These notes refer to the Health and Social Care (Community Health and Standards) Act 2003 (c.43) which received Royal Assent on 20 November 2003

HEALTH AND SOCIAL CARE (COMMUNITY HEALTH AND STANDARDS) ACT 2003

EXPLANATORY NOTES

INTRODUCTION

1. These explanatory notes relate to the Health and Social Care (Community Health and Standards) Act which received Royal Assent on 20th November 2003. They have been prepared by the Department of Health in order to assist the reader in understanding the Act. They do not form part of the Act and have not been endorsed by Parliament.

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

3. The majority of the Act extends to England and Wales with the exception of those provisions set out in *section 202* which have a wider extent. *Sections 124* and *125* allow CHAI and CSCI to carry out cross border inspections of health and social services in certain limited circumstances by arrangement with ministers. Part 3 of the Act relates to injury costs recovery extends to England, Wales and Scotland. *Section 185* relates to the replacement of the Welfare Food Scheme and extends to England, Wales and Scotland. *Section 186* allows similar provision to be made for Northern Ireland by means of an Order in Council. *Sections 187, 188* and *Schedule 12* of the Act relates to appointments to certain NHS bodies and extend to the whole of the UK as does Part 6 of the Act which contains final provisions.

SUMMARY

4. In July 2000 the Government published *The NHS Plan, A plan for investment, a plan for reform*[1]. In April 2002 the Government published a further document, *Delivering the NHS Plan: Next steps on investment, next steps on reform*[2] and this Act gives effect to the proposals to create NHS foundation trusts and to establish an independent healthcare regulator and an equivalent for social care.

5. The Act provides for the establishment of NHS foundation trusts, of the new health care inspectorate and for the new inspectorate for social care, provides for the recovery of NHS charges, makes changes to the way in which primary dental and medical services are delivered and provides for a replacement of the Welfare Food Scheme and other miscellaneous matters.

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[1] For copies: - postal address: PO Box 777, London SE1 6XH. Website address: http://www.doh.gov.uk/nhsplan

[2] ISBN 0101550324 Available from The Stationery Office. Website address: http://www.tso.co.uk/

THE ACT

6. The Act is in 6 Parts:

Part 1 of the Act establishes NHS foundation trusts – a new form of NHS organisation. The Command Paper *Delivering the NHS Plan: Next steps on investment, next steps on reform*[3] set out the Government's proposals to give greater freedoms to NHS organisations and details of the proposals for NHS foundation trusts were set out in *A Guide to NHS foundation trusts*[4].

NHS foundation trusts will not be subject to direction by the Secretary of State. Instead, an Independent Regulator will monitor their performance. NHS foundation trusts will be part of the NHS but they will have greater financial and management freedoms including freedoms to retain surpluses and to invest in delivery of new services, to manage and reward their staff flexibly and to access a wider range of options for capital funding. Each NHS foundation trust will have a Board of Governors responsible for representing the interests of the local community, staff and local partner organisations.

The characteristics of NHS foundation trusts are set out in *section 1* and *Schedule 1* and their functions are set out in *sections 14* to *22*. *Sections 2* and *3* and *Schedule 2* concern appointments to and general duties of the Independent Regulator of NHS foundation trusts.

Part 2 deals with matters relating to quality and standards in health and social care.

Chapter 1 of this Part establishes two new regulatory bodies – the Commission for Healthcare Audit and Inspection (the CHAI) and the Commission for Social Care Inspection (the CSCI). The intention to set up the new inspectorates was announced in *Delivering the NHS Plan*[5] and the proposed role and functions of which were set out in *The Commission for Healthcare Audit and Inspection and the Commission for Social Care Inspection - a statement of purpose*[6]. Both inspectorates are established as executive non-departmental public bodies. Chapter 1 also abolished the National Care Standards Commission ("the NCSC") and the Commission for Health Improvement ("CHI"). The majority of the NCSC's functions transferred to the CSCI, with the exception of those functions relating to the provision of independent healthcare, which transferred to the CHAI. All of the CHI's functions transferred to the CHAI.

Chapter 2 imposes a duty of quality on all NHS bodies that provide or commission health care, and provides for the standards which are to be taken

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[3] For copies – website address: www.doh.gov.uk/deliveringthenhsplan/index.htm
[4] For copies - website address: www.doh.gov.uk/nhsfoundationtrusts/index.htm
[5] ISBN 0215004884 Available from The Stationery Office. Website address: http://www.tso.co.uk/
[6] For copies – website address: www.doh.gov.uk/statementofpurpose/index.htm

into account by NHS bodies in discharging the duty of quality and by the CHAI in reviewing health care provision.

Chapter 3 sets out the functions of the CHAI. Under the Chapter, the CHAI is able to carry out general reviews of health care across NHS bodies in England and Wales. However, reviews and investigations of health care provided by or for particular NHS bodies in Wales are the responsibility of the Assembly under Chapter 4.

Chapter 5 sets out the functions of the CSCI which is an England only body.

In Chapter 6, the Act confers functions on the National Assembly for Wales ("the Assembly") in relation to social care similar to those conferred upon the CSCI.

Chapter 7 sets out the functions under Parts 1 and 2 of the Care Standards Act 2000 ("the CSA 2000") which have transferred to the CHAI and CSCI. Chapter 8 provides for other functions of the CSCI.

Chapter 9 deals with the handling of complaints relating to the provision of NHS health care and local authority social services.

Finally, Chapter 10 provides supplementary and general provisions in relation to the CHAI and CSCI, for example providing for joint working between both Commissions.

Part 3 deals with the recovery of NHS charges. This part of the Act provides for the NHS to recover hospital treatment and/or ambulance costs where people receive compensation for injuries. This is an expansion of the current scheme for traffic accident cases as set out in the Road Traffic (NHS Charges) Act 1999. The costs would be recovered from the compensator and not the patient receiving the NHS treatment.

Although the provisions follow very closely those of the 1999 Act, there are some changes being introduced in the way the scheme will operate. There are three of particular note. Firstly, the provision of ambulance services to the injured person as a result of the injury for which compensation is paid will be brought within the scope of the expanded cost recovery scheme. Secondly, formal findings of contributory negligence, if made by a court or endorsed through certain specified court processes or as part of a settlement of the claim through a prescribed mediation process, will be taken into account when calculating the amount of NHS charges recoverable. Thirdly, compensators who wish to appeal against a certificate of charges will be able to seek to have the requirement that any charges due must be paid before such an appeal can be made waived on the grounds of exceptional financial hardship.

Part 4 of the Act makes provision for primary dental and primary medical services.

For dentistry, the Act introduces a new duty on Primary Care Trusts ("PCTs") and Local Health Boards ("LHBs") to provide or secure the provision of primary dental services. The Act also provides for PCTs, LHBs and the

Assembly to carry out prescribed public dental health functions. It provides for a general dental services contract to be made between PCTs and LHBs and general dental practitioners and dental corporations. The Act also abolishes the Dental Practice Board ("DPB"). Finally, the Act replaces the charging provisions in respect of dental patients in the 1977 Act.

For medical services, the Act also introduces a new duty on PCTs and LHBs to provide or secure the provision of primary medical services. The Act provides for a general medical services contract to be entered into by PCTs and LHBs and general medical practices.

Part 4 of the Act also repeals Part 1 of the Primary Care Act 1997 regarding pilot schemes for personal medical and personal dental services. It makes changes to the provisions regarding "permanent" personal medical and dental services under sections 28C to 28EE of the 1977 Act.

Part 5 of the Act provides for the replacement of the Welfare Food Scheme, a scheme originally set up to provide milk and vitamins to mothers and children during a time of food rationing. Changes are made to the way an Order in Council can be made for the Welfare Food Scheme provisions to be replicated for Northern Ireland.

This part of the Act also provides for the Secretary of State to delegate his function of making appointments to certain health and care bodies to a Special Health Authority.

The Act amends the list provisions in both the Protection of Children Act and the Care Standards Act 2000 (for the Protection of Vulnerable Adults list) so that the requirement to obtain a yearly list check is removed for certain groups.

Finally, this Part provides for the abolition of the Public Health Laboratory Service Board ("the PHLS") and makes minor amendments to other legislation.

Part 6 of the Act contains a number of financial, supplementary and consequential provisions.

TERRITORIAL APPLICATION: WALES

7. NHS foundation trusts have the principal purpose of delivering goods and services for the purposes of the health service in England. They must, however, also be authorised to provide goods and services for "purposes relating to the provision of health care" and this includes the provision of goods and services for the purposes of the health service in Wales.

8. By virtue of *paragraph 3(2)* of *Schedule 1* to the Act, NHS foundation trusts may define an area for a public constituency as including electoral areas in Wales.

9. In relation to functions concerning the review and investigation of health care, Part 2 contains some Wales only provisions (in *sections 68* to *73*) in addition to some provisions that apply both to England and Wales. In addition, *sections 90* to *99* provide for social care functions that apply only to the Assembly.

10. Part 3 (recovery of NHS charges) as for the existing road traffic scheme is not devolved in respect of Wales and will be operated by the Secretary of State on behalf of both England and Wales. However, *section 195(3)* requires that the Secretary of State consult the Assembly before making any regulations relating to the scheme under Part 3.

11. The dental and medical provisions in Part 4 apply to Wales and powers to make subordinate legislation are exercisable in relation to Wales by the Assembly.

12. The provisions for the replacement of the Welfare Food Scheme in Part 5 do not transfer all the functions in relation to Welfare Food Scheme as regards Wales. However, this Act gives the Assembly powers to prescribe the range of foods and descriptions of advice in relation to the operation of the scheme in Wales and a power of direction over bodies administering part or all of the scheme in relation to matters relating to the operation of the scheme or part of a scheme in Wales with the consent of the Secretary of State.

13. Part 5 provides for the amendment to the Protection of Children Act 1999 ("POCA") and Care Standards Act 2000 ("CSA 2000") and these changes will apply equally to England and Wales. In addition, the appointments provisions in Part 5 will apply to Wales as they allow for a Special Health Authority to make appointments, for which the Secretary of State has responsibility, to certain bodies which cover Wales and England. However, appointments that are the responsibility of Ministers in the devolved administrations will remain the responsibility of those Ministers. Finally, the abolition of the Public Health Laboratory Service Board in *section 190* applies to Wales.

14. Annex C provides further detail on the provisions that affect the powers of the Assembly.

COMMENTARY ON SECTIONS

PART 1 – NHS FOUNDATION TRUSTS

Introductory

Section 1: NHS foundation trusts

15. *Section 1* sets out that an NHS foundation trust is a public benefit corporation which is authorised under this Part to provide goods and services for the purposes of the "health service" in England. As this term is defined in section 128 of the National Health Service 1977 ("the 1977 Act") as being the health service that is provided by the Secretary of State, the effect is that every NHS foundation trust has a primary purpose of providing health care to the NHS.

16. *Subsection (2)* makes it clear that a public benefit corporation is a body corporate. Each public benefit corporation must have a constitution that accords with *Schedule 1*.

17. *Schedule 1* sets out minimum statutory requirements for the constitution, governance and membership of public benefit corporations that may be authorised as NHS foundation trusts. It also sets out the audit, accounting and reporting

arrangements that are to apply.

18. *Paragraph 1* requires every public benefit corporation to have a constitution that complies with the terms of *Schedule 1.* A corporation may also make further provision in its constitution that is consistent with the Schedule.

19. *Paragraph 2* requires the constitution of a public benefit corporation to name the corporation, and if the corporation is an NHS foundation trust, to include the words "NHS foundation trust" in its name.

20. *Paragraph 3* sets out the minimum eligibility criteria for the membership of a public benefit corporation. These membership criteria ensure that each corporation has representation from the public and staff. The membership may also include the patients of the hospitals managed by the corporation, and also their carers. Each public benefit corporation is given the power to specify membership criteria in its constitution.

21. The members must include individuals drawn from the public who live in specified areas, with members in each specified area being "a public constituency". The areas from which members of a public constituency are drawn must be defined in terms of local government electoral areas in England and Wales.

22. The members must also include individuals from a corporation's staff, who are "the staff constituency". *Paragraph 3(3)* allows the staff constituency of a public benefit corporation to include individuals who exercise functions for the corporation, but are not directly employed by the corporation. Examples of such individuals include agency nurses, and individuals who work on the premises of the corporation but are employed by an independent subcontractor.

23. The paragraph also provides that the staff constituency may only include individuals with an employment contract of 12 months or longer, or without any fixed term at all; or alternatively, any person who has been continuously employed by the corporation, or exercised functions in terms of *subparagraph (1)(b),* for a 12 month period. *Paragraph 3(4)* provides that a constitution may set out that the staff constituency may be divided into two or more classes.

24. If a corporation chooses, its constitution may also provide for there to be members who are eligible because they have attended any of the corporation's hospitals as a patient, or as the carer of a patient, who are collectively referred to as "the patients' constituency". However, a person who is employed as a carer of a patient, or works as a carer through a voluntary organisation, is not eligible for membership.

25. Under *paragraph 3(6),* if a public benefit corporation has a patients' constituency, its constitution may provide for it to be divided into three or more classes. If it chooses to do so, however, one class must comprise the carers of patients.

26. *Paragraph 3(7)* gives public benefit corporations wide powers to set out other eligibility requirements in the constitution, as they see fit.

27. *Paragraph 4* makes provision about the constituencies of public benefit

corporations. It includes a requirement that a member of a class or constituency cannot be a member of another class or constituency while that membership continues. There is also a requirement that a person who is eligible to be a member of the staff constituency may not be a member of any other constituency.

