These notes refer to the Health Act 2009 (c.21)
which received Royal Assent on 12 November 2009

HEALTH ACT 2009

EXPLANATORY NOTES

BACKGROUND AND SUMMARY

Quality and Delivery of NHS Services in England

General Background: NHS Next Stage Review

8. In a statement to the House of Commons on 4 July 2007[1], the Secretary of State for Health, Rt Hon. Alan Johnson, announced a review of the National Health Service (NHS). The NHS Next Stage Review, which was led by Lord Darzi of Denham, sought to develop a plan for the NHS over the next decade by engaging with patients, staff and the public.

9. On 4 October 2007 the Interim Report, *Our NHS, Our Future*,[2] was published. The Interim Report set out a 10 year plan for the NHS and considered how the NHS could become fairer and more personalised, effective and safe. It set out immediate and longer term priorities in these areas.

10. The NHS Next Stage Review Final Report, *High Quality Care for All*,[3] was published on 30 June 2008. The Final Report responds to the ten Strategic Health Authority strategic plans and puts forward a strategy for the NHS with a focus on quality.

11. This Act implements the parts of the NHS Next Stage Review that require primary legislation. The Act includes provisions concerning the NHS Constitution, Quality Accounts and direct payments for NHS healthcare services.

Chapter 1 - NHS Constitution

12. The Interim Report published in October 2007 set out the case for an NHS Constitution. This was said to be#

    "to enshrine the values of the NHS and increase local accountability to patients and public.

13. On 30 June 2008, the Department of Health published *A Consultation on the NHS Constitution*[4]. The NHS Constitution and the Handbook to the Constitution were published on 21 January 2009[5].

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1 Available at:http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070704/debtext/70704-0004.htm#07070441000007

2 Department of Health (2007). – *Our NHS, Our Future - NHS Next Stage Review Interim Report.* Department of Health, London. Available at: http://www.ourNHS.NHS.uk/fromtypepad/283411_OurNHS_v3acc.pdf

3 Department of Health (2008). *High Quality Care for All - NHS Next Stage Review Final Report,.* CM 7432. Department of Health, London.
Available at:http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825

4 Department of Health (2008). *The National Health Service Constitution – A Draft for Consultation, July 2008.* Department of Health, London.

5 Department of Health (2009). *The NHS Constitution for England, 21 January 2009.* Department of Health, London. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419
Department of Health (2009). *The Handbook to the NHS Constitution for England, 21 January 2009.* Department of Health, London. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093421

14. The sections of the Act on the NHS Constitution set out duties of specified bodies involved in the provision, commissioning or regulation of NHS care and of other persons providing NHS services under contracts or arrangements. The Act provides that those bodies are to have regard to the NHS Constitution, and for the Secretary of State to review the NHS Constitution at least every ten years, after consultation with patients and bodies representing patients, the public, staff and bodies representing staff, carers and local authorities. The Act also provides that the Secretary of State must revise the accompanying Handbook to the NHS Constitution at least every three years. The Secretary of State must also report on the effect of the NHS Constitution on patients, the public, staff and carers every three years.

Chapter 2 - Quality Accounts

15. *High Quality Care for All* said that from April 2010 all healthcare providers working for or on behalf of the NHS would be placed under a legal requirement to publish an annual Quality Account. Sections 8 and 9 of the Act therefore place a duty on those providers although section 8 also gives the Secretary of State a regulation-making power enabling the Secretary of State to exempt prescribed persons, or the providers of prescribed services, from this requirement.

16. The duty is to publish prescribed information about quality of services for the period 1 April to 31 March each year. Section 8 gives the Secretary of State a further regulation-making power, including power to determine the form, content and timetable for publication of a Quality Account.

Chapter 3 - Direct payments

17. The Government made a commitment in *High Quality Care for All* to pilot personal health budgets, including piloting direct payments for health care where this would make most sense for particular patients in certain circumstances. Direct payments are monetary payments to patients with which they can procure health care services.

