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

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[1]. 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)*.

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

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

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*[2], 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:

— 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.

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

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.