28. *Paragraph 5* requires the constitution of a public benefit corporation to specify a minimum number for each constituency, or where there are classes within the constituency, of each class.

29. *Paragraph 6* provides that an individual who is eligible to become a member of a public benefit corporation may do so by making an application to the corporation.

30. The paragraph also allows the constitution of a corporation to provide that an individual who is eligible to become a member of the staff or patient constituency (otherwise than as a carer of a patient) may become a member by way of an invitation. On receiving such an invitation, the individual will become a member of the corporation without making an application under *paragraph 6(1)*, unless he subsequently informs the corporation that he does not wish to be a member.

31. *Paragraphs 7* to *10* require each public benefit corporation to have a Board of Governors. The Board of Governors comprises the elected representatives of the members of the public benefit corporation, and also individuals who have been appointed by the public benefit corporation to represent certain interests. Under *paragraph 7*, the public, staff and (if there is one) patients' constituencies are to elect representatives from their constituencies to the Board of Governors. *Paragraph 8* disqualifies certain individuals from membership of the Board of Governors, and gives public benefit corporations the power to set out other eligibility requirements in the constitution. Under *paragraph 9,* representatives of the public and (if there is one) patients' constituencies must be in the majority. There must also be at least three members from the staff constituency, one member appointed by a Primary Care Trust ("PCT") to which the public benefit corporation provides services and one member appointed by a local authority for an area which includes all or part of the membership area specified for the purposes of a public constituency of the corporation. One member must also be appointed by a university if a hospital of the public benefit corporation includes a medical or dental school. In addition, members may be appointed to represent organisations specified in the constitution as partnership organisations.

32. *Paragraphs 12* and *13* set out some minimum requirements for meetings of the Board of Governors, including requirements relating to public access to these meetings. Under *paragraph 14,* each public benefit corporation is required to make other provisions about certain matters relating to the Board of Governors in its constitution, and has the power to make further provision as it deems necessary.

33. *Paragraphs 15* to *18* require each public benefit corporation to have a Board of Directors. The Board of Directors is the body that is responsible for the day-to-day management of the public benefit corporation, and to this end, *paragraph 15(2)* requires each public benefit corporation to provide for its powers to be exercised by the Board of Directors on its behalf. The Board of Directors is made up of executive directors, one of whom is the chief executive (and accounting officer), and non-

executive directors, one of whom is the chairman of the corporation. One of the executive directors must be a registered medical practitioner or registered dentist, Another executive director must be a registered nurse or registered midwife.

34. The chief executive is appointed and removed by the non-executive directors. The chairman and the other non-executive directors are appointed and removed by the Board of Governors. Only members of the public or patients' constituencies, and if a hospital of the public benefit corporation includes a medical or dental school provided by a university, a representative of that university, are eligible for appointment as a non-executive director. Under *paragraph 16(3),* the disqualifications under *paragraph 8(1)* also apply to directors. *Paragraph 18* sets out provisions for the remuneration of the Board of Directors.

35. *Paragraph 19* makes provision about the initial directors of former NHS Trusts. It provides for the Chief Executive, Chairman and non-executive directors of the former NHS Trust, if they so wish, to become the initial Chief Executive, Chairman and non-executive directors of the corporation.

36. *Paragraph 20* requires that each public benefit corporation must keep a register of members and their constituencies, members of the Board of Governors and their interests, directors, and directors' interests. The details of each register are left to the discretion of the public benefit corporation. In addition, under *paragraph 21*, the constitution of a public benefit corporation must include provision for dealing with conflicts of interest of the members of the board of governors and the directors.

37. The public benefit corporation must make the registers listed in *paragraph 20* of the Schedule, and the documents listed in *paragraph 22(1)* - including its constitution, authorisation, accounts and reports - available to the public. However, there is a power for the Secretary of State to make regulations setting out circumstances in which registers should not be made public.

38. *Paragraph 23* requires each public benefit corporation to appoint an auditor. *Paragraph 23(3)* provides that an officer of the Audit Commission may be appointed as auditor if the Audit Commission agrees. *Paragraph 23(4)* requires that an auditor must be a member of the appropriate professional organisation, and *paragraph 23(6)* requires the establishment of an audit committee to perform monitoring, reviewing and other appropriate functions.

39. *Paragraphs 24* and *25* set out the accounting arrangements for public benefit corporations. The Independent Regulator is given general power to dictate the form and content of these accounts, with the approval of Treasury. The Independent Regulator is also given powers to direct the standards, procedures and techniques for the audit of accounts. To ensure that these bodies remain accountable for their use of public funds, *paragraph 25(4)* requires that each public benefit corporation must lay a copy of their annual accounts before Parliament.

40. *Paragraph 26* requires each public benefit corporation to make annual reports to the Independent Regulator. These reports must include information on steps taken by the public benefit corporation to secure that the membership of its public and (if there is one) patients' constituencies is representative of the population that is eligible for such membership, and any other information the Independent Regulator

requires. The timing, and form of these reports is left to the Independent Regulator's decision.

41. *Paragraph 27* requires that each public benefit corporation must provide the Independent Regulator with annual forward business plans prepared by the directors of the public benefit corporation. The directors must have regard to the views of the Board of Governors in preparing the forward plan.

42. *Paragraph 28* provides that copies of a public benefit corporation's annual accounts, auditor's reports and annual reports must be presented to the Board of Governors at a public meeting.

Section 2: Independent Regulator of NHS foundation trusts

43. This section establishes the Independent Regulator of NHS foundation trusts. The Independent Regulator is responsible for setting the terms of, and granting authorisation to, NHS foundation trusts, and monitoring their compliance with the terms of authorisation and the requirements set out in Part 1.

44. *Subsection (2)* introduces *Schedule 2*, which makes detailed provisions regarding the Independent Regulator. The Schedule includes provisions about the appointment of members and staff to the Independent Regulator and their remuneration, and also sets out the Independent Regulator's powers, funding arrangements, reporting and accounts procedures.

45. *Paragraph 1* sets out that the Independent Regulator is to consist of up to 5 members appointed by the Secretary of State, including a chairman and deputy. *Paragraphs 2* and *3* give the Secretary of State general powers to set the terms and conditions of office of members of the Independent Regulator.

46. *Paragraph 4* provides for the Independent Regulator to appoint staff on terms and conditions it determines, subject to consultation with the Minister for the Civil Service.

47. *Paragraph 6* provides that the Independent Regulator is responsible for regulating its own procedure.

48. *Paragraphs 8* and *9* set out the general and specific powers of the Independent Regulator. *Paragraph 8(1)* gives the Independent Regulator general powers to do anything that is necessary or desirable in relation to its functions. In particular, *paragraph 8(2)* provides that this includes acquiring and disposing of property, entering into contracts, accepting gifts, and co-operating with other public authorities. *Paragraph 9* gives the regulator the power to borrow money temporarily with the consent of the Secretary of State, and to conduct research.

49. Under *paragraph 10*, the Secretary of State may make contributions to the Independent Regulator's expenses. This provision is to be read in conjunction with *section 21* which allows the Independent Regulator to impose fees on NHS foundation trusts.

50. *Paragraph 11* sets out provisions that ensure the accountability of the Independent Regulator to the Secretary of State and to Parliament. The Independent

Regulator must make an annual report on the way it has exercised its functions and prepare a summary of NHS foundation trusts' accounts for each financial year, both of which must be laid before Parliament, and copied to the Secretary of State. In addition, *paragraph 11(6)* gives the Secretary of State the power to require any other reports and information relating to the exercise of the Independent Regulator's functions.

51. *Paragraph 12* sets out the accounting requirements that that will apply to the Independent Regulator.

52. *Paragraph 13* places a requirement on the Independent Regulator to respond in writing to any recommendation relating to the exercise of its functions made by a Committee of either or both Houses of Parliament.

53. *Paragraphs 17* and *18* disqualify the members of the Independent Regulator from membership of the House of Commons and the Northern Ireland Assembly.

Section 3: General duty of regulator

54. This section requires the Independent Regulator to exercise its functions in a manner that is consistent with the Secretary of State's general duties under the 1977 Act. Amongst other things, the Secretary of State must promote and provide a comprehensive health service in England and provide clinical facilities to universities with medical or dental schools. The Secretary of State must also secure that NHS goods and services are provided free of charge.

Authorisation

Section 4: Applications by NHS trusts

55. This section allows NHS trusts to make applications to become NHS foundation trusts. They may only do so with the support of the Secretary of State. The section sets out the minimum information which must be included in an application by an NHS trust for NHS foundation trust status. In addition, once an application to be an NHS foundation trust has been made, *subsection (4)* gives an NHS trust that has made an application the shadow powers necessary to prepare for authorisation to be an NHS foundation trust.

Section 5: Other applications

56. This section allows persons other than NHS trusts to apply to set up an NHS foundation trust. They may only do so with the support of the Secretary of State. This allows organisations that are not currently part of the NHS such as charities and voluntary sector organisations to become involved in the establishment of a new NHS foundation trust.

57. *Subsection (2)* sets out the minimum information which must be included in such an application. In conjunction with this, *subsection (3)* imposes a test which requires the Independent Regulator to consider certain matters before an application made under this section may proceed, and a certificate of incorporation be issued. Once such a certificate is issued, the applicants are incorporated as a public benefit corporation and are given the shadow powers necessary to prepare for authorisation to

be an NHS foundation trust.

Section 6: Authorisation of NHS foundation trusts

58. This section provides the Independent Regulator with the power to authorise applicants under *sections 4* or *5*, whom the Independent Regulator is satisfied have met the necessary criteria set out in *subsection (2),* to be NHS foundation trusts. The criteria are that the constitution and governance arrangements are in accordance with *Schedule 1*, that the applicant has taken steps to secure that the membership of its public and (if it has one) patients' constituencies will be representative of those eligible for such membership, that necessary steps to prepare for NHS foundation trust status have been taken, that the applicant will be able to provide the goods and services which it will be required to provide, and that any other requirements the Independent Regulator considers appropriate are met. Under *subsection (3),* in deciding whether an applicant will be able to provide the goods and services required under its authorisation, the Independent Regulator must consider any Commission for Healthcare Audit and Inspection (CHAI) report or recommendation relating to the applicant, and must also consider the applicant's financial position.

59. *Subsection (5)* sets out that the Independent Regulator may not authorise an applicant as an NHS foundation trust unless satisfied that the applicant has sought the views of specified persons. The specified persons are: individuals who live in the applicant's proposed public and patient constituencies; the local authorities who it is proposed will appoint a member of the board of governors; and, if the applicant is an NHS trust, its staff and its Patients' Forum.

60. Under *subsection (5)(e)* the Secretary of State may make regulations setting out additional consultation requirements. Under *subsection (6)*, an authorisation may not be granted unless the Independent Regulator is satisfied that the applicant has complied with any regulations on consultation.

Section 7: Effect of authorisation

61. *Section 7* sets out the legal effect of an authorisation to be an NHS foundation trust. Under the section, where authorisation is granted to an NHS trust it ceases to be an NHS trust and becomes an NHS foundation trust. Where authorisation is granted to a public benefit corporation it becomes an NHS foundation trust.

62. *Subsection (5)* provides that the property, rights and liabilities of applicants continue with the NHS foundation trust.

63. *Subsection (7)* provides that, like NHS trusts, NHS foundation trusts are not Crown bodies: see paragraph 18 of Schedule 2 to the National Health Service and Community Care Act 1990 ("the 1990 Act").

Section 8: Amendments of constitution

64. This section sets out that an NHS foundation trust's constitution may only be amended with the Independent Regulator's consent, so that the Independent Regulator can ensure any alterations are appropriate.

Section 9: Variation of authorisation

65. This section allows the Independent Regulator to vary an NHS foundation trust's terms of authorisation. In deciding whether to vary an authorisation, the Independent Regulator must take into account any report or recommendation by an overview and scrutiny committee of a local authority made pursuant to the Local Government Act 2000, or by the Commission for Patient and Public Involvement in Health.

Section 10: Register of NHS foundation trusts

66. *Subsections (1)* to *(3)* require the Independent Regulator to keep a register of NHS foundation trusts, and set out the information that the register must contain.

67. *Subsections (4) and (5)* provide that the register must be available to the public for inspection, and that copies or extracts from the register must be available for a reasonable charge.

Financial matters

Section 11: Power of Secretary of State to give financial assistance

68. This section provides for the Secretary of State to give loans, public dividend capital, grants or other payments to NHS foundation trusts.

69. *Subsection (3)* provides the necessary statutory cover for the Secretary of State to guarantee payments due under Private Finance Initiative (PFI) agreements entered into by NHS foundation trusts. Such agreements are currently entered into by NHS trusts. They are certified as "externally financed development agreements" within the meaning of the National Health Service (Private Finance) Act 1997. The section envisages that these certification arrangements will continue.

Section 12: Prudential borrowing code

70. This section provides for the Independent Regulator to set a code according to which the total borrowing limit of an NHS foundation trust will be determined. The code, and any revisions to it, must be laid before Parliament by the Independent Regulator.

71. The section requires that, in making and revising the code, the Independent Regulator must have regard to commercial best practice for determining the amount of loans to not-for-profit sector organisations. This would include taking into account the current and future ability of NHS foundation trusts to service debt. In addition, before making the code, the Independent Regulator must consult interested parties including the Secretary of State, NHS foundation trusts and any other persons the Independent Regulator considers appropriate. The Independent Regulator must also consult interested parties before revising the code.

