*These notes refer to the Health Act 1999 (c.8) which received Royal Assent on 30 June 1999*

# HEALTH ACT 1999

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## EXPLANATORY NOTES

### COMMENTARY ON SECTIONS

### Part II - the National Health Service: Scotland

#### *Section 45: Repeal of law about fund-holding practices*

292. Sections 87A to 87C of the 1978 Act (inserted by the 1990 Act) provided for the establishment of fund-holding practices in Scotland (see the commentary on section 1 for fuller background on fund-holding). As set out in the White Paper *Designed to Care*, GP fund-holding in Scotland will be abolished and Local Healthcare Co-operatives will be set up. These will be voluntary networks of GPs and other primary care professionals working together to plan and provide primary and community health services and provide support for general practice. Local Health Care Co-operatives will be established from April 1999 as part of the management structure of primary care NHS trusts (see sections 46 to 49) and will draw their powers and functions from these trusts. They do not therefore require separate legislative provision. (For the purposes of these Explanatory Notes only, in order to avoid confusion with the Primary Care Trusts being introduced in England and Wales, these bodies are referred to as "primary care NHS trusts". In everyday usage they will be called "Primary Care Trusts", in accordance with the terminology employed in *Designed to Care*.)

293. The repeal of sections 87A to 87C by section 45 will abolish the fund-holding system. The transitional arrangements for winding up the fund-holding scheme will be made under the powers conferred by section 63. The transitional provisions will cover arrangements for closing the fund-holding accounts of residual fund-holders; the transfer of those assets, rights and liabilities that need to be transferred to Health Boards or primary care NHS trusts; and any provision for those that are to remain with the former fund-holders.

#### *Sections 46 to 49: NHS trusts*

294. These sections enable the establishment of primary care NHS trusts in Scotland which will bring together community health services, primary care and mental health within a single organisation. They also provide NHS trusts with greater powers in dealing with their estate. This is intended to improve integration and co-ordination of primary and community health services and the provision of organisational support for GPs and other primary care providers. Through the establishment of Local Health Care Co-operatives (see commentary on section 45) the new organisations will also enable GPs and other primary care staff to become involved in the development and management of services. The new organisations will be governed by the existing legislative provisions relating to NHS trusts (as amended by the Act). In general there will be one primary care NHS trust in each Health Board area.

295. *Section 46* mirrors section 13, achieving the same result for Scotland as section 13 does for England and Wales regarding the establishment of NHS trusts (see the commentary on section 13 for background detail).

296. Subsection (1) provides a new function for NHS trusts. It permits the Secretary of State for Scotland to establish NHS trusts to provide goods and services for the purpose of the health service. In addition, the Secretary of State will be able to confer, in an NHS trust's establishment order, a duty to provide particular goods or services, at or from particular hospitals or facilities. This includes responsibility for services under Part II of the 1978 Act. These Part II services, also known as family health services, are: general medical services; general dental services; general pharmaceutical services; and general ophthalmic services. Primary care NHS trusts will be able take on the responsibility for a range of functions currently carried out by Health Boards including: making arrangements with suitably qualified Part II practitioners to supply services in their area; ensuring that patients have access to family health services; associated functions relating to the remuneration and discipline of practitioners and the development of primary care services. The intention is that primary care NHS trusts with responsibility for these functions, will be able to develop community and primary care health services in an integrated way.

297. Although it is intended to delegate to primary care NHS trusts the day to day operational functions relating to Part II services, Health Boards will continue to have a responsibility for the overall planning of primary care services. This will be achieved, as now, through Health Boards exercising on behalf of the Secretary of State the duty in section 18 of the 1978 Act to secure the provision of Part II services.