18. The Department published *Personal Health Budgets: First Steps* in January 2009, setting out its intentions for personal health budgets, including direct payments.[6]

19. Direct payments have been used in lieu of social care services for some time. Social care direct payments are payments for individuals to purchase services from various providers directly, to meet their social care needs. The Act allows for a similar model of direct payments to be used for health care.

20. Section 11 in Chapter 3 of Part 1 of the Act amends the National Health Service Act 2006 (NHS Act) to allow the Secretary of State to make monetary payments to patients in lieu of providing them with health care services. In practice the intention is to delegate this power to local NHS organisations, generally Primary Care Trusts (PCTs), though some Strategic Health Authorities or Special Health Authorities may also wish to use direct payments. Initially, the power will be available under regulations in pilot schemes only.

21. Direct payments for health care will allow patients to purchase health care services directly from a variety of providers, including private organisations and the voluntary sector.

22. The Act provides powers to allow the Secretary of State to make regulations to govern the operation of direct payments and direct payment pilot schemes. The regulations may make provision about the persons who might receive direct payments, potentially appropriate health conditions and the services in respect of which payments could be made. The regulations may also specify categories of patients who would not be able to access direct payments for health care, or services that could not be purchased. The

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6 Department of Health (2007), *Personal Health Budgets: First Steps,* Department of Health, London. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093842

regulations may provide for the necessary monitoring in order to ensure accountability and that direct payments are effective in meeting the health outcomes agreed between a patient and the NHS. Provision could also be made for money to be recouped in the event of a large surplus or misuse of direct payments.

23. The Government intends that every pilot scheme will be reviewed. The Government intends that the pilot programme as a whole should be reviewed by an independent person, the review should be published, and it should examine a range of issues. These include the administration of direct payments, the effect of direct payments on cost or quality of care, and the effect of direct payments on the behaviour of patients, carers or people providing services. Provision for review of a pilot scheme must be made in regulations.

24. Following a review there is an order making power, subject to approval by each House of Parliament under the affirmative resolution procedure, to remove the requirement that payments be made through a pilot scheme so that direct payments could become more generally available while still following rules in a framework established by regulations.

Chapter 4 - Innovation

25. *High Quality Care for All* stated the Government's intention to create prizes for innovation that directly benefits patients and the public. Section 14 will enable the Secretary of State to make payments to promote innovation in the provision of health services.

Powers in Relation to Health Bodies

Chapter 1 – Powers in Relation to Failing NHS Bodies in England

De-authorisation of NHS foundation trusts

26. NHS foundation trusts are public benefit corporations, usually former NHS trusts, authorised under Chapter 5 of Part 2 of the National Health Service Act 2006 (the NHS Act) and are regulated by the Independent Regulator of NHS Foundation Trusts (Monitor). NHS foundation trusts must comply with the terms of the authorisation given by Monitor under the NHS Act. Monitor has powers to require a failing trust to do specified things or to remove its directors (section 52 of the NHS Act) and to require it to enter into a voluntary arrangement with creditors (section 53). If a trust fails to comply and Monitor considers that the further exercise of its powers would not be likely to secure the provision of the goods or services which the authorisation required the trust to provide, the Secretary of State may make an order to dissolve the trust, transfer property or liabilities to other NHS bodies and apply the provisions of insolvency legislation relating to the winding up of companies to the trust, in order to deal with outstanding liabilities, etc (section 54). But those provisions do not give either Monitor or the Secretary of State the power to de-authorise a foundation trust, or return it to ordinary NHS trust status.

27. Section 15 deals with de-authorisation of NHS foundation trusts without the appointment of a trust special administrator. Section 16 deals with the appointment of trust special administrators in respect of NHS trusts and NHS foundation trusts. It also deals with de-authorisation of NHS foundation trusts in the context of the appointment of the trust special administrator. So in effect there are two regimes for de-authorisation of NHS foundation trusts. One without the appointment of a trust special administrator dealt with in section 15 where the regulator must be satisfied that the trust in question is contravening or failing to comply with, or has contravened or failed to comply with, any term of its authorisation or any requirement imposed on it under any enactment and the seriousness of the contravention or failure, or if there has been more than one of any

taken together, is such that it would justify the Secretary of State making an order de-authorisation order (section 52B of the NHS Act).

