 of the HSC Act. Section 29A (inserted by section 32 of the Primary Care Act and amended by section 20 of the HSC Act) prevents a HA making arrangements with a doctor unless he is on a medical list, and sets out certain restrictions on who is eligible to be on such a list, but are not yet in force. Section 29B gives a regulation-making power for the filling of vacancies for doctors which was also extended by section 20 of the HSC Act. Sections 31 and 32 provide for regulations requiring that each GP must be "suitably experienced" as prescribed. Section 33 provides the Secretary of State with power to control GP numbers if necessary. Provision relating to the Medical Practices Committee, set up under section 7 of the 1977 Act, which had a role in admitting GPs to the medical list is repealed by sections 14 and 15 of the HSC Act. Vacancies are now determined by HAs. A new power for regulations to enable HAs to conditionally include doctors in the medical list is in the new section 43ZA prospectively inserted into the 1977 Act by section 21 of the HSC Act but not yet in force. Similar provision is made for all the professions. Section 43D inserted by section 24 of the HSC Act gives power in regulations for HAs to keep lists of persons who assist in the provision of General Medical Services (in contrast to GP principals, who are included in the medical list) (See the National Health Service (Supplementary List) Regulations 2001 (SI 2001/3740) as amended). Similar provision is made for the other professions.

216. It is the duty of each HA in accordance with regulations to administer the arrangements made for the provision of GMS (and the other services): see section 15 of the 1977 Act. The HA must also perform such other management and other functions relating to those services as may be prescribed; and a number of functions have indeed been prescribed.

217. In contrast to the Part 1 system, the duty to make the arrangements for these services is conferred directly upon HAs, rather than upon the Secretary of State. Nonetheless, in exercising functions under Part 2, HAs may be the subject of Secretary of State directions issued under section 17 of the 1977 Act. HAs are able to delegate their Part 2 functions in accordance with regulations made under section 16 of the Act.

218. Subject to any Secretary of State directions under section 17A(4) of the 1977 Act, HAs may direct PCTs to exercise their functions in relation to GMS, but not in relation to other Part 2 services (see section 17A(3) of the Act).

219. This broad structure of the Part 2 system is similar for dentists, opticians, and chemists, but there are significant differences, most notably relating to chemists and opticians.

220. The provision for dentists (section 35 of the 1977 Act) is in very similar terms to that for doctors in section 29, although it will be noted that the duty upon the HA is subtly different. In the case of doctors, the HA must arrange for sufficient GMS to be provided for everybody in the area who wishes to take advantage of the arrangements. In the case of dentists this duty is not quite the same: the duty is not to arrange the provision of GDS for every-body in the area who wishes to have GDS, but rather to arrange with dentists in the area that any person for whom those dentists have under-taken to provide GDS receive the promised GDS. However, subject to that, the systems are by no means dissimilar: there exists a dental list of GDPs who undertake to provide GDS, there is a system of dental vocational training (although it has been introduced by regulations and not by primary legislation); the relationship between the HA and the GDP is (usually) again a statutory one between a HA and an independent professional. Unlike the case of GPs, however, there is in regulations provision in the case of dentists for the employment of salaried dentists at health centres: these dentists are employed by the HA, and represent one of the rare occasions when it is the HA itself which provides the services in question via its employees.

221. So far as chemists and opticians are concerned, opticians are provided for in section 38 of the 1977 Act, again according to the same scheme where-by the HA makes statutory arrangements with independent practitioners (who, in this case, might be individuals or bodies such as companies). However, the range of services to be provided by opticians is very much smaller. The only content now surviving of general ophthalmic services is sight testing for children, for persons whose resources are less than their requirements, and for other prescribed persons. Section 39 is a regulation making power in respect of ophthalmic services, which has also been extended by section 20 of the HSC Act.

222. More significant is the category of pharmaceutical services, provided for under section 41 of the 1977 Act. Again, the arrangements are made by HAs with independent persons or bodies; the system is governed by regulations; but the duty this time is to arrange for the provision of drugs, medicines and listed appliances, which are pre-scribed for them by health service doctors, dentists, or nurses, and of such other services as may be prescribed, to persons who are present in the HA's area. So far as pharmaceutical services are concerned, there are detailed regulations (introduced by sections 42 and 43) relating to entry on to a pharmaceutical list.