Section 13: Public dividend capital

72. Under section 10 of the 1990 Act, each NHS trust is given an originating capital representing the excess of its assets over its liabilities when it is established.

This originating capital is "public dividend capital" and the NHS trust must pay dividends on it at a set rate. It constitutes an asset of the Consolidated Fund.

73. *Subsection (1)* sets out that the public dividend capital of an NHS trust applicant immediately before authorisation is granted continues as public dividend capital under the same conditions for the NHS foundation trust. Under *subsection (2)* the capital remains an asset of the Consolidated Fund.

74. *Subsection (3)* provides for the Secretary of State, with the consent of Treasury, to decide the terms on which any public dividend capital of an NHS foundation trust is issued. Under *subsection (4)* the dividend to be paid by an NHS foundation trust is the same as that payable by NHS trusts in England under section 9(7) of the 1990 Act.

75. *Subsection (5)* requires the Secretary of State to consult the Independent Regulator before deciding the terms on which any public dividend capital of an NHS foundation trust is to be issued.

76. *Subsection (6)* requires that any repayment of public dividend capital made to the Secretary of State must be paid into the Consolidated Fund, as it is for NHS trusts.

Functions

Section 14: Authorised services

77. This section sets out the powers and functions of the Independent Regulator when authorising an NHS foundation trust to provide goods and services.

78. Under *subsection (1)* an authorisation must authorise an NHS foundation trust to provide goods and services for purposes related to the provision of health care. But *subsection (2)* provides that the authorisation must ensure that the principal purpose of the NHS foundation trust is the provision of goods and services for "the health service in England", which, by virtue of *section 40* (the interpretation provision to Part 1) means the National Health Service provided by the Secretary of State pursuant to the 1977 Act.

79. *Subsection (3)* gives NHS foundation trusts powers to enter into other, non-health care related activities for the purposes of generating income to be used for the health service in England. Such activities may be subject to any restrictions set out in the authorisation.

80. *Paragraph 85(a)* of *Schedule 4* gives NHS foundation trusts the power to make accommodation or services or both available for patients who give undertakings to pay such charges as the trust may determine. The power is conferred in the same terms as it is conferred upon NHS trusts.

81. *Subsection (4)* allows the Independent Regulator, as part of an authorisation, to require an NHS foundation trust to provide particular NHS services. By exercising this power, the Independent Regulator can ensure that NHS foundation trusts are obliged to continue to provide certain goods and services to the NHS. *Subsection (6)* provides that an authorisation must authorise an NHS foundation trust to carry out health care research and to make facilities and staff available for education, training and research carried on by others. An authorisation may also require such

services. *Subsection (7)* sets out the factors the Independent Regulator is to consider in deciding whether to require provision of particular services by an NHS foundation trust; and *subsection (8)* sets out the terms in which such a requirement may be framed.

Section 15: Private health care

82. This section gives the Independent Regulator power to restrict any goods or services provided by an NHS foundation trust that are not provided for the purposes of the health service in England.

83. *Subsection (2)* obliges the Independent Regulator to exercise this power to impose a cap on the total level of income derived from the provision of services to private patients, if the NHS foundation trust was an NHS trust. In the case of an NHS foundation trust that was an NHS trust in the financial year ending 31 March 2003, the cap must restrict the NHS foundation trust to the proportion of total income received from private patients in that year. For NHS foundation trusts that were not an NHS trust throughout this period, the cap must restrict the NHS foundation trust to the proportion of total income received from private patients in its first full financial year as an NHS trust.

Section 16: Protection of property

84. This section provides a 'lock' on any assets of an NHS foundation trust that are needed for the provision of goods or services required under its authorisation.

85. The section allows the Independent Regulator to designate property as "protected" if it considers that the property is needed for the provision of: goods or services that the NHS foundation trust must provide to the NHS in England; research the trust is required to carry out, or staff and facilities that the trust is required to make available for the purposes of education, training and research under its authorisation.

86. If property is designated as protected in this way, an NHS foundation trust may not dispose of it without the Independent Regulator's approval.

Section 17: Financial powers

87. This section gives NHS foundation trusts powers to borrow money, subject to the prudential borrowing limit calculated according to the code set under *section 12*.

88. *Subsections (4)* and *(5)* give NHS foundation trusts financial and investment powers for the purposes of their functions, including powers to invest money, form subsidiaries and enter into joint ventures.

89. In addition, *subsection (6)* allows NHS foundation trusts to give financial assistance to anyone in connection with their functions. The powers are however, potentially subject to any terms of the authorisation set by the Independent Regulator.

Section 18: General powers

90. This section gives an NHS foundation trust general powers to do anything it needs to in relation to its functions. In particular, *subsection (2)* sets out that this

includes acquiring and disposing of property, entering into contracts, accepting gifts and employing staff.

Section 19: Information

91. This section sets out requirements for NHS foundation trusts and other health service bodies to provide information in certain circumstances.

92. Under *subsection (1)*, both the Secretary of State and the Independent Regulator are given the power to specify information which an NHS foundation trust is required to disclose. In each case, the provision of the information is included as a term of the NHS foundation trust's authorisation.

93. *Subsection (2)* gives the Independent Regulator a power to require other health service bodies – defined in *section 40* as being Strategic Health Authorities, Special Health Authorities, NHS trusts, Primary Care Trusts and NHS foundation trusts - to provide any information the Independent Regulator requires for the purposes of its functions.

Section 20: Entry and inspection of premises

94. This section provides for the Independent Regulator to include right of entry and inspection of premises as a term of authorisation for NHS foundation trusts.

Section 21: Fees

95. This section allows the Independent Regulator to charge NHS foundation trusts a reasonable annual fee as a term of their authorisation.

Section 22: Trust funds and trustees

96. This section provides for the Secretary of State to appoint trustees for an NHS foundation trust to manage charitable assets on its behalf. The arrangements are analogous to those set out under the 1990 Act for NHS trusts.

97. *Subsection (2)(a)* allows for the Secretary of State to make provision as to the persons by whom trustees are to be appointed. It is anticipated that the appointment of trustees will be delegated to the NHS Appointments Commission, which is a Special Health Authority established under the 1977 Act.

98. *Subsection (3)* allows the Secretary of State to transfer property from an NHS foundation trust to the trustees of the NHS foundation trust where trustees have been appointed under this section.

99. *Subsection (4)* provides that trustees of an NHS trust that becomes an NHS foundation trust are to be treated as though they were appointed under this section.

Failure

Section 23: Failing NHS foundation trusts

100. This section gives the Independent Regulator broad powers where an NHS foundation trust is breaching or has breached obligations under an Act or its authorisation. Under the section, the Independent Regulator may issue a

warning notice, and may also require Directors or the Board of Governors to act, or to cease acting, in a particular way. The Independent Regulator also has the power to remove or suspend any or all of the directors and members of the Board of Governors, and appoint directors to act in the interim period.

Section 24: Voluntary arrangements

101. This section gives the Independent Regulator powers to intervene in the operation of an NHS foundation trust in cases of financial difficulty.

102. Under this section, the Independent Regulator has powers to require an NHS foundation trust's directors to make a proposal for a voluntary arrangement with its creditors. In addition, the Independent Regulator also has the power to require an NHS foundation trust's directors to obtain a moratorium on its business prior to the approval of a voluntary arrangement.

103. Provisions to require the directors of a company to reach a voluntary arrangement with the company's creditors, and also to obtain a moratorium over its business, are set out in detail in Part 1 of the Insolvency Act 1986. *Subsection (2)* gives the Secretary of State the powers to apply Part 1 of the Insolvency Act 1986, including related provisions of that Act, with modifications to NHS foundation trusts.

Section 25: Dissolution etc.

104. This section gives the Secretary of State the power in certain specified circumstances to dissolve an NHS foundation trust by order. The power may be exercised where an NHS foundation trust fails to comply with a notice under *sections 23* or *24*, or where an NHS foundation trust fails to implement a voluntary arrangement under *section 24*, and where the Independent Regulator considers that, despite the exercise of its powers under either of those sections, the goods and services of the NHS foundation trust remain at risk. Before an NHS foundation trust is dissolved, the Independent Regulator must consult those individuals specified by the Secretary of State. This provision is intended as a safeguard on the use of the power. Where an NHS foundation trust is dissolved under this section, the Secretary of State may transfer any of its property, rights and liabilities to the persons listed in *subsection (3)*. The transfer is made by order.

105. *Subsection (4)* makes provision for *Schedule 3* which sets out the legal effect of any transfer of employees of a dissolved NHS foundation trust. Under the Schedule, the contract of any employee that is transferred under *section 25(3)* is not terminated. Rather, it transfers to the transferee as if it were originally made between the employee and the transferee. The employee is however, given the right to object to such a transfer. Where an employee objects in this way, his contract of employment is terminated.

106. *Subsection (6)* gives the Secretary of State the powers to apply Part 4 of the Insolvency Act 1986, which relates to the winding up of companies, with modifications to the dissolution of NHS foundation trusts.

107. *Subsection (7)* allows the Secretary of State to exercise his powers under this section where the Independent Regulator refuses to give an authorisation to a public

benefit corporation.

Section 26: Sections 24 and 25: supplementary

108. This section makes further provision about modification of the Insolvency Act 1986 under *section 24*, and the transfer of property, rights and liabilities under *section 25(3)*.

109. *Subsection (3)* provides that an order made under *section 25(3)* must be exercised to secure the provision of essential NHS goods and services.

110. *Subsection (4)* requires the power in *section 25(3)* to be exercised in a way that does not result in a net loss of value to the trust. If necessary, this can be achieved through the use of the powers in section 11, which allow the Secretary to give financial assistance to NHS foundation trusts. *Subsection 4* provides for regulations to set out how to determine whether a transfer would result in a net loss of value.

Mergers

Section 27: Mergers

111. This section provides a mechanism for mergers between two NHS foundation trusts or between an NHS foundation trust and an NHS trust.

112. Under *subsection (1)* an NHS foundation trust and another NHS foundation trust, or an NHS foundation trust and an NHS trust, may make a joint application to the regulator for authorisation as a new NHS foundation trust. *Subsection (2)(a)* provides that, as for new NHS foundation trusts, if the application involves an NHS trust, the application must be supported by the Secretary of State; and *subsection (2)(b)-(d)* sets out the matters that must form part of such an application.

113. *Subsection (4)* allows the Independent Regulator to issue a certificate incorporating the directors of the applicants as a public benefit corporation, and to authorise the corporation to become an NHS foundation trust, if the Independent Regulator is satisfied that the criteria set out in *subsection (5)* have been met. The criteria are that the constitution and governance arrangements are in accordance with *Schedule 1*, that the actual membership of the applicant's public constituency (and, if there is one, of its patients' constituency) will be representative of those eligible for such membership, that the new NHS foundation trust will be able to provide the goods and services which it will be required to provide, and that any other requirements the Independent Regulator considers appropriate are met.

114. *Subsection (8)* sets out that the Independent Regulator may not issue an authorisation unless satisfied that the applicant has sought the views of specified persons.

115. Under subsection *(5)(f),* the Secretary of State may make regulations setting out additional consultation requirements. Under *subsection (7)*, an authorisation may not be granted unless the Independent Regulator is satisfied that the applicant has complied with any such regulations.

Section 28: Section 27: supplementary

116. This section provides for the Secretary of State to make orders dissolving the applicants, and transferring their property, rights, liabilities and staff to the new NHS foundation trust authorised under *section 27*.

Co-operation

Section 29: Co-operation between NHS bodies

117. This section amends section 26 of the Health Act 1999. This amendment requires NHS foundation trusts to co-operate with other NHS bodies in exercising their functions. In turn, other NHS bodies must also co-operate with NHS foundation trusts.

Patient and public involvement

Section 30: Public involvement and consultation

118. This section amends section 11(2) of the Health and Social Care Act 2001. This amendment provides that, when planning service provision and considering service change, NHS foundation trusts must involve and consult patients and the public.

Section 31: Patients' Forums

119. *Subsection (2)* amends section 15 of the National Health Service Reform and Health Care Professions Act 2002 ("the 2002 Act"). This amendment will require a Patients' Forum to be established for every NHS foundation trust.

120. *Subsections (3)-(5)* make consequential amendments to Part 1 of the 2002 Act so that the provisions relating to public and patient involvement in health apply to NHS foundation trusts in a consistent way. The subsections include an amendment to section 17(1) of the 2002 Act, which provides for the Secretary of State to make regulations requiring NHS foundation trusts to allow members of a Patients' Forum authorised to do so under the regulations to enter and inspect the premises of NHS foundation trusts. There is also an amendment to section 18(2) of the 2002 Act, which provides that where a Patients' Forum prepares an annual report about activities that relate to an NHS foundation trust, it must send a copy to the Independent Regulator.

Section 32: Commission for Patient and Public Involvement in Health

121. This section amends section 20 of the 2002 Act. The amendments enable the Commission to promote the involvement of members of the public in England in decisions made by NHS foundation trusts which might affect their health.

Miscellaneous

Section 33: Taxation

122. *Subsection (1)* amends section 519A of the Income and Corporation Taxes Act 1988. This amendment exempts NHS foundation trusts from income and corporation

taxes.

123. *Subsection (2)* amends section 61(3) of the 1990 Act. This amendment exempts NHS foundation trusts from stamp duty.

124. *Subsection (3)* amends section 41(7) of the Value Added Tax Act 1994. This amendment provides for Value Added Tax to apply to NHS foundation trusts in the same way it applies to NHS trusts.

Section 34: Other amendments relating to NHS foundation trusts

125. This section introduces *Schedule 4,* which includes various minor and consequential amendments relating to NHS foundation trusts.