28. The section 16 procedure on the other hand requires the regulator to trigger the regime if satisfied that an NHS foundation trust is failing to comply with a notice under section 52 of the NHS Act (failing NHS foundation trust) and further exercise of the powers conferred by section 52 of the 2006 Act would not be likely to secure the provision of the goods and services which the trust's authorisation requires to provide (section 65D(1)of the NHS Act). So in effect the test for the trigger the regime under section 16 is more stringent than that under section 15. Where the Secretary of State makes a de-authorisation order under section 16 he must also make an order authorising the appointment of a trust special administrator in relation to the trust (section 65E(6) of the NHS Act).

29. In July 2009 the Government published its consultation document on de-authorisation of foundation trusts where the Government sought views on the proposals to de-authorise NHS foundation trusts where a foundation trust had significantly contravened or failed to comply with the terms of its authorisation.[7]

30. Following publication of the consultation response in October 2009 one substantial amendment (adding section 15) and seventeen consequential amendments were made to the Bill for the Act at Commons Report Stage.

Trust special administrators

31. *Developing an NHS Performance Regime*[8]*,* published in June 2008, announced the Government's intention to—

"establish a failure regime for state-owned providers that reflects the Government's obligations to ensure service continuity and protect public assets.

32. It detailed the steps that would be taken if an NHS organisation failed, either for clinical or organisational reasons.

33. In September 2008, the Government published the *Consultation on a regime for unsustainable NHS providers*[9], which set out Government proposals and sought views on such a regime. The consultation response document[10] was published in January 2009, alongside the Bill for the Act.

34. Further detail on how the wider performance framework will work for NHS trusts was published in April 2009 and is included in *The NHS Performance Framework: Implementation Guide*[11].

35. Chapter 1 of Part 2 of the Act amends the NHS Act to make provision for the appointment of trust special administrators (TSAs) for NHS trusts, NHS foundation trusts and PCTs in England. These NHS bodies are established under the NHS Act. The new provisions are intended to form part of a wider process for dealing with the poor performance and failure of such NHS bodies. The appointment of a TSA will be the final stage in this process, where earlier attempts to improve performance using existing powers have failed and the continuation of the body in its present situation is not considered to be in the interests of the health service.

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7 Department of Health (2009), Consultation on de-authorisation of NHS foundation trusts, Department of Health, London. Available at: http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_103359

8 Department of Health (2008). Developing an NHS performance Regime , Department of Health, London. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085215

9 Department of Health (2008). *Consultation on a regime for unsustainable NHS providers.* Department of Health, London Available at: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_087835

10 Department of Health (2009), Response to Consultation on Regime for Unsustainable Providers. Available at: www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_093261

11 Department of Health (2009), NHS Performance Framework: Implementation Guidance, Department of Health, London. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098525

36. Under the existing provisions of the NHS Act, there are various means to address poor performance of NHS trusts and PCTs. Strategic Health Authorities are responsible for the performance management of PCTs and NHS trusts; and the arrangements between NHS trusts and PCTs may include provisions relating to performance. The Secretary of State has power to give directions to NHS trusts and PCTs about their exercise of functions (section 7 of the NHS Act) and has powers to remove the chairs and non-executive directors (regulations made under Schedules 3 and 4 to the NHS Act). If the Secretary of State considers that a trust is not performing its functions adequately or at all, or that there are significant failings in the way the body is being run, and considers it appropriate to intervene the Secretary of State may make an intervention order under sections 66 and 67. Finally, the Secretary of State may dissolve a PCT or an NHS trust (section 18(2) of, and paragraph 28 of Schedule 4 to, the NHS Act).