298. *Section 47* inserts a new section 12AA in the 1978 Act which provides for the delegation of Part II services, currently the responsibility of Health Boards, to NHS trusts. For each Board, functions will be delegated to the NHS trust designated by direction of the Secretary of State. This will be the relevant primary care NHS trust established to provide services in the Board's geographic area. In most cases there will be only one primary care NHS trust in each Health Board area, but where there is more than one (as is proposed for Argyll & Clyde and Lothian Health Boards), the Secretary of State will be able to designate which trust will have responsibility for Part II services in which particular area. Where there is no primary care NHS trust (as in Shetland, Orkney and Western Isles Health Boards), Part II services will continue to be the responsibility of the Health Board.

299. *Section 48:* The White Paper *Designed to Care* signalled the intention to modify the existing arrangements for NHS trust boards as part of the new proposals. Provisions for the broad composition of NHS trust boards are set out in section 12A(3) of the 1978 Act. This provides that an NHS trust board is a body corporate with a board of directors consisting of a chairman appointed by the Secretary of State, and executive and non-executive directors. Section 48 amends section 12A(3)(a) of the 1978 Act to provide that in future non-executive directors will be known as "trustees". Regulations made under section 12A(5) allow the Secretary of State to specify the maximum and minimum numbers of members of the trust board. The power is likely to be used to specify that an NHS trust board must have not more than 5 executive directors (who are employees of the trust) and not more than 5 non-executive trustees. In the case of NHS trusts which are teaching hospitals, however, an extra trustee will be appointed to represent the relevant university. The overall intention is to broaden the range of those who can be appointed to act as trustees.

300. *Section 49:* The current direction-giving powers in respect of NHS trusts are conferred by paragraph 6 of Schedule 7A to the 1978 Act and relate to a limited number of very specific matters. Section 49 replaces these powers of direction with a general power, in line with that relating to Health Boards, which enables directions to be given in relation to the full range of NHS trusts' functions. The Government intends to use this power to meet the commitment in the White Paper *Designed to Care* to ensure that the NHS trusts manage their estate in ways which are consistent with local strategic plans.

### *Section 50: Transfer of staff among health service bodies*

301. This section makes provision for the transfer of staff among health service bodies. Section 12B of the 1978 Act ensured that when facilities transferred from Health Board to NHS trusts on the original establishment of NHS trusts, the rights and terms of employment of staff who worked in those facilities transferred with them. Under section 47 of this Act, provision is made for the Secretary of State for Scotland to direct Health Boards to delegate some of their functions to NHS trusts. In most cases no transfer of facilities will be involved. However, there are likely to be other changes in future (for example, some functions in relation to services may move from one NHS trust to another). This section extends to all transfers of functions between health service bodies, the protection for staff that section 12B conferred upon staff transferring from Health Boards to NHS trusts.

### *Section 51: Quality of Care*

302. The White Paper *Designed to Care* announced the intention to amend the statutory duties of NHS trusts to make explicit their responsibility for quality of care. Under the terms of the 1978 Act, NHS Trusts have a duty to meet such financial objectives as are set by the Secretary of State. Section 51 adds a new duty relating to the quality of health care provided to patients.

303. Under section 51, NHS Trusts, the Island Health Boards (which have responsibility for directly managed units), the Common Services Agency and the State Hospital will be required to draw up arrangements which will enable them to monitor and improve the quality of health care for which they have responsibility. A fundamental component of those arrangements will be implementation of the clinical governance arrangements set out in the Scottish Office publication MEL(1998)75, issued in November 1998.

### *Section 52: Expenditure of Health Boards and other bodies*

304. Section 85 of the 1978 Act currently provides for two streams of funding from the Secretary of State to Health Boards to allow them to perform their functions as required by that Act. The section draws a clear distinction between resources for functions covered by Part I of the 1978 Act (hospital and community health services) and functions under Part II of the 1978 Act. Funding for the Part II functions includes provision for the pay and expenses of GPs, dentists, pharmacists and optometrists. In particular, this includes the reimbursement of costs incurred by pharmacists (and other dispensing contractors) in dispensing prescriptions issued by GPs, known as "prescribing costs".