126. *Paragraph 18* amends section 113 of the Local Government Act 1972. This amendment allows NHS foundation trusts to enter into joint staffing arrangements with local authorities.

127. *Paragraph 20* amends Part 3 of Schedule 1 of the House of Commons Disqualification Act 1975. This amendment disqualifies Chairmen and other non-executive directors of NHS foundation trusts from membership of the House of Commons.

128. *Paragraph 25* amends section 22 of the 1977 Act. This amendment includes NHS foundation trusts among the list of NHS bodies required to co-operate with one another in exercising their functions.

129. *Paragraph 34* amends section 91 of the 1977 Act. This amendment sets out that where property held on trust is given to an NHS foundation trust for a specified purpose, the trustees for the NHS foundation trust must apply those funds for the specified purpose.

130. *Paragraph 37* amends section 96A of the 1977 Act. This amendment allows NHS foundation trusts to raise money by appeals etc. and to hold, administer and apply any property given on trust for the purpose it was given.

131. *Paragraph 84* amends section 21 of the 1990 Act. This amendment provides that NHS foundation trusts may choose to participate in schemes established by the Secretary of State for meeting losses and liabilities etc. of certain health service bodies. *Paragraph 109* amends section 31 of the Health Act 1999. This amendment allows regulations to be made which enable NHS foundation trusts to enter into joint arrangements with local authorities.

132. *Paragraph 116* amends section 7 of the Health and Social Care Act 2001. This amendment provides for the powers of local authority oversight and scrutiny committees to apply to NHS foundation trusts as to other NHS bodies.

Section 35: Conduct of elections

133. This section provides a power for the Secretary of State to make regulations about the conduct of elections for the membership of an NHS foundation trust. The regulations may include details on the nomination of candidates, systems and methods of voting, supervision of elections and the consequences of irregularities. There is

also a power to create offences, punishable on summary conviction with a maximum fine not exceeding level 4 on the standard scale.

Section 36: Offence

134. This section makes it an offence for a person to vote at an election to the Board of Governors, stand for election to the Board of Governors or vote at a meeting of the Board of Governors unless the person has made a declaration about the particulars of his qualification to be a member of the corporation. The provision does not apply to elections held for the staff constituency.

Section 37: Representative membership

135. This section provides that an authorisation may require an NHS foundation trust to take steps to ensure that, taken as a whole, the actual membership of its public constituency (and, if there is one, of its patients' constituency) is representative of the population eligible for such membership.

Section 38: Audit

136. This section introduces *Schedule 5* which sets out provisions relating to the audit of NHS foundation trusts' accounts.

137. *Paragraph 1* of the Schedule places a number of duties on auditors of NHS foundation trusts. They include a duty that, when auditing an NHS foundation trust's accounts, the auditor must be satisfied that they are prepared in accordance with directions and any relevant enactments, and that proper practices have been observed in their compilation. The auditor must also be satisfied that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

138. *Paragraph 2* gives the auditor rights of access to documents and information relating to the NHS foundation trust. The provision also gives auditors the power to require such explanation as is necessary to enable an audit to be properly completed. Failure to provide information, or to give an explanation related to audit matters, is an offence.

139. *Paragraphs 3* to *5* set out some provisions relating to auditors' reports on NHS foundation trusts, including requirements for submitting reports.

140. *Paragraph 6* requires the auditor to inform the Independent Regulator if an NHS foundation trust has or is about to incur unlawful expenditure or take action that is likely to be unlawful and cause a loss or deficiency.

141. *Paragraph 8* places restrictions on when auditors may disclose information relating to an NHS foundation trust. It is an offence to contravene these restrictions.

Section 39: General duty of NHS foundation trusts

142. This section requires each NHS foundation trust to exercise its functions effectively, efficiently, and economically.

Supplementary

Section 40: Interpretation of Part 1

143. *Subsection (2)* provides that expressions used in Part 1, other than those specifically defined in *subsection (1)*, have the same meaning as in the 1977 Act. Examples are the terms "property", which in the 1977 Act includes rights; "hospitals" which is given a detailed definition that includes a number of health care institutions; and "the health service", which means the National Health Service provided by the Secretary of State pursuant to the 1977 Act.

PART 2 –STANDARDS

CHAPTER 1 – REGULATORY BODIES

Sections 41 and 42: The Commission for Healthcare Audit and Inspection and the Commission for Social Care Inspection

144. The Command Paper *Delivering the NHS Plan: Next steps on investment, next steps on reform*[7] set out the Government's intention to create a new Commission for Healthcare Audit and Inspection ("the CHAI") which would have responsibility for the review and inspection of providers of NHS health care and also for the registration under the CSA 2000 of independent providers of health care in England, and a new Commission for Social Care Inspection ("the CSCI") which would have responsibility for inspecting local authority social services in England and also for the registration under the CSA 2000 of providers of social care services in England.

145. *Schedule 6* deals with the constitution of the CHAI. In particular it provides that the appointment of the chairman and members of the CHAI will be carried out by a Special Health Authority, which is directed to do so by the Secretary of State. It is envisaged that the Special Health Authority in question will be the NHS Appointments Commission or any similar successor body. *Schedule 7* makes the same provision for the CSCI as *Schedule 6* does for the CHAI with the following notable exceptions.

- *Paragraph 3* provides for the membership of the CSCI but gives no role to the Assembly in the appointment and removal from office of members. This is because the CSCI will be an England only body.
- *Paragraph 5* provides for the staffing of the CSCI. *Subparagraph (2)* provides that the CSCI must appoint a member of staff as a Children's Rights Director, whose role will be prescribed in regulations. The intention is that the Children's Rights Director should ensure that the CSCI's work takes full account of children's rights and welfare.
- *Paragraph 9* allows the Secretary of State to make payments to the CSCI and to make the payments subject to conditions. Again, because the CSCI is an England only body there is no role for the Assembly in this process.

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[7] For copies – website address: www.doh.gov.uk/deliveringthenhsplan/index.htm

Reviews of NHS health care in England and Wales – overview

146. In relation to NHS health care in England and Wales, responsibility is divided between the CHAI and the Assembly. The Assembly remains primarily responsible for reviewing the provision of health care by and for NHS bodies in Wales (Chapter 4). CHAI has responsibility for reviewing the provision of health care by and for NHS bodies in England and cross-border Special Health Authorities (Chapter 3). However, CHAI also has some functions relating to the review of the overall provision of health care across England and Wales (see *sections 49* and *51*); and could in the future be given further functions relating to England and Wales (*section 58*).

CHAPTER 2 - NHS HEALTH CARE: INTRODUCTORY

Section 45: Quality in health care

147. *Section 45* places a duty on all NHS bodies to ensure that appropriate arrangements are in place to monitor and improve the quality of health care they provide or commission. This replaces the current duty of quality in section 18 of the Health Act 1999. Under *subsection (2),* "health care" includes the promotion and protection of public health, whereas in the Health Act 1999 it was limited to services for or in connection with the prevention, diagnosis or treatment of illness.

148. *Subsection (3)* states that 'illness' has the same meaning as in *section 128(1)* of the 1977 Act, that it includes mental disorder within the meaning of the Mental Health Act 1959 and any injury or disability requiring medical or dental treatment or nursing.

Section 46: Standards set by Secretary of State

149. *Section 46* gives the Secretary of State the power to prepare and publish a statement of standards in relation to the provision of health care by and for English NHS bodies and cross-border Special Health Authorities. It is envisaged that these standards are likely to be informed by Government National Service Frameworks (NSFs)[8], guidance issued by the National Institute for Clinical Excellence (NICE)[9] and other relevant sources.

150. *Subsection (4)* makes it clear that English NHS bodies and cross-border Special Health Authorities should take these standards into account in making arrangements under *section 45. Section 54(2)* enables the CHAI to advise the Secretary of State or the Assembly of any changes that it considers should be made in relation to these standards.

Section 47: Standards set by the Assembly

151. As accountability for NHS provision in Wales rests with the Assembly, *section 47* provides for the Assembly to publish its own statement of standards.

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[8] The objective of Government National Service Frameworks (NSFs) is to tackle particular health issues, for example mental health, by setting out aims to improve particular services or care provided.
[9] NICE is a special health authority set up to give advice on best clinical practice to NHS clinicians, to those commissioning NHS services and to patients and carers.

152. As with standards published by the Secretary of State, it is likely that NSF guidance and NICE guidelines will inform the Assembly standards. *Subsection (4)* operates in the same manner with respect to Welsh NHS bodies as *subsection (4)* of *section 46* does in respect of English NHS bodies and cross-border Special Health Authorities. The CHAI may advise the Assembly under *section 54(2)* of any changes it considers should be made to the standards.

CHAPTER 3 - NHS HEALTH CARE: FUNCTIONS OF CHAI

Healthcare provided by and for NHS bodies

Section 48: Introductory

153. *Section 48* gives the CHAI the function of encouraging improvement in NHS health care by or for all NHS bodies. Under this section, the CHAI will be able to give information or advice to NHS bodies or others who provide NHS health care. It states that the CHAI, in exercising its functions under *sections 49* to *56*, shall be concerned in particular with the availability of and access to, the quality and effectiveness, and the economy and efficiency of health care provided by or for NHS bodies, and with the need to safeguard and promote the rights and welfare of children. CHAI shall also be concerned with the availability and quality of information provided to the public about the health care, such as generic information that is not specific to individual patients or service users, such as leaflets, hospital signage and other patient and service user information, such as information about medical conditions generally.

Section 49: National Performance Data

154. This section enables the CHAI to publish data on the performance of NHS bodies and other persons who provide health care, across NHS bodies in England and Wales.

Section 50: Annual Reviews

155. *Section 50* gives the CHAI the function of undertaking annual reviews, taking the statement of standards (as provided for in *section 46*) into account, of the provision of health care by and for each English NHS body and each cross-border Special Health Authority. Following each annual review of a body, the CHAI will award a performance rating. *Subsections (2)* and *(3)* provide for the CHAI to devise and publish criteria against which these reviews will be carried out. The Secretary of State will approve such criteria.

Section 51: Reviews: England and Wales

156. This section gives the CHAI a function of conducting reviews across England and Wales of health care generally or of particular kinds of health care, for example, national cancer services. CHAI may undertake such reviews under its own initiative or at the request of the Secretary of State, who must first consult the Assembly before making a request.

157. *Sections 51(6), 52(7), 53(9), 54(9)* and *57(5)* enable the Secretary of State, after consulting the CHAI, to issue regulations making provision as to any procedure that must be followed before the award of any performance rating under section 50 or publication of any report under *sections 52* to *54* in order to give the reviewed body time to comment and for any comments to be considered by CHAI. Such regulations could specify, for example, the numbers of days that NHS bodies would have to respond to draft reports issued by CHAI under differing circumstances, and could in particular require the CHAI to take into account any material observations made by NHS bodies about apparent factual errors in draft reports.

Section 52: Reviews and Investigations: England

158. *Section 52* provides for the CHAI to review or investigate health care provided by or for English NHS bodies and cross-border Special Health Authorities with a view to making a report. The CHAI may also review the arrangements made by such bodies under section 45 to monitor and improve the health care they provide or commission. English NHS bodies may provide health services on behalf of Welsh NHS bodies, and where this occurs the Assembly may review and investigate such services under *section 68.* This also applies in respect of cross-border Special Health Authorities.

159. The CHAI may undertake reviews either under its own initiative or at the request of the Secretary of State.

Section 53: Failings

160. Where the CHAI considers that there are significant failings in the health care provided by or for NHS bodies, *subsections (2), (4)* and *(6)* oblige the CHAI to make a report to the Secretary of State, the Assembly or the Regulator as appropriate. *Subsections (3), (5)* and *(7)* enable the CHAI to recommend that the appropriate authority take special measures to improve the health care provided. Such measures could include calling on the CHAI to undertake a re-inspection of the body concerned or other practical assistance or organisational support.

Section 54: Functions relating to the Secretary of State and Assembly

161. *Section 54* places a duty on the CHAI to keep the Secretary of State, in relation to English or cross-border NHS bodies, and the Assembly in relation to Welsh NHS bodies, informed about health care provided by or for NHS bodies.

162. *Subsection (2)* allows for the CHAI, where it considers it timely or appropriate, to give advice to the Secretary of State or the Assembly on any particular changes which it thinks should be made in order to secure improvements in the quality of NHS health care including in relation to the statement of standards referred to in *sections 46* and *47.*

Section 55: Reviews of data

163. This section enables the CHAI to review the quality of any data collected by others on health care provided by and for NHS bodies and to make a report of its

findings.

Section 56: Co-ordination of reviews

164. *Section 56 gives* the CHAI the function of promoting the effective co-ordination of reviews or assessments by public bodies or other persons which undertakes reviews of the provision of health care by or for English NHS bodies and cross border Special Health Authorities. It is envisaged that the Assembly will perform this function in relation to Welsh NHS bodies under its powers in the 1977 Act.

Other functions

Section 57: Studies as to economy, efficiency etc

165. This section enables the CHAI to carry out comparative or other studies for improving economy, efficiency and effectiveness in the exercise of any of the functions of English NHS bodies with the exception of Special Health Authorities (which are to be reviewed in this respect by the National Audit Office).

166. The Audit Commission, under section 33(1) of the Audit Commission Act 1998 previously carried out such studies in relation to these bodies. *Paragraphs 12(6)* and *(8)* of *Schedule 9* of the Act removes all of these bodies - apart from NHS foundation trusts, which are not currently within the scope of those provisions - from the scope of section 33(1) and (4) and 35 of the 1998 Act.