37. As explained in paragraph 26 above, NHS foundation trusts are regulated by Monitor and are subject to its various powers to deal with failing trusts (sections 52 to 54) In particular, if a trust fails to comply with a notice under section 52 or 53 and Monitor considers that the further exercise of its powers would not be likely to secure the provision of the goods or services which the authorisation required the trust to provide, the Secretary of State may make an order to dissolve the trust, transfer property or liabilities to other NHS bodies and apply the provisions of insolvency legislation relating to the winding up of companies to the trust, in order to deal with outstanding liabilities, etc (section 54).

38. Historically, before the Act, failing NHS trusts had been dealt with in a relatively *ad hoc* way. The policy intention behind the Bill for the Act was to provide for a regime in legislation which would ensure clarity and transparency and ensure that key processes of the regime were applied systematically. As indicated, for NHS foundation trusts, the provisions of the Health and Social Care (Community Health and Standards) Act 2003, now consolidated in the NHS Act, provide for a regime in which a trust being dissolved by order could be subject to insolvency procedures under the order applying and modifying the statutory provisions for the winding up of companies (Part 4 of the Insolvency Act 1986), but there was discussion about how such procedures would be modified and applied. The Department concluded that it was not appropriate to apply insolvency procedures to most NHS foundation trusts and instead the new provisions inserted by sections 15 to 17 of the Act will apply. *Consultation on a regime for unsustainable providers*, September 2008 and *The Regime for Unsustainable NHS Providers: response to consultation*, January 2009 provide further background and set out more detail on the policy.

39. The provisions introduced by sections 16 and 17 in Chapter 1 of Part 2 of the Act enable the Secretary of State to appoint, or in the case of a PCT, require a body to appoint a TSA to take control of the body for a temporary period, during which the TSA will be responsible for ensuring that the body continues to exercise its functions (for example, in the case of an NHS trust, that it continues to provide services in accordance with its NHS contracts). During the period of appointment, the TSA must produce a report stating the action which the TSA recommends the Secretary of State should take in relation to the trust. The TSA will be obliged to consult various persons before finalising the report. The Secretary of State will be obliged to make a decision as to what action to take in the light of the final report, within 20 working days of receiving the report. In the case of NHS foundation trusts, it is for Monitor to initiate the regime, by giving a notice to the Secretary of State in accordance with the provisions. On receiving such a notice, the Secretary of State will be obliged to make an order providing that the trust ceases to be a foundation trust and instead becomes an NHS trust (described as "de-authorisation"), and appointing a TSA. A de-authorised NHS foundation trust will become an NHS trust and be subject to the other provisions of the Chapter relating to such trusts.

Chapter 2 –Suspension

40. The Healthcare Commission report in October 2007 on outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS trust[12] highlighted the need for swift action, in extreme cases, to suspend chairs and members of NHS boards. A Review of NHS public appointments processes carried out with the NHS and published in January 2008, recommended that the Secretary of State should have powers to suspend those whom the Secretary of State appoints and that powers to suspend should, as with powers to appoint, be delegated to the Appointments Commission.

41. The Government consulted on proposals to introduce new powers of suspension for chairs and other non-executives of PCTs and NHS trusts between January and March 2008[13]. The Government stated during the consultation that the Government's intention was to introduce the same powers for chairs and non-executives of Strategic Health Authorities and national bodies established by the Department of Health in a second phase of legislation to follow later in 2008/09. The proposals for local trusts and PCTs received full support from the NHS and, following amendments to regulations,[14] the Appointments Commission was provided with the new powers on 16 June 2008.

42. A Government consultation document,[15] published in July 2008, considered proposals to introduce powers of suspension and a single approach to the removal of chairs and non-executives of the second group of bodies – Strategic Health Authorities, national health sector bodies and arms length bodies. The consultation concluded on 9 October 2009 and, as with the previous local consultation, it was supportive of introducing new suspension proposals.

43. Chapter 2 of Part 2 of the Act introduces Schedule 3 providing for new powers of suspension of chairs and other members of NHS and other health bodies. The provisions in the Schedule amend the relevant legislation dealing with appointments to Strategic Health Authorities, Special Health Authorities, Monitor, standing advisory committees (committees which advise the Secretary of State pursuant to section 250 of the NHS Act, such as the Joint Committee on Vaccination and Immunisation), community health councils in Wales, the Human Tissue Authority, the Health Protection Agency, the Human Fertilisation and Embryology Authority, bodies established under the Medicines Act 1968, the Alcohol Education and Research Council and the Appointments Commission itself. The provisions also ensure that appropriate procedures are or could be put in place for notification of suspension, review on request after a given period and for temporary replacement of a suspended chair.