223. Additional pharmaceutical services may also be provided under section 41A of the 1977 Act, as inserted by the Primary Care Act. Such services are governed by Secretary of State directions, rather than by regulations, as for pharmaceutical services under section 41. A HA is only under a duty to make arrangements for such additional services where required to do so by direction.

224. Sections 43A and 43B of the 1977 Act, as substituted by section 10 of the Health Act, provide a structure for the remuneration of persons providing Part 2 services. Section 10 of the Health Act has, however, yet to be brought into force. Neither have the original sections 43A and 43B inserted by the Health and Social Security Act 1984 been commenced. In effect the original sections inserted by the 1984 Act must be complied with because of section 7 of the Act, which provides that a determination of remuneration made before the coming into force of those provisions is deemed to be validly made if regulations authorising it could have been made had that provision been in force at that time. It is therefore not open to the Secretary of State or anyone else to make a determination which is inconsistent with the provisions of sections 43A and 43B as inserted by the 1984 Act. What in fact happens is that the Secretary of State makes and publishes a determination for each of the professions, which takes the form

of the separate document referred to in each of the sets of regulations governing the four professions. These determinations therefore have the force of law, although they are not subject to any further degree of formality or Parliamentary procedure. The revised version of sections 43A and 43B, substituted by section 10 of the Health Act, were intended to provide a new framework to govern the remuneration of Part 2 practitioners, but have yet to be brought into force.

225. Each profession has in each HA area an LRC (called the Local Medical Committee, the Local Dental Committee, and so on). These represent local practitioners and are provided for under sections 44 and 45 of the 1977 Act.

226. There are detailed provisions for the removal or suspension of practitioners from the list in which their names are included. Initially, this was the responsibility of the NHS Tribunal, provided for under sections 46 to 49 of the 1977 Act. These sections were extensively amended by the National Health Service (Amendment) Act 1995, section 40 of the Health Act and, prospectively, by the HSC Act. A decision has been taken that section 40 of the Health Act will not be brought into force as it has been overtaken by the HSC Act amendments. However, the HSC Act repeals the provisions relating to the Tribunal in England, though it remains in force for Wales and inserts new sections 49F to 49R. These provide powers for HAs to remove doctors, dentists, opticians and those providing pharmaceutical services from their lists on prescribed grounds, or contingently remove them i.e. provide they will be removed unless they comply with certain specified conditions. HAs may also suspend doctors, dentists, opticians and those providing pharmaceutical services in certain circumstances. There is provision for review of HA decisions and for appeal to a new statutory body, the Family Health Services Appeal Authority (FHSAA). The FHSAA is set up by section 49S of the 1977 Act, inserted by section 27 of the HSC Act. It is constituted in accordance with new Schedule 9A. This new body may turn a local removal from a particular HA list into a national disqualification that prevents any HA from including them in their list.

227. The funding of these services is effected through section 97 of the 1977 Act, as substituted by the 1995 Act, Schedule 1, paragraph 47, and amended by section 36 of the Primary Care Act, section 4(2) of the Health Act and section 1(2) of the HSC Act. Section 97 must be read in conjunction with Schedule 12A to the 1977 Act, as inserted by section 4(1) of the Health Act. Section 97(1) and paragraph 1(1) of Schedule 12A provide for the remuneration of family health services practitioners in so far as it does not fall within paragraph 1(2) of Schedule 12A. Those paragraphs provide for:

a) the reimbursement of certain designated expenses (which also counts as "remuneration");

b) remuneration referable to the costs of drugs (i.e. that which is paid to pharmacists to reimburse them for the cost of drugs dispensed by them on the orders of GPs);

c) remuneration of chemists providing certain designated additional pharmaceutical services under section 41A of the 1977 Act;

d) designated remuneration of persons providing GMS which is determined by the HA.