167. Within Wales, the function of carrying out these studies remains with the Audit Commission. However, in carrying out reviews and investigations generally, the Assembly is required under *section 70* to be concerned with the economy and efficiency of the provision of health care. It is envisaged that the Audit Commission will continue to work with the Assembly in relation to reviews and investigations of health care by or for Welsh NHS bodies.

Section 58: Additional functions

168. It is envisaged that the CHAI may need to be given additional functions with respect to the provision of health care by or for NHS bodies or for the improvement of economy, efficiency and effectiveness in the exercise of the functions of English NHS bodies, in the future. This section therefore makes provision for such functions to be given by regulations.

Supplementary

Section 59: Criteria

169. This section provides for the Secretary of State or the Assembly as appropriate to make regulations requiring the CHAI to devise and publish statements of criteria to be used by it in exercising its functions under *sections 48(1), 49, 51* or *52*, in relation to health care provided by and for NHS bodies.

170. The Secretary of State may also make such regulations with respect to the exercise of the CHAI's functions under *sections 52, 56, 57* and *58(1).*

171. The regulations may require the CHAI to obtain the consent of the appropriate authority before publishing any such statement. Before making any such regulations the appropriate authority must first consult the CHAI.

Section 62: Fees and section 63:Fees: Wales

172. *Section 62(1)* provides a power for the CHAI to be able to make and publish provision requiring persons to pay fees in relation to the exercise of prescribed functions under this Chapter. *Section 62(1)(a)* provides for it to be able to charge fees to NHS bodies and cross border Special Health Authorities, and *section 62(1)(b)* provides for it to be able to charge fees to any person of a prescribed description who provides health care for an English NHS body or cross border Special Health Authority.

173. Similar powers in relation to the exercise of the CHAI's functions in relation to Welsh NHS bodies are provided under *section 63*. Therefore, the CHAI may not charge a Welsh NHS body under the provisions of *section 62(1)(b)* and may not charge an English NHS body or cross border Special Health Authority under *section 63(1)(b).* By *subsection (5)* of both sections, CHAI is under a duty to consult appropriate persons before specifying any provisions.

174. *Subsection (6)* of both sections confers a regulation making power on the appropriate authority to prescribe the manner in which CHAI's fees are to be made and published and to enable the appropriate authority to specify the matters that CHAI must take into account before it determines any fee.

175. *Subsection (7)* of both sections will allow the appropriate authority to make provisions for an independent person or panel to review the charge levied by CHAI in a particular case, and to substitute a lesser one if they deem it appropriate.

Section 66: Right of entry

176. This section provides that individuals authorised by the CHAI may enter and inspect premises that are owned or controlled by an NHS body or which are used or proposed to be used for any purpose connected with the provision of health care by or for NHS bodies, or the discharge of functions of those bodies.

Section 67: Right of entry: supplementary

177. *Subsection (1)* allows a person (authorised to enter and inspect premises by virtue of *section 66*) to inspect and copy relevant documents or records. It also allows inspectors to interview any person working at the premises or any patients or persons receiving health care that consent to be interviewed. Inspectors may also require relevant records or other documents on the premises to be produced for inspection, and where they are stored on computer, for them to be produced in a legible, not encrypted, form. *Subsection (4)* imposes a requirement to assist an inspector and permits the inspector to take such measurements and photographs and make such recordings as he considers necessary to enable him to exercise his powers under *section 66.*

Section 68: Power to require documents and information

178. *Section 68* confers on the CHAI a general power to require information and documents from the bodies or persons listed in *subsection (2)* irrespective of whether or not the CHAI is conducting an inspection, where such information relates to the provision of health care by or for an NHS body or the discharge of functions of an NHS body and where the CHAI considers it necessary or expedient to have the information or documents for its purposes under this Chapter.

179. *Subsection (2)(c)* gives the CHAI the right to require information or documents from a local authority. This will enable the CHAI to obtain information or documents kept by a local authority for its own purposes, where that information is relevant to the exercise of the CHAI's functions under this Chapter. For example, the CHAI might request information as to how quickly the local authority responds to requests by an NHS trust to assess the social services needs of persons ready to be discharged from hospital.

Section 69: Power to require explanation

180. Under this section, regulations may make provision for the CHAI to require a prescribed person to provide it with an explanation of any documents or information it obtains under *sections 66* to *68* or any matters which are the subject of the CHAI's functions under this Chapter. *Subsection (2)* enables these regulations to set the requirement that individuals must be present at a specified place to give an explanation. The CHAI will use this power to enable it to discuss with those responsible any matters of concern that its inspections have brought to light.

181. *Sections 67(5), 68(4)* and *69(3)* make it an offence for a person to obstruct the exercise of any of the CHAI's powers under these sections or to fail to comply with any requirement. The penalty on summary conviction is a fine not exceeding level 4 (£2500) on the standard scale.

CHAPTER 4 – NHS HEALTH CARE: FUNCTIONS OF NATIONAL ASSEMBLY FOR WALES

Reviews and investigations

Section 70: Reviews and investigations relating to Wales

182. The Commission for Health Improvement undertook reviews of, and investigations into, health care provided by NHS bodies both in England and Wales. This section provides for the Assembly to exercise these functions in relation to health care by or for Welsh NHS bodies. Under section 63 of the Government of Wales Act 1998, the Assembly has the power to delegate its inspection function to its staff. It is the stated intention of the Assembly to set up an internal unit to carry out this function.

183. In the same way that *section 51* provides for particular matters to be considered by the CHAI in undertaking its review and investigation functions, *subsection (4)* provides that the Assembly shall be concerned with the availability of and access to, the quality and effectiveness and the economy and efficiency of health

care provided by and for Welsh NHS bodies, the availability and quality of information provided to the public about the health care and the need to safeguard and promote the rights and welfare of children.

Section 71: Reporting to Secretary of State and the Regulator

184. English NHS bodies may provide health services on behalf of Welsh NHS bodies, and where this occurs the Assembly may review and investigate these services under *section 70.* Where the Assembly detects significant failings in the provision of services by an English NHS body or cross-border Special Health Authority, *section 71* provides that the Assembly must report this to the Secretary of State. If the Assembly detects failings relating to NHS foundation trusts it will be required to report the same to the Regulator. *Section 145* provides that the Assembly must co-operate with the CHAI for the efficient and effective discharge of their respective functions. This means that the Assembly and CHAI will need to co-operate in particular in order to avoid any unnecessary overlap between the inspections and reviews that each carry out.

185. Any reports so provided by the Assembly under *section 71* may include recommendations that the Secretary of State or the Regulator, as the case may be, take special measures with a view to improve the health care provided.

Ancillary powers

Section 72: Right of entry, section 73: Right of entry: supplementary, section 74: Power to require documents and information and section 75: Power to require explanation

186. *Sections 72* to *75* make the same provision with respect to powers of entry and powers to obtain documents and information in relation to the Assembly as *sections 66* to *69* do in relation to the CHAI.

CHAPTER 5 – SOCIAL SERVICES: FUNCTIONS OF CSCI

Provision of social services

Section 76: Introductory

187. This section places a duty on the CSCI to encourage improvement in the provision of local authority social services in England. It provides that in exercising its functions in respect of local authority social services, the CSCI will be concerned in particular with the availability, access, quality, effectiveness, management, economy and efficiency of these services, and also have regard to the need to promote and safeguard the rights and welfare of children and should consider in particular how local authorities are doing this. *Subsection 2(e)* also places a duty upon CSCI to be concerned with the availability and quality of information provided to the public about social care services. This applies to general information that is not specific to individual service users, such as leaflets about the different social care services that are available and telephone helpline services.

188. The Act defines English local authority social services at *section 148*. The definition of English local authority social services in the Act includes both local

authority social services as defined in the Local Authority Social Services Act 1970 ("LASS Act") and services provided under local authorities' broad discretionary power under section 2(1)(b) of the Local Government Act 2000 where those services are similar to local authority social services as defined in the LASS Act.

189. Local authority social services are defined in the LASS Act as services provided under the enactment specified in Schedule 1 to that Act. Examples of local authority social services are child protection services, support services to elderly people to enable them to stay in their own homes and the provision of special equipment to help disabled people with their daily living needs. Section 2(1)(b) of the 2000 Act provides local authorities with a broad discretionary power to provide services calculated to improve the wellbeing of people in their area.

Section 77: Information and advice

190. *Section 77* places a duty on the CSCI to keep the Secretary of State informed about the social services provided by English local authorities. *Subsection (2)* allows for the CSCI to give advice to the Secretary of State on any matters connected with this subject as it sees fit. In particular, the CSCI may advise the Secretary of State of any changes to standards issued under section 23 of the CSA 2000 that, if made, could secure an improvement in the performance by local authorities in England of their adoption and fostering functions. These standards are National Minimum Standards that represent the minimum service level expected of local authorities in exercising their adoption and fostering functions. Similar National Minimum Standards are also issued under section 23 of the Care Standards Act ("CSA 2000") in respect of adoption and fostering services provided by voluntary sector adoption and fostering agencies.

Section 78: Review of studies and research

191. This section enables the CSCI to evaluate work carried out by other bodies, such as academic institutions, into the provision of English local authority social services. The CSCI will be able to make a judgement on the lessons that may be learned from such work. The CSCI must publish a report of the work it undertakes in this area.

Section 79: Annual Reviews

192. *Section 79* gives the CSCI the function of undertaking an annual review of social services provided by every local authority England. This includes services 'commissioned' by a local authority. For example, a local authority might pay for an elderly person to be placed in a voluntary or private sector care home. In assessing how well a local authority is discharging its social services functions the CSCI will consider the extent to which 'commissioned' services meet the needs of those for whom they are have been 'commissioned'.

193. Following each annual review of a local authority, the CSCI will award a performance rating *(subsection 2).* In practice this will mean the award of a 'star rating'. 'Star rating' is not a term set out in the legislation. The star rating system was introduced by the Secretary of State in October 2001. Its aim is to provide a simple

indicator of the level of performance of a local authority in its provision of social care services in any one year. The star ratings awarded for social services are included in the annual comprehensive performance assessment of local authorities.

194. *Subsections (3)* and *(4)* provide for the CSCI to devise and publish criteria against which these reviews will be carried out. The Secretary of State will approve such criteria. *Subsection (5)* places a duty upon CSCI to carry out any annual reviews under this section in accordance with any timetable that has been specified by the Secretary of State. The Secretary of State could specify for example that the reviews must be carried out to fit in with the timetable of the Comprehensive Performance Assessment (carried out annually of all local authorities) so that disruption to local authorities' work was minimised.

195. When carrying out annual reviews the CSCI must take into account guidance issued to local authorities under section 7 of the LASS Act[10] *(subsection (6)). Subsection (7)* provides that when CSCI inspects a local authority's adoption and fostering functions as part of an annual review it must also take into account standards published under section 23 of the CSA 2000 that relate to such functions (National Minimum Standards for local authority adoption and fostering services).

196. In order for the CSCI to carry out these reviews and investigations, *subsection (8)* enables the CSCI to inspect the local authority being reviewed or any person 'commissioned' on behalf of that local authority to provide a local authority social service.

197. *Section 79(8),* together with *sections 81(8), 81(7)* and *82(5),* makes the same provision in relation to CSCI as *sections 50(6), 51(7), 52(9), 53(9)* and *57(5)* make in relation to CHAI. This enables the Secretary of State, after consulting the CSCI, to issue regulations making provision as to any procedure that must be followed before the award of any performance rating or publication of any report. The purpose of such procedure is to give the reviewed body time to comment and for any comments to be considered by the CSCI.

Section 80: Other reviews and investigations

198. *Section 80* provides for the CSCI to review or investigate the provision by local authorities in England of social services in circumstances other than when the CSCI is conducting an annual review. Under this function the CSCI may, in particular, undertake a review of the social services provided by local authorities across the whole of England *(subsection 2(a))*, a review of one or more social services across the country, in a particular area or by a particular type of local authority (for example the provision of child protection services by local authorities in large cities) *(subsection 2(b)*), or the services (or any of them) provided by an individual local authority *(subsection 2(c)). Subsection (3)* provides that the CSCI must, where

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[10] This is guidance issued by the Secretary of State to local authorities with regard to the exercise of their functions. Case law establishes that local authorities must comply with such guidance unless they have good reason not to do so.

requested to do so by the Secretary of State, carry out a review of the local authority social services specified in the Secretary of State's request.

Section 81: Failings

199. This section gives the CSCI certain duties that it must carry out when, following a review or investigation, it judges that there are failings in the provision of social services by a local authority.

200. *Subsections (2)* and *(3)* provide that the CSCI must recommend certain measures that the Secretary of State should take where local authorities' social services have been awarded the lowest performance rating (currently a zero star) or where the CSCI judges that a local authority is failing to discharge its social services functions to an acceptable standard. Such measures might include the Secretary of State asking CSCI to monitor the local authority concerned more closely or use of the Secretary of State's powers of intervention (as set out in the Local Authority Social Services Act 1970 (section 7), the Children Act 1989 (section 81 and 84), the NHS and Community Care Act 1990 (section 50), the Local Government Act 1999 (section 15), and the Health and Social Care Act 2001 (section 46)). Following a request from the Secretary of State, the CSCI must undertake a further inspection of the local authority concerned and prepare a further report.

201. Where failings are of a less significant nature, *subsections (4)* and *(5)* provide for the CSCI to notify the local authority, setting out the detail of the failure, the action to be taken to rectify it, and the time by which by CSCI considers that this should be done. The CSCI must at this time inform the Secretary of State of the action it has taken.