Miscellaneous

Tobacco

44. The Department of Health's *Consultation on the Future of Tobacco Control,* [16] published on 31 May 2008, sought views from stakeholders and the public on further action to combat smoking and the negative effects it has on public health. The consultation was expressed as the first step in developing a new national tobacco control strategy and focused on four main areas: reducing smoking rates and health inequalities caused by smoking; protecting children and young people from smoking; supporting smokers to quit; and, helping those who cannot quit.

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12 Healthcare Commission (2007) Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS trusts, Commission for Healthcare Audit and Inspection

13 Department of Health (2008). *Removing or suspending chairs & non-executives from PCTs and NHS trusts: Consultation on introducing powers of suspension.* Department of Health, London.

14 The Primary Care Trusts and National Health Service Trusts (Membership and Procedure) Amendment Regulations 2008 (SI 2008/1269)

15 Department of Health (2008). *Removing or suspending chairs & non-executives of Health Bodies – Consultation on introducing new powers of suspension.* Department of Health, London.
Available at: http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_086308

16 Department of Health (2008). *Consultation on the Future of Tobacco Control.* Department of Health, London.
Available at: http://www.dh.gov.uk/en/consultations/liveconsultations/dh_085120

45. The consultation ran for three months and sought views on possible measures to reduce young people's access to tobacco and on reducing exposure to tobacco promotion. The consultation received nearly 100,000 responses, details of which can be found in the consultation report published on 8 December 2008[17].

46. The Act includes a series of amendments to the Tobacco Advertising and Promotion Act 2002 (the 2002 Act), the Children and Young Persons (Protection from Tobacco) Act 1991 (the 1991 Act) and the Children and Young Persons (Protection from Tobacco) (Northern Ireland) Order 1991 (the 1991 (NI) Order) to adopt some of these measures for protecting public health. The amendments make further provision in relation to the display of tobacco products and the sale of such products from vending machines.

47. The provisions inserted into the 2002 Act subject to exclusions, prohibit the display of tobacco products in the course of a business. Powers are also given to the Secretary of State, the Welsh Ministers and the Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) to regulate (but not prohibit) the display of prices of tobacco products and (Secretary of State only) the display of tobacco products and their prices in the course of a business on a website where such products are offered for sale. The 1991 Act and the 1991 (NI) Order are also amended to give power to the Secretary of State, the Welsh Ministers, and DHSSPSNI to prohibit the sale of tobacco from vending machines.

Pharmaceutical services

48. The Department of Health published a pharmacy White Paper, *Pharmacy in England: Building on strengths – delivering the future*[18] on 3 April 2008. The White Paper set out the Government's programme for a reformed pharmaceutical service. A series of consultation events were held in May 2008 to consider the proposals in more detail[19]. The White Paper also provided the Government's response to the *Review of NHS pharmaceutical contractual arrangements*[20] commissioned in 2007 and conducted by Anne Galbraith. In addition, the White Paper took account of recommendations of the All Party Pharmacy Group's report, *The Future of Pharmacy*[21] published in June 2007.

49. The White Paper was developed to align closely with the NHS Next Stage Review and the development of a new primary and community care strategy, *Our Vision for primary and community care,*[22] which was published on 3 July 2008.

50. The White Paper promised consultation on a number of proposals for structural change, including any necessary revisions to primary legislation. That consultation, *Pharmacy in England: Building on strengths – delivering the future – proposals for legislative change,*[23] began on 27 August 2008 and ended on 20 November 2008. A series of national listening events were held in October 2008 in support and a report of these events, together with the Department's report of the consultation concerning the primary legislation proposals in the Bill for this Act, was published on 16 January 2009.