228. Paragraph 3 of Schedule 12A provides a mechanism whereby the Secretary of State may apportion among HAs the total remuneration referable to the cost of drugs which is paid by each HA. Each HA has a duty to reimburse the pharmacists in their area for the costs of the drugs which they dispense on the orders of GPs. In some cases, a GP in the area of one HA prescribes a drug which is dispensed in the area of another HA. The power in paragraph 3 is used so that the cost of the drugs prescribed by the GP in first HA area is met from that HA's allotment, even though it is the other HA which initially reimburses the pharmacist for the cost of the drug.

THE 1990 ACT

229. It should be noted that the 1990 Act introduced a number of innovations in the systems described above. The system of GP fund-holding provided for by sections 14 to 17 was abolished by section 1 of the Health Act and is not described here.

NHS TRUSTS

230. Section 5 of the 1990 Act, and the immediately following provisions, provide for the setting up of bodies known as "NHS trusts". These are not HAs and are separate, independent bodies which were set up to assume responsibility for the ownership and management of hospitals or other establishments or facilities previously managed or provided by a HA (or, before 1 April 1996, its predecessor under the pre-1995 Act structure of the NHS), or to provide and manage hospitals or other establishments or facilities which were not previously so managed or provided. Section 5(1), as amended by section 13 of the Health Act, now provides that trusts are established to provide goods and services for the purposes of the health service. A trust's functions are conferred by its establishment order made under section 5(1) and by Schedule 2 of the Act.

231. Nearly all the hospitals in the country are now run by NHS trusts, although increasingly, smaller "community" hospitals are being run by PCTs. The essential difference between NHS trusts and the hospitals run directly by HAs is that the latter were funded by money paid to HAs for the purpose by the Secretary of State under (what is now) section 97(3) of the 1977 Act; generally speaking, NHS trusts do not have money paid to them direct by the Secretary of State, but instead must compete with each other for orders for their services placed by HAs (or more recently PCTs). HAs have thus been "purchasers" or "commissioners" of health care on behalf of the local population; while trusts are included among the "providers" of this health care. HAs may also choose to purchase health care from private sector institutions. In the period leading up to the creation of PCTs, HAs performed their commissioning functions through committees called Primary Care Groups. Today, most commissioning is carried out by PCTs (in England).

232. This system resulted in the creation of what was known as the "internal market", whereby the whole of the operation (including trusts) is still the NHS, but for internal purposes the purchasers or commissioners were split from the providers. However, it should not be of any concern to the patient how the internal arrangements work: so far as the patient is concerned, the whole thing is still the NHS.

233. The 1990 Act conferred on NHS trusts a substantial degree of autonomy. As well as not being funded centrally, the Secretary of State was able to give directions to NHS trusts only in relation to a limited range of subjects (paragraph 6 of Schedule 2). The Health Act restricted this freedom by extending to NHS trusts the Secretary of State's power of direction under section 17 of the 1977 Act (see section 12 of the Health Act).

234. Paragraph 5A of Schedule 3 to the 1990 Act, as inserted by section 3 of the HSC Act, now provides that the Secretary of State may make supplementary payments direct to NHS trusts. Most NHS trust income, however, continues to consist of payments by HAs/PCTs for the provision of services.

NHS CONTRACTS

235. The nature of the arrangements between HAs and trusts is not that of an ordinary contract enforceable at law. Instead, the 1990 Act provided for a system of "NHS contracts" (section 4), which were explicitly not contracts enforceable at law (section 4(3)), but which had attaching to them a special form of internal arbitration by the Secretary of State. The list of bodies between whom certain agreements take the form of NHS contracts rather than ordinary contracts is contained in section 4(2).

THE PRIMARY CARE ACT

236. The Primary Care Act introduced a new method of delivery of family health services. PMS and PDS may be provided under agreements known (in the initial stage at least) as "pilot schemes" (sections 1-3 of the Primary Care Act). These agreements are made between the HA and one or more of the persons or bodies listed in section 3(2). Before a pilot scheme may be made, the proposals for the scheme must be submitted to, and approved by, the Secretary of State (sections 4 and 5). The system of pilot schemes is intended ultimately to be replaced by a permanent regime, which is in substance the same as the pilot scheme regime but instead of being provided for in free standing provisions of the Primary Care Act is provided for by way of amendments to the 1977 Act: see sections 21 to 25 of the Primary Care Act which insert, in relation to England and Wales, sections 28C to G and 34A, none of which are in force. Further prospective amendments are made by the Health Act which inserts section 28EE, and section 26(1) of the HSC Act which inserted section 28DA.