305. The allocations to Health Boards for Part I functions are cash limited whereas the majority of the Part II functions are funded from non-cash limited resources. With the exception of certain general medical services expenditure, it is not possible under the present section 85 of the 1978 Act to include any of the Part II functions in the cash limited stream of funding where so desired. Section 52 inserts a new section 85AA in the 1978 Act to provide for certain Part II expenditure to be funded from within cash limited resources. This underpins the introduction of a single stream of cash limited funding to Health Boards to collectively cover expenditure on hospital and community health services and GPs' prescribing costs. This will give Boards and, in turn, primary care NHS trusts increased financial flexibility in the use of their resources.

306. The new section 85AA retains the Secretary of State's power, currently at section 85(1), to issue cash limited allocations (for "main expenditure") and to provide, as per the current section 85(2)(b), non-cash limited resources (for "general Part II expenditure") to Health Boards. Subsections (4)(a) and (b) provide for certain defined elements of Part II expenditure to be brought within cash limited allocations. Subsection (4)(d) makes the same provision for certain elements of GMS remuneration designated by the Secretary of State.

307. The new section 85AA also retains the Secretary of State's power of direction, currently at section 85(2A), on the application of sums paid to Health Boards for Part I functions, and extends that power to Part II sums.

308. Section 52 also inserts a new section 85 into the 1978 Act, consequential on the changes described above, which retains the current funding regimes of the other health agencies listed in section 85(1).

### *Sections 53 to 55: NHS trust financial provisions*

309. These sections together with paragraph 63 of Schedule 4 effect changes in the current NHS trust financial regime. The provisions reflect the same changes being made to the equivalent English and Welsh provisions, which are explained fully in the commentary on sections 15 to 17. In summary they provide for the following:

- NHS trusts' originating capital debt will be comprised wholly of public dividend capital – this removes interest bearing debt and the administrative arrangements for its ongoing recovery;
- additional borrowing by NHS trusts other than from the Secretary of State will be at his direction and subject to conditions he may determine – the aim is to ensure that, in the main, NHS trusts borrow only from the Government, although there will be exceptions to this notably in the area of PFI schemes;
- investment of temporary surpluses by NHS trusts will be at the direction of the Secretary of State – in practice this will largely be restricted to Paymaster Accounts with the effect of reducing overall Exchequer borrowing.

### *Section 56: Indemnity cover for Part II services*

310. This section (which makes the same provision for Scotland as section 9 does for England and Wales) will allow the Secretary of State to require Part II family health service practitioners (those providing general medical services, general dental services, general ophthalmic services, or pharmaceutical services) to hold indemnity cover.

311. The Secretary of State would be able to enforce the requirement in either (or both) of two ways. Regulations could specify that having approved indemnity cover is a requirement to joining a Health Board's list for a Part II service, and that practitioners on the list must hold approved indemnity in order to remain on the list, in order to practice those services on the NHS. Regulations would also allow the Secretary of State to specify that the holding of approved indemnity cover be set out in terms of service for a Part II service. This would mean that if approved cover was not held, the practitioner in question would be subject to the established Health Board disciplinary committees and, ultimately, to the NHS Tribunal which might strike them from the Health Board list if it was determined that their continued inclusion would be prejudicial to the efficiency of the service.

312. The indemnity could also be required to cover other persons prescribed in relation to the practitioner, i.e. employees, assistants or deputies of the practitioner. The intention is that the cover currently held by responsible practitioners should be quite adequate to meet any new requirements, and only those contractors who fall short of reasonable cover will find themselves affected. Regulations under the amendment would allow the Secretary of State to specify the type of indemnity cover that would be approved.

### *Section 57: Remuneration for Part II services*

313. Section 57 mirrors section 10, achieving the same result for Scotland as section 10 does for England and Wales regarding the remuneration of Part II practitioners (see the note on section 10 for background detail).

314. This section substitutes new sections 28A and 28B of the National Health Service (Scotland) Act 1978. The intention is to legitimise the current practice in relation to the determination of remuneration for Part II practitioners and in particular to ensure that the existing basis by which Health Boards are appointed as determining bodies is put on a firmer footing. It provides for remuneration for Part II services in Scotland to be determined by determining authorities. The determining authority will be the Secretary of State and any Health Board or other person appointed by him.