51. The purpose of the pharmacy provisions contained in the Act is threefold. First, the provisions concerning market entry replace the previous "control of entry" test which was applicable to all pharmaceutical contractors seeking to enter onto a pharmaceutical

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17 Department of Health (2008). *Consultation on the Future of Tobacco Control – Consultation Report, December 2008.* Department of Health, London. Available at:http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_091382

18 Department of Health (2008). *Pharmacy in England: Building on strengths - delivering the future,* Cm 734. Department of Health, London.
Available at: http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_083815

19 A summary report of those is now available at http://www.dh.gov.uk/en/Publicationsandstatistics/index.htm

20 Anne Galbraith (2007). *Review of NHS pharmaceutical contractual arrangements – Report by Anne Galbraith*

21 All-Party Pharmacy Group (2007). *The Future of Pharmacy- Report of the APPG Inquiry.*
Available at: http://www.appg.org.uk/home.htm

22 Department of Health (2008). *Our Vision for primary and community care,* Department of Health, London.
Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937

23 Department of Health (2008). *Pharmacy in England: Building on strengths – delivering the future – proposals for legislative change.* Department of Health, London.
Available at: http://www.dh.gov.uk/en/consultations/Liveconsultations/DH_087324

list. The new test requires PCTs first to develop and to publish statements of pharmaceutical needs and then to use these to determine applications. The previous test referred to the adequacy of the pharmaceutical services in the neighbourhood in which the premises were to be located.

52. Second, the market exit provisions enable PCTs to be given new powers to take action where there are concerns about the quality or performance of services provided by pharmacy contractors.

53. Third, the pharmacy provisions enable PCTs themselves to provide local pharmaceutical services (LPS) in certain circumstances.

Private patient income

54. The private patient income cap was introduced by the 2003 Act (consolidated by the NHS Act). The private patient income cap, set out at section 44 of the NHS Act, applies to NHS foundation trusts which were previously NHS trusts. It has the effect that the proportion of an NHS foundation trust's total income in any financial year derived from private charges must not exceed the proportion of its total income derived from private charges in the 'base financial year'. The base financial year is the first financial year in which a trust was an NHS trust, or if it was an NHS trust throughout the financial year 2002-2003, that year. As the cap is by reference to the *proportion* of income derived from private charges, NHS foundation trusts can treat more private patients so as to increase their income derived from private charges, but only if there is a corresponding increase in NHS provision.

55. As no mental health NHS foundation trust treated private patients in the base financial year, their cap is set at zero per cent. The Act amends section 44 of the NHS Act so that an authorisation given by the regulator must in the case of a mental health foundation trust restrict the provision of goods and services by the trust with a view to securing that the proportion of its total income derived from private charges does not exceed 1.5 per cent of the trust's total income, or the existing cap if greater. The figure of 1.5% is based on the average cap level of all NHS foundation trusts delivering acute care in 2008-09. New section 44(2A) provides for NHS foundation trusts to be designated as mental health foundation trusts if it appears to the regulator that they meet a specified description.

Optical appliances

56. Section 34 and Schedule 6 (repeals and revocations) amend section 180(2) of the NHS Act to omit paragraph (c) which extended eligibility for optical vouchers to persons aged 60 or over. This provision was inserted into the 2006 Act by mistake. Government policy was at the time of the 2006 Act and has continued to be that all people aged 60 and over are eligible for NHS-funded sight tests and that of these, some should also be entitled to optical vouchers, if they are on relevant income-related benefits or require a complex appliance. An optical voucher is intended to meet or contribute to the cost of optical appliances (glasses or contact lenses).

57. Section 180 was inserted into the NHS Act along with provisions to reform NHS optical services to bring them into line with the contractual framework that operates for GPs and dentists. Provisions were also inserted to give Ministers greater control over the redemption of optical vouchers. However, the Government did not intend to extend eligibility for optical vouchers.