237. Although the provider of PMS may be an NHS trust or other qualifying body, the services themselves must be *performed* by a "suitably experienced" medical practitioner. Section 26 of the HSC Act amends the Primary Care Act by inserting a new section 8ZA that provides powers to require the HA to keep a list of all the performers of PMS. No regulations have yet been made. It also provides for a services list of doctors to be kept under the permanent regime by inserting section 28DA into the 1977 Act.

238. Pilot schemes allow PMS and PDS (essentially the same as GMS and GDS) to be under the Part 1 system. The provisions of the 1977 Act apply in relation to functions of the Secretary of State in relation to pilot schemes as if the functions were functions under Part 1 of the Act. NHS trusts may enter into a pilot scheme as a provider of PMS or PDS. The 1977 Act (and in particular section 17) has effect in relation to services under pilot schemes as if the services were provided as a result of delegation by the Secretary of State (by directions given under section 16D of that Act) of functions of his under Part 1 (section 9 of the Primary Care Act).

239. These provisions allow PMS to be provided otherwise than through the rigid regulatory system of Part 2 of the 1977 Act. They allow HAs the power to determine locally the content of the service in their area or the practitioners with whom they choose to make the arrangements.

240. The HA funds the services provided under a pilot scheme from its cash-limited allocation under section 97(3). This means that in effect the remuneration of practitioners providing PMS or PDS under the Primary Care Act is cash-limited, in contrast to the remuneration of Part 2 practitioners.

THE HEALTH ACT

241. Part 1 of the Health Act made further changes to both the Part 1 system and the Part 2 system.

PCTS

242. In England, PCTs are a new tier of administrative body below HAs, and have primarily been concerned with the Part 1 system, although they may exercise certain HA functions relating to GMS. PCTs are established by the Secretary of State by orders under section 16A of the 1977 Act (as inserted by section 2(1) of the Health Act), with a view to their carrying out the activities listed in paragraphs (a) to (c) of that section. Their functions are conferred, in the main, by directions given by HAs under section 17A of the 1977 Act, as inserted by section 12 of the Health Act. There is currently no power for Secretary of State to delegate his functions direct to PCTs although he can under s17A(4) direct HAs to so delegate their 'delegable' functions. Under section 18(3) the Secretary of State can make regulations precluding the 'delegator' exercising delegated

functions. It is expected that all PCTs (i.e. covering all of England) will be established and operating by April 2002.

243. Most HA functions are delegable to PCTs (s17A). S17A(3) sets out those 'excepted functions' which may not be delegated.

244. In the exercise of the functions under Part 1 of the 1977 Act delegated to them by their HAs, PCTs have taken on the "commissioning" activities of the HAs. Unlike HAs, however, they also provide certain services (usually community health services rather than hospital services) in the exercise of those functions. A PCT is something of a "hybrid" between a HA and an NHS trust. The other significant feature of PCTs is that the regulations for the membership of PCTs made under paragraph 5 of Schedule 5A to the 1977 Act, as inserted by Schedule 1 to the Health Act, provide that a substantial number of PCT members and PCT committee members must be GPs, local nurses and other health care professionals providing or assisting the provision of services under the 1977 Act.

PART 2 SERVICES

245. The Health Act inserts section 43C into the 1977 Act to provide new powers for the Secretary of State to require persons providing Part 2 services to have indemnity cover (section 9), and a new structure for the remuneration of Part 2 practitioners (section 10, which has not yet been brought into force). and makes further provision for the disqualification of such practitioners by the NHS tribunal on the grounds of fraud (section 40, which again has not yet been brought into force and because of the intention in the HSC Act to abolish the Tribunal will never be, although fraud is one of the new grounds for HAs to remove practitioners).