315. The new section 28A describes how such remuneration can be paid. Subject to sections 19(3) and 25(3) of the NHS (Scotland) Act 1978, remuneration under section 28B may consist of payments by way of salary, fees, allowances or reimbursement of expenses of FHS practitioners such as doctors, dentists, community pharmacists and optometrists in Scotland. Primary Care NHS Trusts in Scotland will be given the function of determination of such GP remuneration as comes from cash-limited funds.

316. Provision is also made for the Secretary of State to consult national representative bodies of each group before making a national determination that would affect the whole of that group. Determinations may be made in several stages, as is currently the case. The changes in the new sections are intended to reflect and validate current practice.

### *Section 58: Disqualification of practitioners for fraud etc.*

317. Section 58 substitutes new sections 29, 29A, 29B, 29C and 30 for sections 29 and 30 of the 1978 Act, as amended by the NHS (Amendment) Act 1995, mirroring changes being made to the equivalent English and Welsh provisions. Consequential amendments in Schedule 4 (paragraphs 49 to 53 and 64) amend sections 31, 32, 32A, 32B and 32D and paragraph 8 of Schedule 8 to the 1978 Act. These provisions give new powers to the NHS Tribunal to disqualify practitioners in the family health services who have caused or risked causing detriment to any health scheme by securing financial or other benefits to which they knew they were not entitled. (In addition to the NHS, a "health scheme" can include other publicly funded schemes such as the prison medical service and the defence medical service, where these have been prescribed by virtue of the power in new section 29(9)(b).)

318. The NHS Tribunal is an independent statutory body with strictly defined duties and powers. Its existing role is to decide whether the continued presence of a practitioner on the list of family health service contractors (either nationally or locally) would prejudice FHS efficiency and, where proven, to remove such practitioners from the list and, if it chooses, prevent them from being employed by other FHS practitioners. Such cases are defined as "efficiency cases" in new sections 29(6) and (11). The Tribunal is also able to suspend practitioners pending inquiries in order to protect patients.

319. Practitioners must join family health service lists to offer general medical, dental, ophthalmic or pharmaceutical services and representations to the Tribunal about removal from such lists are usually made by Health Boards. Section 58 gives effect to the recommendation in the Report of an Efficiency Scrutiny on Prescription Fraud, published in June 1997, that Health Authorities (and therefore, in Scotland, Health Boards) should have discretion to refuse to accept onto family health service lists practitioners found guilty of serious financial irregularity. This section enables Health Boards to make representations about such cases (defined as "fraud cases" at new sections 29(7) and (11)) to the NHS Tribunal and extends the Tribunal's powers to deal with these.

320. *New section 29* gives the NHS Tribunal new powers to inquire into cases where it is alleged that a practitioner has acted in a way detrimental to any NHS service by securing, or attempting to secure, benefits to which he knew he was not entitled. This includes securing, or attempting to secure, benefits for another who the practitioner knows is not entitled to them. Detriment to a health service is defined in section 29(10)

as including detriment not only to any patient, but also to another person working in that scheme.

321. *New section 29A* allows the Tribunal to disqualify pharmaceutical and ophthalmic bodies corporate from FHS lists where any director or, in the case of a pharmacy business, any person controlling the body corporate meets the condition for disqualification, whether or not he was a director or person controlling the company at the time. It also provides for liability for the conduct of employees or deputies in fraud cases where the practitioner failed to take reasonable steps to prevent the acts or omissions concerned.

322. *New section 29B* sets out, for both efficiency and fraud cases, the sanctions the Tribunal already has in efficiency cases:

- to disqualify the practitioner from the list(s) in respect of which representations have been made;
- to disqualify the practitioner from the corresponding lists of other Health Boards;
- to make a declaration that the disqualified practitioner should not be engaged in any capacity connected with provision of family health services.