Other functions

Section 82: Studies as to economy, efficiency etc.

202. *Section 82* replicates, for the CSCI, the powers that sections 33 and 34 of the Audit Commission Act 1998 give to the Audit Commission with respect to local authority social services.

203. *Subsection (1)* provides for the CSCI to carry out studies designed to enable it to make recommendations for improving economy, efficiency and effectiveness in the provision of local authority social services, and for improving the management of social services. These provisions will enable the CSCI to carry out value for money studies in a local authority's area. Where there are studies looking at the performance of an individual local authority's social services, or where there is a national study into one particular aspect of social service provision, these will be carried out by the CSCI.

204. The Audit Commission will retain powers enabling it to carry out studies of local authority social services. However, although this will mean that the functions of the Audit Commission and CSCI will overlap, it is envisaged that in practice they will exercise them in different circumstances. It is envisaged that in the future the CSCI will carry out studies that focus specifically on social services, calling on the assistance of the Audit Commission where necessary. Where the primary focus of a

study is on local authority services other than social services, it is envisaged that such studies will be carried out by the Audit Commission, calling on the assistance of CSCI where necessary. *Subsection (5)* provides that CSCI must provide the National Audit Office with any material relevant to such a study.

Section 83: Joint working with the Audit Commission

205. *Section 83* provides that the Audit Commission and the CSCI may exercise jointly the functions given them by *section 82* of this Act and sections 33 and 34 of the Audit Commission Act. This section also imposes on the CSCI and the Audit Commission a duty to co-operate with one another when performing their respective functions in these areas *(subsection (2)). Subsection (3)* enables the Secretary of State to give guidance about their functions to both the CSCI and the Audit Commission. The object of such guidance will be to enable the Secretary of State to detail circumstances where he considers that the most appropriate use of public resources, and of the expertise of CSCI and the Audit Commission would be for either the Audit Commission or the CSCI to take the lead in work which could be undertaken by either of them.

Section 84: Additional functions

206. *Section 84* allows the Secretary of State to confer additional functions through regulations on the CSCI in respect of local authority social services in England. The social care sector is constantly changing, so this might necessitate giving additional functions to the CSCI which have not yet been identified and therefore cannot be dealt with on the face of the Act itself. The purpose of this power therefore is to ensure that sufficient flexibility is retained to ensure that the CSCI can be given additional functions by means of secondary legislation, where this would be desirable, in order to enable it to be responsive to changing trends in social services and social care provision.

Supplementary

Section 85: Criteria

207. This section provides for the Secretary of State to make regulations requiring the CSCI to devise and publish criteria to be used in relation to its functions under this Chapter (other than the annual review function in respect of which provision about criteria is made in *section 79*). The regulations will be used to specify exactly what functions CSCI will need to draw up inspection criteria for. The Secretary of State must approve the criteria prior to their publication.

Section 86: Fees and section 87: Reports and information

208. *Sections 86* and *87* refer to the levying of fees. *Section 86* provides for the CSCI to be able to determine and levy fees in relation to the exercise of such of its functions under *sections 79, 80* or *82* as may be prescribed. The CSCI may levy a fee upon the local authority (rather than the service provider) where it has exercised its functions under *sections 79, 80 or 82*, in relation to services commissioned by the local authority. *Subsection (5)* requires that the CSCI must consult appropriate

persons before it devises the fee scale. Appropriate persons are likely to be local authorities in general or organisations representative of local authorities, such as the Local Government Association or the Association of Directors of Social Services. *Subsection (6)* provides for regulations allowing an independent panel to review in individual cases the amount chargeable by the CSCI for a particular service.

209. *Section 87* makes the same provision as respect as the provision of reports and other information to the public as *section 64* makes for the CHAI.

Section 88: Right of entry

210. This section allows persons authorised by the CSCI to enter premises which are used or are proposed to be used in the provision of an English local authority social service, or where the CSCI believes such use has or will be likely to take place *(subsection (2))*. Individuals authorised by the CSCI will not have the right, by virtue of this section, to enter private homes where social services are being provided. The powers given to CSCI inspectors by this section largely mirror those given to the CHAI inspectors by *section 66*.

Section 89: Right of entry: supplementary

211. This section gives persons authorised to enter premises under *section 86* rights to copy and inspect documents and remove them from the premises, interview persons working at the premises etc. The powers given to the CSCI inspectors by this section mirror those given to the CHAI inspectors by *section 67.*

Section 90: Power to require information etc

212. This section provides for the CSCI the same right to require information from the bodies specified in *subsection (2)* as *section 68* does for the CHAI.

Section 91: Power to require explanation

213. This section provides that the Secretary of State may make regulations to give the CSCI power to require an explanation of any documents or information it obtains under *sections 88* to *90* or of any matters that are the subject to the exercise of its functions under this Chapter. This section is identical to *section 69* in the CHAI provisions.

CHAPTER 6 – SOCIAL SERVICES: FUNCTIONS OF NATIONAL ASSEMBLY FOR WALES

Provision of social services

Section 92: General function

214. *Section 92* confers a general function upon the Assembly of encouraging improvement in the provision of Welsh local authority social services. The same provision is made as respects the CSCI for England by *section 76*.

Section 93: Reviews of studies and research

215. The powers given to the CSCI in *section 78* are replicated in this section for the Assembly.

Section 94: Reviews and investigations

216. *Section 94* gives the Assembly similar functions of undertaking reviews and investigations of Welsh social services authorities to those is given to the CSCI in relation to English authorities under *sections 79* and *80.* However, the provisions are less prescriptive under *section 94* to take account of the fact that the Assembly is itself also a central governmental body and to provide it with the flexibility to decide how to discharge its function of undertaking reviews and investigations. For example: the Assembly does not have a duty to undertake annual reviews, it may (rather than must) award performance ratings to local authorities, and no provision is necessary to provide links between the Assembly and a central governmental body.

Section 95: Studies as to economy, efficiency etc

217. This section provides powers for the Assembly in relation to Welsh social services authorities (in the same way that *section 82* does for the CSCI in relation to English authorities), that are similar to those conferred upon the Audit Commission by sections 33 and 34 of the Audit Commission Act 1998. *Subsection (1)* provides for the Assembly to promote or undertake studies designed to enable it to make recommendations for improving economy, efficiency and effectiveness in the provision of local authority social services ('value for money' studies), and for improving the management of social services. *Subsection (3)* provides that the Assembly must publish, or otherwise make available, its recommendations and a report resulting from these studies. *Subsection (4)* provides that the Assembly and the Audit Commission must co-operate with each other with respect to their similar functions.

Section 96: Additional Functions

218. Where the Secretary of State confers additional functions on the CSCI by regulations under *section 84*, *section 96* provides that the Assembly may make regulations to confer such functions on itself in relation to the provision of Welsh social services.

Section 97: General considerations

219. This section sets out the matters with which the Assembly must in particular be concerned in the exercise of its functions under the preceding social care sections of the Act.

Ancillary powers

Section 98: Right of Entry, section 99: Right of entry: supplementary, section 100: Power to require information, section 101: Power to require explanation

220. The powers given to the CSCI in *sections 88, 89, 90* and *91* in relation to

English social services authorities are replicated in these sections for the Assembly in relation to Welsh authorities.

CHAPTER 7 – FUNCTIONS UNDER THE CARE STANDARDS ACT 2000

221. The National Care Standards Commission ("NCSC") was established by the Care Standards Act 2000 ("CSA 2000") to regulate specified types of social care and private and voluntary health care services in England. Its functions were set out in Parts 1 to 3 and Part 8 of the CSA 2000.

222. Regulation is dealt with in Part 2 of the CSA 2000. The types of service subject to regulation under Part 2 are collectively defined in the Act as "establishments and agencies". Persons wishing to carry on establishments and agencies of the types required to be regulated must apply to be registered in respect of the establishment or agency which they wish to carry on. Under section 11 of the CSA 2000, it is a criminal offence to carry on or manage an establishment or agency subject to registration requirements without having registered with the registration authority.

223. Where an establishment or agency applies to register under the CSA 2000, it is assessed whether it meets the applicable regulatory requirements under the CSA 2000 or other legislation. In deciding this, the regulator is obliged to take into account the requirements of any National Minimum Standards applying to the service in question issued by the Secretary of State under section 23 of the CSA 2000. The registration authority may grant or refuse an application to register an establishment or agency or may register it subject to conditions. The establishment or agency may appeal to an independent tribunal against the refusal of registration or the imposition of conditions.

224. The registration authority will periodically re-inspect the establishment or agency to ensure that appropriate standards continue to be maintained. Section 14 of the CSA 2000 provides that the registration authority may cancel registration in the circumstances set out in that section. Section 20 sets out an urgent cancellation procedure whereby the registration authority may apply to a justice of the peace for an order cancelling registration, or varying any conditions imposed as to registration.

225. The types of establishment and agency currently regulated under the Act are as follows:

- residential and nursing homes,
- children's homes,
- private and voluntary hospitals and clinics,
- fostering agencies,
- independent medical agencies,
- domiciliary care agencies,
- nurse agencies,
- residential family centres and

- voluntary adoption agencies.

Functions of CHAI and CSCI

Section 102: Transfer of functions to CHAI and CSCI

226. This section transfers to the CHAI the responsibility for regulating independent hospitals, independent clinics and independent medical agencies, and transfers to the CSCI the responsibility for regulating children's homes, residential and nursing homes, residential family centres, domiciliary care agencies, nurses agencies, fostering agencies, voluntary adoption agencies and adoption support agencies (defined in *section 107* of the Act as 'registered social care services'). The NCSC is abolished by *section 44* of the Act.

227. Part 3 of the CSA 2000 gave the NCSC the function of inspecting local authority adoption and fostering services. These are defined as 'relevant services' by section 43 of the CSA 2000. In carrying out such inspections, the NCSC was obliged to take account of national minimum standards issued under section 23 of that Act. This part of the CSA 2000 is repealed in part (see *Schedule 14*).

228. Chapter 5 of this Act provides the CSCI with general powers to inspect local authority social services. These powers also allow the CSCI to inspect local authority adoption and fostering services. The separate powers of inspection with regard to adoption and fostering services in Part 3 of the Care Standards Act are, therefore, no longer needed. The elements of Part 3 that have been retained provide for the Secretary of State to make regulations with regard to relevant services and also to make regulations prescribing the frequency with which relevant services must be inspected by CSCI.

229. *Subsection (4)* transfers the inspection of relevant services, previously carried out by the NCSC, to CSCI for any interim period before CSCI takes on its general powers to inspect local authority social services under Chapter 5.

Section 105: Fees

230. Fees are currently chargeable in respect of registered social care services and independent health care services under the CSA 2000. They are set out in regulations made by the Secretary of State. This section amends section 113 of the CSA 2000 to provide for the CHAI and the CSCI to determine fees in respect of their respective functions under Part 2 of that Act. Both Commissions and the Secretary of State must consult appropriate persons before fees devised by them come into effect (*subsections (5)* and *(6)* of the new *section 113A*). *Subsection (4)* of the new *section 113A* provides that Secretary of State must approve any fees determined by either Commission before they come into effect.

Miscellaneous

Section 106: Meaning of "independent medical agency"

231. For the avoidance of doubt *section 106* amends section 2(4) of the CSA 2000 to make clear that the term 'independent medical agency' neither includes independent clinics nor independent hospitals. The term "independent clinic" in the

CSA 2000 refers to an establishment in which one or more medical practitioners provide services other than those that would render the establishment an independent hospital.

Section 107: Children's homes providing secure accommodation

232. This section amends the CSA 2000 so that children's homes providing secure accommodation will require registration by the CSCI. Previously such combined services had to be registered with the NCSC to operate and with the Secretary of State to provide secure accommodation. Under the provisions in the Act the CSCI took on both the registration role of the NCSC and the Secretary of State's function of assessing suitability to provide secure accommodation.

Section 108: Information and inspection

233. *Subsection (2)* of this section amends section 31 of the CSA 2000 to give inspectors the power to require at any time, from a person who carries on or manages an establishment or agency, copies of any medical or other personal records or other documents, insofar as is necessary to enable the registration authority – the CHAI or the CSCI in England, the Assembly in Wales - to discharge its functions. Where these documents or records are stored on a computer they must be produced in a legible form. Currently inspectors may only inspect such documents or records when they are already engaged in the inspection of an establishment or agency.

234. *Subsections (3)(a)* and *(4)* also amend section 31 to enable inspectors to inspect and take copies of medical and other personal records when inspecting a premises. *Subsection 3(b)* replaces the inspectors' power to interview anyone 'employed' at premises with a power to interview anyone 'working' there. This will enable inspectors to interview temporary and agency staff contracted by a provider as well as permanent employees.

Section 109: Assembly: duties relating to children

235. *Section 109* amends the CSA 2000 so that the Assembly must have particular regard to the need to safeguard and promote the rights and welfare of children in the exercise of its regulatory functions under that Act.

CHAPTER 8 – OTHER FUNCTIONS OF CSCI

Section 110: Boarding schools and colleges

236. This section transfers to the CSCI the responsibilities of the NCSC with respect to boarding schools and colleges. This means that the CSCI has responsibility for inspecting such establishments.

Section 111: Boarding schools and colleges: reports

237. This section amends section 87 of the Children Act 1989 (welfare of children accommodated in independent schools) to make clear that the CSCI and the National Assembly for Wales must each publish reports in relation to the exercise of their functions under that section where they carry out an inspection. They must also make

such reports available for inspection and send a copy of the report to the school in question.