QUALITY

246. Section 18 of the Health Act imposes a "duty of quality" on HAs, PCTs and NHS trusts. Sections 19 to 24 provide for the establishment and operation of a new independent statutory body known as CHI, which is responsible for monitoring the quality of care for which NHS bodies have responsibility. CPPIH is able to conduct a variety of reviews and investigations: see section 20(1).

THE HSC ACT

247. The HSC Act made further changes. The following paragraphs summarise those changes, although the relevant provisions may already have been referred to in the general description above of the NHS system.

HEALTH SERVICE FUNDING

248. Sections 1 to 5 of the Act makes various changes to health service funding: the Secretary of State and HAs may take into account the level of general Part 2 expenditure (which is not cash-limited) when determining the cash limited allotments of HAs and PCTs; changes are made to the arrangements under which Secretary of State may make payments to HAs on the basis of their past performance; the Secretary of State is given the power to make supplementary payments direct to PCTs; and provision is made for the Secretary of State to form, or participate in the formation of, companies, either for the purpose of providing facilities or services to the NHS (section 4) or for the purposes of income generation (section 5).

TERMS OF EMPLOYMENT OF HEALTH SERVICE EMPLOYEES

249. Section 6 of the HSC Act amends the 1977 and 1990 Acts so as to extend the Secretary of State's powers to direct as to the terms and conditions of staff of PCTs and NHS trusts. Section 6 came into force on 1st October 2001.

PART 2 SERVICES AND PMS/PDS

250. Sections 14 and 15 of the HSC Act provide for the abolition of the Medical Practices Committee and for HAs to determine GP vacancies. Section 16 provides for the abolition of the NHS tribunal; the Act provides that instead HAs will remove or suspend practitioners from Part 2 lists (section 25), subject to appeal to the FHSAA (section 27). Sections 17 to 24 make provision in relation to Part 2 services, including provision for out of hours GP services, changes to the Part 2 list arrangements and for supplementary lists for persons assisting the provision of Part 2 services. Section 26 enables the Secretary of State to make regulations for HAs to hold lists of persons who may perform PMS/PDS. Many of these provisions are not free-standing but proceed by way of amending or inserting new sections in the 1977 Act. For example, section 25 inserts new sections 49F to 49R and section 27 inserts section 49S and Schedule 9A. Not all of these provisions are in force.

PHARMACEUTICAL SERVICES

251. Sections 28 to 41 of the Act provide for the provision of "local pharmaceutical services" under arrangements similar to those for PMS and PDS under the Primary Care Act. Sections 42 to 44 makes a number of changes to the existing system for the provision of pharmaceutical services under Part 2 of the 1977 Act.

CARE TRUSTS

252. Section 45 provides for the Secretary of State to designate NHS trusts or PCTs as "Care Trusts" where those trusts exercise Local Authority functions under "partnership arrangements" under section 31 of the Health Act (see the following section). The designation does not affect the trust's powers and duties in relation to their NHS functions. Section 45 has not yet been brought into force.

THE NHS AND LOCAL AUTHORITIES

253. Local Authorities are responsible for the provision of what may be described as "social care," e.g. residential accommodation for the disabled or elderly. The enactments under which functions in this respect are conferred on Local Authorities are set out in Schedule 1 to the Local Social Services Act 1970 (c.42) and other legislation. Section 21 and Schedule 8 of the 1977 Act make provision for the exercise of certain specified functions. Local Authorities also exercise functions in respect of housing (e.g.: the Housing Act 1985 (c.68)) and education (the Education Act 1996 (c.56)).

254. Sections 22 and sections 26 to 28BB of the 1977 Act, as amended by sections 27, 29 and 30 of the Health Act, make provision for co-operation between the NHS and Local Authorities. Section 22(1) of the 1977 Act, as substituted by section 27(2) of the Health Act, places a general duty on NHS bodies (on the one hand) and Local Authorities (on the other) to co-operate in the exercise of their functions in order to secure and advance the health and welfare of the people of England and Wales. Sections 26 to 28 make provision for the supply of goods and services by the Secretary of State to Local Authorities and vice-versa. Section 28A of the 1977 Act, as amended by section 29 of the Health Act, makes provision for HAs in England to make payments towards expenditure by Local Authority bodies on community services, such as social services, housing and education for the disabled. Section 28B makes similar provision for Wales.