323. In fraud cases representations may also be made to the Tribunal in respect of applicants to family health service lists as well as those already on such lists (new section 29(2)(b).

324. *New section 29C* contains a new power enabling the Tribunal to make a conditional disqualification in efficiency or fraud cases. It can make an order for disqualification which does not come into effect unless the practitioner breaches conditions which are also specified by the Tribunal. Where necessary, the Tribunal may vary the practitioner's terms of service and confer functions on the Health Board to give effect to the conditions.

325. *New section 30* provides that the Tribunal may review, where it considers appropriate, any declaration or disqualification, including the conditions attached to a conditional disqualification. It may also review them at the request of the disqualified practitioner or review conditions attached to a conditional disqualification at the request of a Health Board. It can then remove a disqualification, make it conditional, or, in the case of a conditional qualification, vary the conditions (e.g. where circumstances have changed) or make it unconditional (e.g. where the conditions have been breached). In fraud cases only, the Tribunal may also impose for the first time on review a disqualification from the lists of the Health Boards, or a declaration of unfitness.

326. The amended section 32A extends the Tribunal's current power of interim suspension to fraud cases. The Tribunal may direct suspension in order to prevent further fraud or prejudice to the investigation of the case or review (new section 32A(2A)(b)).

327. In addition to the NHS Tribunal in Scotland, there are separate NHS Tribunals under corresponding legislation in England and Wales, and in Northern Ireland. Decisions by any of the NHS Tribunals for national disqualification already apply automatically in each country. Section 31(1) now provides for a decision for total disqualification (a declaration of unfitness to practice) by the Tribunals for England and Wales, and for Northern Ireland to be recognised similarly (see paragraph 49 of Schedule 4 to the Act). New section 31(2) provides for the conditions specified in a conditional disqualification made by the Tribunal in England and Wales or in Northern Ireland to be translated for equivalent effect in Scotland. Schedule 4 to the Act also contains provisions for dealing with overlapping cases.

### *Section 59: Recovery of charges and payments*

328. Section 59 inserts new sections 99ZA and 99ZB into the 1978 Act and amends section 105(3). It contains provisions for a new civil penalty to deter patient evasion of

NHS charges. The penalty will apply to NHS charges for prescriptions, dental treatment or optical services, including those provided for hospital outpatients, and to payments or benefits such as NHS optical vouchers or free NHS sight tests.

329. It is intended that regulations will be made to provide for a penalty to be imposed where a person fails to pay an NHS charge, or claims a payment to which he is not entitled, towards the cost of an NHS charge or service. Exemptions from charges are granted on a number of grounds, including age, certain medical conditions, receipt of some Social Security benefits or low income. The regulation making power in the new section 99ZB will allow regulations to provide for a penalty notice to be sent requiring the patient to pay the original charge and an additional penalty, where it is found that an exemption, reduction or payment has been claimed incorrectly.

330. Under the powers in new section 99ZB, regulations will be made which will set out the information that penalty notices must contain, the amount of the penalty payable, the payment period and the arrangements for payment. The amount of the penalty will be subject to the maximum in subsection (2) which is either £100 or 5 times the unpaid charge, whichever is the less. Subsection (3) provides a power allowing these maxima to be changed by Order which, under amended section 105(3), would be subject to affirmative resolution procedure in Parliament.

331. Under new sections 99ZB(4) and (5), regulations may also provide that, where the penalty charge is not paid within the period prescribed, a surcharge may be levied of up to 50% of the penalty charge. All sums payable under the penalty provisions will be recoverable as a civil debt.

332. Where more than one person may be liable for payment, for example, where a patient has a representative who signs forms or claims on his behalf, new section 99ZA(3) provides for them to be liable for payment "jointly and severally". In practice, either the patient or the representative could be held liable to pay according to the circumstances but the penalty may only be recovered once. Under new section 99ZB(7)(b), a person shall not be liable if he shows that he did not act "wrongfully, or with lack of due care".