58. In the provisions as introduced in the Health Bill 2005 the reference to optical vouchers defined eligibility by referring to an earlier clause in the bill that set out the eligibility for sight tests. Eligibility for sight tests included those aged 60 or over in view of their increased risk of eye disease. The effect of this clause was to oblige the Secretary of State to make regulations for payments for the costs of optical appliances to any person

aged 60 or over – not just those in receipt of income related benefits or who require a complex appliance. That was not what the Government had intended.

59. The provisions in the Health Act 2006 were later consolidated into the NHS Act. The provisions relating to payments towards the costs of optical vouchers were consolidated into section 180 of the NHS Act and were commenced on 1 August 2008, but no regulations have been made under section 180(2)(c).

60. As it was never the Government's intention to extend eligibility for optical vouchers the Government has taken the first opportunity after it came to light to bring forward legislation to correct this mistake. The effect of section 34 is to repeal section 180(2)(c) of the 2006 Act with prospective effect.

Adult social care

61. An issue raised in the House of Lords during the debate on the Health and Social Care Bill (now the Health and Social Care Act 2008) was that users of adult social care that has been arranged or funded privately do not have recourse to an independent complaints procedure. A government commitment was made in Parliament[24] to address this matter at the next legislative opportunity.

62. The Government's objective was to enable the Local Commission for Administration (the LGO) to investigate complaints made by people whose adult social care is not arranged or provided by a local authority. This group comprises people who arrange or pay for their own care, estimated to be about 35 per cent of adult social care service users, and also those who are given direct payments by local authorities to purchase their own adult social care services.

63. People whose care is funded and arranged by a local authority have access to the existing statutory local authority social services complaints procedure, under the Health and Social Care Act 2003, and have the right to refer their complaints to the LGO if they are dissatisfied with the local authority's response. During 2007, Department of Health Ministers became concerned, as a result of representations made by stakeholders, that the arrangements for people arranging and paying for their own care were unsatisfactory and that such people should also have access to independent investigation of their complaints. The Government therefore gave a commitment in Parliament to address this issue.

64. The LGO is responsible for investigating complaints of injustice arising from maladministration by local authorities and certain other bodies. The LGO comprises three Local Commissioners, and they each deal with complaints from different parts of the country. They investigate complaints about most council matters including housing, planning, education, social services, consumer protection, drainage and council tax.

65. The Act inserts a new Part 3A into the Local Government Act 1974 (the 1974 Act), the legislation that established the LGO. Part 3A creates a new scheme, which extends the remit of the LGO to include the investigation of complaints about adult social care not arranged or funded by a local authority. The new scheme is largely modelled on the existing legislation for investigation of complaints concerning local authorities in Part 3 of the 1974 Act.

Disclosure of Information

66. HMRC holds information relating to the tax affairs of individuals – including those of GPs and dentists who provide medical and dental care on behalf of the NHS. It has been the practice of HMRC, over a number of years, to assist in statistical enquiries carried out by or on behalf of the Department of Health relating to the earnings and expenses of GPs and dentists by providing summarised data in aggregate anonymised form.

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24 Available at: http://www.publications.parliament.uk/pa/ld200708/ldhansrd/text/80616-0015.htm

67. This annual exercise has been conducted on behalf of the Secretary of State and the devolved administrations by the NHS Information Centre for Health and Social Care. The dental exercise has not included Scotland or Northern Ireland but there are proposals to extend the scope to include them in future.

68. The Commissioners for Revenue and Customs Act 2005 prohibits officials of HMRC from disclosing information of any kind held by HMRC in connection with a function of the HMRC – subject to certain exceptions.

69. The Act provides a further exception to the restrictions on the disclosure of information by HMRC to enable them to continue to participate in these annual earnings and expenses exercises.

70. The Act will allow HMRC to disclose certain information relating to the income and expenses of GPs and dental practitioners to the Secretary of State and to the devolved administrations or to persons providing services to, or exercising functions on behalf of, the Secretary of State or the devolved administrations. The information disclosed will be an anonymised summary of the earnings and expenses of GPs and dental practitioners and will not extend to other details disclosed to HMRC as part of the tax assessment process, such as investment income. Earnings that are identified as unconnected with medical or dental activities will be excluded.