255. The Health Act makes further provision for co-operation between the NHS and Local Authorities. Most importantly, section 31 makes provision for NHS bodies and Local Authorities to enter arrangements under which an NHS body exercises LA functions or vice-versa. Provision is also made for arrangements to operate a "pooled fund" from which payments may be made towards expenditure on either NHS or LA functions. In addition to section 31, section 28 provides for HAs, with the assistance of PCTs, NHS trusts and Local Authorities, to prepare plans setting out a strategy for improving both the health of the local population and the provision of health care to that

population. Section 30 of the Health Act inserts a new section 28BB into the 1977 Act, which makes provision for Local Authorities to make payments towards expenditure incurred by NHS bodies: this provision mirrors section 28A of the 1977 Act.

256. The HSC makes further changes in relation to "partnership arrangements." Sections 45, 47 and 48 makes provision for NHS trusts and PCTs to be designated as Care Trusts where those trusts exercise Local Authority functions under arrangements under section 31 of the Health Act. Section 46 provides that the Secretary of State may, in certain circumstances, direct NHS bodies and Local Authorities to enter into such arrangements. Sections 46 to 48 came into force on 1st August 2001 but section 45 is not yet in force.

MISCELLANEOUS

Involvement and representation of the public

257. Section 20 of, and Schedule 7 to, the 1977 Act provide for CHCs. CHCs have the function of representing the interests in the health service of the public in its district. By virtue of regulations under paragraph 2 of Schedule 7, and the provisions of the 1977 and 1990 Acts relating to the establishment of PCTs and NHS trusts, CHCs must be consulted by the Secretary of State or HAs on various proposals relating to the health service in a CHC's district.

258. The HSC Act made a number of additions to these arrangements. Sections 7 to 10 of the Act provide for the scrutiny of health service provision by Local Authority overview and scrutiny committees established under the Local Government Act 2000. Section 11 imposes a duty on NHS bodies to make arrangements with a view to securing that the public (or their representatives) are involved in and consulted on the planning of NHS services, proposals for changes in the way services are provided and decisions affecting the operation of those services. Section 12 inserts a new section 19A in the 1977 Act, imposing on the Secretary of State a duty to provide "independent advocacy services," i.e. services providing assistance (by way of representation or otherwise) to individuals making or intending to make complaints under the various NHS complaints procedures. None of these sections have yet been brought into force.

Inquiries, and default, emergency and intervention powers

259. Section 84 of the 1977 Act enables the Secretary of State to appoint an inquiry in connection with matters arising under the 1977 Act, Part 1 of the 1990 Act or Part 1 of the Health Act. In addition to these formal inquiries, the Secretary of State conducts or appoints a variety of 'informal' inquiries, investigations and reviews in the exercise of his powers under section 2(b) of the 1977 Act. Finally, CHI may investigate matters relating to the management, provision and quality of health care for which NHS bodies are responsible (see section 20(1)(c) of the Health Act).

260. The Secretary of State has powers to intervene if NHS bodies fail to perform their functions or fail to comply with regulations or directions (section 85) and if, by reason of an emergency, a service under the 1977 Act may cease to be provided (section 86).

261. Sections 84A and 84B of the 1977 Act, as inserted by section 13 of the HSC Act, which came into force on 1st August 2001, provides for the Secretary of State to make intervention orders where NHS bodies are not performing functions adequately or there are significant failings in the way they are being run. The orders may provide for the removal, suspension and replacement of the members/directors of the body in question, and for the body to enter arrangements for another person or body to perform its functions.