Section 112: Secure training centres

238. Secure training centres accommodate children aged under 18 who are sentenced to Detention and Training Orders under the Crime and Disorder Act 1998 section 73 (since consolidated into section 100 of the Powers of Criminal Courts (Sentencing) Act 2000), and children sentenced under sections 90 and 91 of the Powers of Criminal Courts (Sentencing) Act 2000 (for 'grave crimes'). The Home Office is responsible for secure training centres. This section enables the CSCI to enter into an agreement to inspect secure training centres if they are asked to do so by the Home Secretary. The arrangements they may enter into with the Home Secretary may specify such things as frequency with which inspections must be carried out and the criteria that will be used in inspections.

CHAPTER 9 - COMPLAINTS

Section 113: Complaints about health care

239. *Section 113* gives the Secretary of State and the Assembly powers to make regulations about the handling and consideration of complaints.

240. *Subsection (1)* sets out what matters may be the subject of complaints under the regulations. It includes the provision of services by an English NHS body or cross-border Special Health Authority under a partnership arrangement made by it under section 31 of the Health Act 1999 in relation to the exercise of the health-related functions of a local authority. That section allows the NHS and local authorities to work together by enabling them to pool resources, delegate functions from one to another and enables a single provider to provide both health and local authority services. The intention is that a person receiving both health and local authority services from a health body under such an arrangement will be able to complain to that health body even if the complaint is about the local authority services which it provides.

241. *Subsection (2)* gives the Assembly the same power in respect of Welsh NHS bodies as the Secretary of State has in relation to English NHS bodies and cross border bodies in *subsection (1)*.

242. By *subsection (3),* the regulations may provide for who may consider a complaint. It is envisaged that in both England and Wales regulations will provide that the complaint be made to the health care provider which is the subject of the complaint, where an attempt will be made to investigate and resolve the matter. If this is not possible, the second stage will involve consideration by the CHAI and by an independent lay person in England. In Wales, if further investigation under the complaints procedure is felt to be warranted, this will be conducted by an independent panel for complaints.

243. It is envisaged that the focus of the CHAI's role in the second stage of the complaints procedure in England will be to establish the facts pertinent to a complaint in order to identify how, and by whom, the complaint is most likely to be resolved to

the satisfaction of the complainant and the body or persons complained about. Following the CHAI's assessment of an individual case, it is envisaged that it will decide what, if any, further action, and by whom, is appropriate. Options likely to be available to the CHAI include: making recommendations to the NHS body complained about in relation to further action that may be needed locally to resolve the complaint; full investigation by the CHAI, either by itself or by any independent panel established or engaged by the CHAI; referral for consideration by other agencies (for example a professional regulatory body); referral, subject to agreed criteria, for consideration by the Health Service Commissioner or no further action to be taken.

244. In Wales, it is envisaged that an independent lay person, with the benefit of independent clinical advice if necessary, will determine how a complaint that has not been dealt with to the patient's satisfaction by the NHS body complained about, should proceed. The options open to the independent lay person are likely to include, as set out above in relation to CHAI in England, making recommendations to the NHS body in question about further action that may be taken to resolve the complaint locally; full investigation by an independent panel; referral for consideration by other agencies; referral, subject to agreed criteria, for consideration by the Health Service Commissioner; or no further action. The principal difference in the way that Wales will deal with NHS complaints is that it is not currently envisaged that there will be a role for CHAI. As set out above, it is envisaged that an independent lay person and, if convened, an independent panel will fulfil the same role in relation to NHS complaints in Wales as CHAI will in England.

245. The regulations may, by virtue of *subsection (4),* provide for a complaint or any matter raised by a complaint to be referred to a Health Service Commissioner for consideration as to whether to investigate the complaint under the Health Service Commissioners Act 1993, or to any other person or body, such as the police or a professional regulatory body, for them to decide whether to take any action themselves.

Section 114: Complaints about social services

246. *Section 114* gives regulation making powers to the Secretary of State and to the Assembly to establish procedures for making complaints about social services. These will replace the current complaints procedures set up under section 7B of the Local Authority Social Services Act 1970, which is repealed (see *Schedule 14*).

247. *Subsections (1) and (3)* respectively give to the Secretary of State (as regards England) and to the Assembly (as regards Wales) the power to make regulations which make provision about the handling and consideration of complaints about local authority social services. They set out what complaints can be considered under the regulations. This includes complaints about the provision of services by a local authority or other person under a partnership arrangement under section 31 of the Health Act 1999 in relation to the functions of an NHS body. The intention is that a person receiving both health and local authority services from a local authority under such an arrangement will be able to complain to that local authority even if the complaint is about health services which it provides.

248. *Subsection (2)* allows for the regulations to make provision for who will consider a complaint in England and *subsection (4)* allows for the regulations to make provision for who will consider a complaint in Wales. It is envisaged that in both England and Wales, the first stage of the procedure will involve a complaint being made to the local authority concerned, where an attempt will be made to resolve the matter informally. If this is not possible, the complaint may be followed up with a formal investigation. If the complaint is still not resolved satisfactorily, the second stage, involving consideration by the CSCI for complaints in England and an independent panel for complaints in Wales, will follow.

249. *Subsection (5)* provides for complaints, or any matter raised by a complaint, to be referred elsewhere: regulations may in particular provide for a complaint, or any matter raised by a complaint, to be referred to a Local Commissioner (under Part 3 of the Local Government Act 1974) who is a member of the Commission for Local Administration in England, or to a Local Commissioner (under Part 3 of the Local Government Act 1974) who is a member of the Commission for Local Administration in Wales. In each case it will be for the Commissioner to consider whether to investigate the complaint or matter. Otherwise the complaint, or matter raised by the complaint, may be referred to any other body so that it can decide whether to take any action.

250. *Subsection (6)* precludes regulations made under this section from making provision for complaints and representations capable of being made under the Children Act complaints procedure under sections 24D and 26 of that Act. The separate Children Act complaints procedure is being maintained, with provision for the further consideration of such complaints being made by *section 116*.

251. Section 24D requires local authorities to establish procedures for dealing with complaints about the services provided by them under the Children Act for young people who have been looked after by them as they move towards independent living; section 26 requires local authorities to establish procedures for complaints about the discharge of their functions under Part 3 of the Children Act which is about local authority support for children and families.

Section 115: Complaints regulations: supplementary

252. *Section 115* sets out supplementary provisions relating to both health and social care complaints regulations.

253. *Subsection (2)* provides for regulations to be made to specify such matters as who may make a complaint and to whom, the complaints which may or may not be made, and the procedure for making, handling and considering a complaint.

254. *Subsection (3)* is concerned with the making of a payment in relation to the consideration of a complaint. It is envisaged that regulations under this provision would provide for any payment to be made to CHAI or CSCI in respect of the costs incurred by it. Regulations could also provide for an amount charged in a particular case to be made subject to review by an independent panel.

255. *Subsection (4)* enables the regulations to make provision requiring persons or bodies handling complaints to make information available to the public about the

procedures to be followed under the regulations.

256. *Subsection (5)* enables the regulations to authorise the production or disclosure of information or documents. Where it would not be possible owing to common law duties of confidentiality to disclose relevant information about a complaint to the body which is to consider it under the regulations, or to the body to which a complaint is to be referred for consideration under other provisions, *subsection (5)* allows for the regulations to make the disclosure lawful. This provision will not override the specific provisions of the Data Protection Act 1998, to the effect that information relating to an individual must not be disclosed without the consent of that individual unless it is necessary to do so for any of the reasons specified in the Act.

257. Regulations made under *subsection (6)* may provide for a situation in which a complaint raises matters which fall to be considered both under regulations made under *section 113* or *114*, and also under another complaints procedure. The regulations may provide that the complaint may be made under the regulations, and that insofar as it concerns matters falling to be considered under the other procedure, it shall be treated as having been raised in a complaint made under the other procedure (e.g. regulations may provide that a complaint may be made to an NHS body about both NHS and local authority services, and that the complaint about local authority services shall be treated as having been made under the regulations made under section 114). In this way, the complainant will be able to make his complaint to only one body, with both sets of procedures being activated. It is also envisaged that the two procedures will thereafter operate as far as possible in parallel so that for the complainant it appears as one system.

Section 116: Further consideration of representations under the Children Act 1989

258. *Section 116* inserts two new sections*, 26ZA* and *26ZB*, into the Children Act 1989 which provide for the further consideration of complaints made under the Children Act complaints procedure that have not been resolved by the local authority concerned. *Section 26ZA* is concerned with complaints about local authorities in England; *section 26ZB* makes similar provisions for complaints about Welsh local authorities.

259. The Children Act complaints procedures is established under section 24D and section 26 of the Children Act. Section 24D requires local authorities to establish procedures for dealing with complaints about the services provided by them under the Children Act for young people who have been looked after by them as they move towards independent living; section 26 requires local authorities to establish procedures for complaints about the discharge of their functions under Part 3 of the Children Act which is about local authority support for children and families.

260. Under the current Children Act complaints procedure, if a complaint has not been resolved after consideration by the local authority and the independent person appointed to assist in the consideration of such complaints, the local authority must on the request of the complainant set up a panel that includes at least one independent person to consider the complaint. The intention is that the regulations made under *section 26ZA*, inserted by *section 114,* will replace the panel stage with a new

procedure for further consideration, initially by the CSCI.

261. *Section 26ZA(3)* concerns payment. The intention is that any payments for the further consideration of complaints would be paid by the local authority to the CSCI. An independent panel may review the amount chargeable and substitute a lesser amount if it thinks fit.

262. By *section 26ZA(4)* the regulations may authorise the disclosure of information relevant to a complaint to a person or body who is considering the complaint or to a Local Commissioner, that is a Local Commissioner under Part 3 of the Local Government Act 1974 who is a member of the Commission for Local Administration in England, when a complaint is referred to him under the regulations. Such a disclosure may be authorised notwithstanding any rule of common law of confidentiality that would otherwise prohibit or restrict it. This provision will not override the specific obligations under the Data Protection Act 1998, namely, that information relating to an individual must not be disclosed without the consent of that individual unless it is necessary to do so for any of the reasons specified in the Act. This is consistent with provisions made in *section 113*.

263. *Section 116(2)* inserts *section 26ZB* into the Children Act 1989. It broadly replicates for Wales the provision of *section 26ZA* except that it makes provision for unresolved complaints to be considered further by an independent panel.

264. *Section 116(3)* amends 26A of the Children Act which is concerned with advocacy services. The section imposes a duty on local authorities to provide assistance, including assistance by way of representation, for children and young persons making complaints under section 24D and section 26 of the Children Act. The new *section 26A(2A)* extends the duty to cover the provision of assistance where complaints are further considered under *sections 26ZA* and *26ZB*.

Section 117: Representations relating to special guardianship support services

265. *Section 117* makes provision for certain complaints about special guardianship support services to be considered under the Children Act complaints procedure. The new *section 26(3C)* of the Children Act 1989 extends the duty placed on local authorities by section 26(3) to establish a complaints procedure to include complaints made to the authority about the discharge by the authority of such functions under section 14F (special guardianship support services) as may be specified in regulations. The section specifies who may make such a complaint under the procedure.

266. Special guardianship orders, made under section 14A of the Children Act 1989, are intended to meet the needs of children who cannot live with their birth parents, for whom adoption is not appropriate, but who could still benefit from a legally secure placement. It is intended that regulations under section 14F of the Act (special guardianship support services) will ensure that local authorities offer a range of support services to be available where appropriate for special guardians and children subject to special guardianship order, their parents and others such as members of the birth family.

267. The intention is that the regulations made under *section 26(3C)* will require the Children Act complaints procedure to apply where a complaint is about a support

service that is provided for the direct benefit of a child subject to a special guardianship order. In all other cases complaints will be made under the social services complaints procedure under *section 114*.

268. This replaces the power to make regulations about handling complaints about special guardianship support services contained in section 14G of the Children Act 1989, which is repealed by this amendment.

Section 118: Complaints about handling of complaints

269. Section 118 amends the Health Service Commissioners Act 1993 to enable the Commissioners to consider complaints from individuals who are dissatisfied with the way in which a complaint has been handled under the regulations made under *section 113.*

Section 119: Complaints: data protection

270. *Section 119* makes the CHAI, the CSCI and other persons charged under the regulations with consideration of complaints, exempt from the subject information provisions of the Data Protection Act 1998 to the extent to which application of those provisions would be likely to prejudice the proper discharge of the function of considering the complaint. The subject information provisions of the Data Protection Act allow for individuals except in certain defined circumstances to seek and obtain information which is held on them by others. Section 31 of the Data Protection Act provides an exemption from these provisions by reference to a number of different categories of regulatory function exercised by public bodies.

CHAPTER 10 – SUPPLEMENTARY AND GENERAL

Joint working

Section 120: Co-operation etc

271. *Section 120* places a duty on both the CHAI and the CSCI to co-operate with one another where it seems to them appropriate to do so for the efficient and effective discharge of their respective functions. This will in particular allow the CHAI and the CSCI to co-ordinate their work programmes.

272. *Subsection (2)* provides for regulations to prescribe circumstances where the CHAI and the CSCI must consult each other in relation to the proposed exercise of their functions. It is envisaged that in many of the instances where it would be desirable for the CSCI and the CHAI to co-operate, that they would do so without needing to be asked by the Secretary of State. However, there will be instances where co-operation will be essential and it is considered necessary to be able to make regulations to specify the circumstances in which co-operation may be necessary. Regulations may require the CHAI and the CSCI to consult each other before carrying out inspections of a particular type of service, for example, a mental health facility providing integrated health and social services provision, in order to reduce the burdens on those subject to inspection, or could require the CHAI and the CSCI to consult each other on the contents of their respective work programmes.