Wales

262. Many of the functions of the Secretary of Sate in relation to the NHS have been exercised in Wales since 1 July 1999 by the Assembly (see the National Assembly for Wales (Transfer of functions) Order 1999 SI

1999/6720)

ANNEX B: TABLE OF EFFECTS OF THE ACT IN RELATION TO WALES

(PROVISIONS MARKED WITH AN ASTERISK HAVE EFFECT IN RELATION TO BOTH WALES AND ENGLAND)

Provision	*Effect*
Section 1(2)*	Inserts a new section 8 into the 1977 Act which continues the existing law in relation to HAs established for areas in Wales.
Section 4*	Amends the Primary Care Act, the HSC Act 2001 and (via Schedule 3) other enactments to allow for the continuation of HAs in Wales.
Section 6(1)	Inserts three new sections into the 1977 Act, which make provision for the following - Section 16BA - establishment of LHBs in Wales by the Assembly; Section 16 BB - conferring of functions on LHBs; Section 16 BC - the exercise by LHBs of their functions.
Section 6(2)	Refers to Schedules 4 and 5 (see below).
Section 6(3)	Applies the general provisions of s.126 of the 1977 Act (relating to the making of orders, regulations and directions) to orders, regulations and directions concerning LHBs.
Section 6(4)	Applies the provisions of the National Health Service (Private Finance) Act 1997 (power to enter into externally financed development agreements) to LHBs.
Section 9	Inserts three new sections into the 1977 Act which deal with the following - 97F - public funding of LHBs 97G - financial duties of LHBs 97H - resource limits for LHBs.
Section 10(1)*, (2), (3)*, (4), (9) and (10)*	Amend the 1977 Act to apply to LHBs the relevant provisions regarding expenditure of NHS bodies.
Section 10(5)*, (6)* and (7)*	Make amendments to the 1977 Act concerning remuneration for drugs and pharmaceutical services.
Section 11*	Extends the duty of quality under section 18 of the Health Act to include the environment in which health care services are provided.
Section 12*	Confers further functions on CHI by amending the 1999 Act.
Section 13*	Amends the 1999 Act in relation to inspections and investigations by CHI.
Section 14*	Amends the 1999 Act in relation to the constitution of CHI.
Section 22(1)* and (3)*	Abolish CHCs in England only and ACHCEW.
Section 22(4)	Continues (in relation to Wales) a power to create a body in Wales equivalent to ACHCEW, to be exercisable by the Assembly.
Section 22(5)(b)* and (7)*	Provide for the transfer to the Assembly (after consultation) of any property, rights and liabilities of ACHCEW.

Provision	*Effect*
Section 23*	Provides for joint working between the NHS and prison service (in England and Wales) in relation to securing and maintaining the health of prisoners.
Section 24	Provides for the joint formulation and implementation by LHBs and Local Authorities in Wales of a strategy for the health and well-being of the public in their area.
Section 25*	Provides for the establishment and functions of the Council for the Regulation of Health Care Professionals (the Council).
Section 26*	Provides for the powers and duties of the Council.
Section 27*	Deals with the relationship between the Council and regulatory bodies
Section 28*	Makes provision in respect of complaints about the regulatory bodies.
Section 29*	Deals with the reference by the Council of disciplinary cases to court.
Section 30*, 31*, 32* 33* and 34*	Deal with appeals by medical practitioners, dentists, opticians, osteopaths and chiropractors.
Section 35*	Deals with regulation of the profession of pharmacy.
Section 36*	Provides for consolidation of the health legislation in relation to England and Wales.
Section 37*	Effects minor and consequential amendments and repeals.
Section 38*	Deals with the making of regulations and orders.
Section 39*	Confers a power (exercisable in Wales by the Assembly) to make regulations to give full effect to any of the provisions of this Act.
Section 40	Amends the National Assembly for Wales (Transfer of Functions) Order 1999 (SI 1999/672) to include the amendments made by this Act.
Section 42(4)*	Provides that the Assembly is the appropriate authority in relation to the sections listed, and provides for the Assembly to be consulted by the Secretary of State in certain cases.
Schedule 3*	See notes relating to section 4 above.
Schedule 4	Inserts a new Schedule 5B into the 1977 Act which provides further detail on the establishment of LHBs, their status, constitution and membership, and other matters.
Schedule 5	Makes amendments to other enactments relating to LHBs.
Schedule 7*	Provides further detail on the Council.
Schedule 8*	Makes minor and consequential amendments.
Schedule 9*	Makes certain repeals.