273. *Subsection (3)* gives the CHAI and the CSCI the power to delegate their

functions to one another. *Subsection (4)* allows for the CHAI and the CSCI to enter budget-pooling arrangements, subject to prescribed conditions. It is anticipated that these conditions will relate to matters such as the requirement to keep proper accounts in respect of pooled funds.

Section 121: Reviews and investigations

274. *Subsection (1)* provides for the CHAI and the CSCI to conduct joint reviews and investigations with one another. This will allow for the joint inspection of bodies such as NHS Care Trusts.

275. *Subsection (2)* with *subsection (6)* provides that, without prejudice to any other powers which they may have, (for example by virtue of their general power to do anything which appears to them necessary or expedient in connection with the exercise of their respective functions) the CHAI may conduct a joint review, investigation or study with any other body (for example Audit Commission or the Housing Commission) that is carrying out a review or investigation relating to the functions of an NHS body. *Subsection (3)* makes the same provision for the CSCI where another body is conducting a review, investigation or study of the functions of a local authority. Following a joint review, investigation or study, the CHAI and the CSCI may publish, under *subsections (5)* and *(6)* a report in conjunction with the body they worked with.

Section 122: Joint Annual Reviews

276. *Section 122* allows the Secretary of State to make regulations that would specify that CSCI and CHAI must carry out a joint review and award a star rating of certain health and social care services provided jointly where a local authority and a health service body (such as an NHS trust or Primary Care Trust) have entered into a partnership arrangement under a section 31 of the Health Act 1999.

277. Section 31 allows health and social care bodies, such as local authorities, primary care trusts (PCTs) and NHS trusts to form partnerships to improve the provision of health and social care services. This is used to provide services which involve elements of both health and social care provision. The key powers that section 31 provides are the abilities to pool funds and delegate functions to enable integrated provision and lead commissioning (where partners come to an agreement that one of them will take the lead in commissioning services for their mutual benefit). Many different types of health and social care services are provided under the arrangements and these can vary widely with respect to size and the amount of resource involved. Services commonly provided under a section 31 partnership include services for older people, rehabilitative care, child and adolescent healthcare and mental health services.

278. This section introduces a broad regulation making power that would enable Secretary of State to prescribe certain services for which a review should be carried out should this be deemed appropriate in the future. For example, regulations could specify that all jointly provided mental health services provided under a section 31 partnership should be subject to a joint annual review by the CHAI and the CSCI.

279. Such a joint review would enable a separate performance rating to be given for the jointly provided service, in addition to separate health and social care ratings. This would recognise the jointly provided service as something distinct and would be able to demonstrate whether it had added any value to the service provision.

Section 123: Power to assist

280. *Section 123* provides for the CHAI or the CSCI to assist other UK public authorities with the exercise of their functions. This will allow for the CHAI or the CSCI to provide assistance to each other, or to other bodies, for example, the Office for Standards in Education (OFSTED), the Housing Inspectorate or Her Majesty's Inspector of Prisons. Assistance could include matters such as seconding employees to the other inspectorate, assisting them in devising their inspection criteria or providing one off advice in relation to areas where the other body has expertise.

Arrangements with public authorities

Section 124: Arrangements with Ministers etc: CHAI

281. *Section 124* enables a Minister of the Crown to arrange for the CHAI to carry out any of its functions in relation to health schemes for which the Minister is responsible. For example, arrangements may be made between the CHAI and the Secretary of State for Defence in respect of provision of health care to the Armed Forces. *Subsection (2)* provides for the CHAI to also enter into similar arrangements with a Northern Ireland Minister for the Northern Irish health service.

Section 125: Arrangements with Ministers etc: CSCI

282. This section enables a Minister of the Crown to arrange for the CSCI to advise him with respect to services that are similar to English local authority social services. *Subsection 1(b)* also allows a Minister to request that the CSCI review, or conduct inspections in relation to social care services. For example, arrangements may be made between the CSCI and the Secretary of State for Defence in respect of provision of social care to members of the Armed Forces and their families stationed abroad. *Subsection (2)* provides for the CSCI to provide advice and assistance to a Northern Ireland Minister in respect of the provision of social services in Northern Ireland.

Section 126: Arrangements with the Isle of Man and Channel Islands: CHAI

283. This section enables CHAI to provide advice and assistance to the Government of the Isle of Man and the States of Jersey and the States of Guernsey with respect to the provision of health care. Such advice and assistance would only be given upon the request of the authorities in the Islands. The terms and conditions of any such arrangements could include provision for payments to be made to the CHAI.

Section 127: Arrangements with the Isle of Man and Channel Islands: CSCI

284. This section enables the same arrangements to be made between CSCI and the Isle of Man and Channel Islands as for CHAI in *section 126*.

Reports

Section 128: Reports: CHAI

285. This section places a duty on the CHAI to produce a report on the way it has exercised its functions during the financial year, on the provision of health care by and for NHS bodies in England and Wales and on what it has found in the course of exercising its functions under the CSA 2000.

Section 129: Reports: CSCI

286. This section places a duty on the CSCI to produce a report on the way it has exercised its functions during the financial year, and on what it has found in the course of exercising its functions during the year.

287. *Sections 128(4) and 129(4*) place both the CHAI and the CSCI under a duty to provide other additional reports and information on the exercise of their respective functions as the Secretary of State may request during the year.

Relationship with Government

Section 130: Duty to have regard to government policy: CHAI; and section 131: Duty to have regard to government policy: CSCI

288. These sections place duties upon the CHAI and the CSCI in exercising their respective functions to have regard to such aspects of government policy as the Secretary of State (and the Assembly with respect to certain functions of the CHAI) may direct. It is intended that such a direction would be used to direct the CSCI and CHAI to have regard to broad aspects of government policy - for example, in respect of the CSCI, improving the educational attainment of looked after children.

Section 132: Failure in discharge of functions: CHAI; and section 133: Failure in discharge of functions: CSCI

289. These sections provide that where the Secretary of State considers that the CHAI or the CSCI is significantly failing to discharge any of its functions, or to discharge them properly then he is able to issue a direction to the CHAI or the CSCI with which it must comply.

Inquiries

Section 134: Inquiries: CHAI

290. *Section 134* provides for the Secretary of State or the Assembly to initiate a public or private inquiry into matters concerning the exercise of any of the CHAI's functions. *Subsection (1)* provides that the Secretary of State may initiate an inquiry in respect of the exercise of any matter connected with the exercise of the functions of the CHAI. *Subsection (2)* provides that the Assembly may do likewise in respect of any matter connected with the exercise of the functions of the CHAI in relation to health care by or for Welsh NHS bodies.

291. *Subsection (3)* gives the Secretary of State or the Assembly the power to make the inquiry wholly private, but where no such direction is given, *subsection (4)* enables the person holding the inquiry to make it wholly or partly private. This might be necessary, for example, to protect patient confidentiality.

292. *Subsection (5)* provides for section 250(2) to (5) of the Local Government Act 1972 to apply in relation to an inquiry undertaken in England or Wales. This will enable the person holding the inquiry to issue a summons requiring an individual to give evidence or produce any documents in their custody or under their control at a stated time and place. If that person fails to attend (for reasons other than not having the necessary expenses of their visit paid or tendered), they may be liable to a fine or imprisonment.

293. *Subsections (6)* and *(7)* require that reports of inquiries set up under the powers in this section should be published unless the Secretary of State or Assembly, as appropriate, decides, for good reason, that publication would be inappropriate. Grounds for not publishing might include, for example, publication being prejudicial to any ongoing criminal investigation.

Section 135: Inquiries: CSCI

294. This section makes the same provision for CSCI as *section 134* does for CHAI, with the exception that it does not allow the Assembly to initiate a public inquiry into the exercise of CSCI's functions because CSCI is an England only body.

Information

Section 136: Disclosure of information obtained by CHAI; and section 137: defence

295. *Section 136(2)* makes it a criminal offence for any person, including a member or employee of the CHAI, to knowingly or recklessly disclose confidential information that relates to or identifies an individual.

296. *Subsections (1)* to *(3)* of *section 137* set out a defence to the offence in section 136. It is a defence to prove that any of the circumstances listed in *subsection (2)* applied or that the person charged reasonably believed that they applied. It is also a defence to prove that the disclosure was made for a purpose in *subsection (3).* One of the circumstances in *subsection (2)* is where the disclosure is made in a form in which the individual to which the information relates is not identified. *Subsection (4)* sets out when an individual is to be regarded as identified for the purposes of this defence.

Section 138: Information obtained by CHAI: supplementary

297. Subject to the provisions outlined in this section, the CHAI may use any information it obtains or is provided with during the course of its functions, for the purposes of any of its other functions, for example information obtained in relation to NHS health care provided by an independent hospital could be taken into account when dealing with issues relating to the registration of that hospital under the CSA 2000.

Section 139: Information obtained by CSCI: Supplementary

298. This section provides that the CSCI may use any information it obtains or is provided with during the course of its functions for the purposes of any of its other functions. For example, where the CSCI obtains information as a result of inspecting

a children's home in exercise of its functions under Part II of the CSA 2000, that a child placed there may have suffered harm it may use this information to evaluate the performance of the local authority that placed the child there.

Section 140: Code of Practice CHAI and section 141: Code of Practice CSCI

299. *Sections 140* and *141* place CHAI and CSCI under a statutory duty to prepare and publish a code of practice in relation to how CHAI and CSCI will obtain, use, handle and disclose confidential personal information within their powers under legislation. This will ensure that such information is dealt with in an appropriate manner. In drawing up their codes CHAI and CSCI must consult with such persons as they deem appropriate.

Wales: Supplementary

Section 142: Annual reports of Assembly

300. *Section 142* places a duty on the Assembly to make an annual report or reports, of the way in which it has exercised its social care and health care functions in the Act, and its functions under the CSA 2000 in relation to the registration of independent health services and registered social care services in Wales, and its findings in the course of the exercise of those functions over the year.

Section 143: Use by the Assembly of information

301. *Section 143* allows the Assembly to use information it obtains in exercising functions listed in *subsection (2)*, namely its health and social care review functions under the Act and functions under the CSA 2000 and section 80 of the Children Act 1989 (inspection of children's homes) for the purpose of exercising any other of those functions listed in *subsection (2).*

Section 144: Inquiries: Wales

302. *Section 144* applies where the Assembly holds an inquiry into any matter connected with its social care functions (which are all its functions under the CSA 2000 which equate to those of the CSCI and the CHAI and all its other functions which equate to those of the CSCI). In the same way as is provided by *sections 134* and *135* for inquiries in relation to the CHAI and the CSCI's functions, *subsections (2)* and *(3)* of this section enable the Assembly to direct any inquiry, or part of an inquiry, to be held in private, and where the Assembly does not direct, the person holding the inquiry may decide.

Section 145: Co-operation between Assembly and CHAI

303. *Section 145* places a duty on the CHAI and the Assembly to co-operate in order to ensure that their functions of reviewing and investigating health care under Part 2 of the Act are carried out efficiently and effectively.

General

Section 146: Offences by bodies corporate

304. This section provides that an individual may be held liable where a body corporate is judged to have committed an offence under this Part. *Subsection (2)* makes it clear that an individual may be proceeded against if they are a director, manager or secretary of a body corporate (or acting in such a capacity) found guilty of an offence, where the offence is judged to have occurred with their consent or connivance or be attributable to their neglect.

Section 147: Minor and consequential amendments

305. *Section 147* makes provision for *Schedule 9,* which makes minor and consequential amendments to other legislation. The following amendments are of particular note:

306. *Paragraph 8* of *Schedule 9* amends the Children Act 1989 to make the CSCI responsible for notifying the Secretary of State of instances where it believes an individual has not been added to the Protection of Children Act or Protection of Vulnerable Adult lists, when they should have been. That Act is also amended to ensure that the CSCI is notified by the relevant local authority when a child dies whilst in local authority care.

307. *Paragraph 12* amends the Audit Commission Act 1998 ("he 1998 Act"). *Subparagraph (2)* provides for the Audit Commission to consult the CHAI, the CSCI and the Assembly when drawing up various codes of audit practice prescribing the way in which auditors are to carry out their functions. *Subparagraph (3)* provides that the Audit Commission must obtain the agreement of the CHAI before preparing or making any changes to provisions of a code applicable to the accounts of health service bodies that concern an auditor's consideration of whether arrangements have been made for securing economy, efficiency and effectiveness in the use of resources. *Subparagraph (5)* provides for the Audit Commission to consult the CSCI and the Assembly when it is considering undertaking a study for improving economy, efficiency and effectiveness in services connected with English and Welsh local authority social services respectively.

308. *Subparagraph (6)* provides that the Audit Commission's functions under section 33(1) of the 1998 Act of undertaking studies for improving economy, efficiency and effectiveness in the provision of services, and for improving the financial or other management of bodies do not (apart from functions of conducting studies on financial management) apply in relation to Primary Care Trusts, Strategic Health Authorities, and NHS trusts all or most of whose establishments are situated in England.

309. *Subparagraph (7)* provides for the Audit Commission to consult the CSCI when it is considering undertaking a study on the impact of statutory provisions, or directions or guidance given by a Minister, that are connected with English local authority social services and consult the Assembly where this concerns Welsh local authority social services.

PART 3 - RECOVERY OF NHS CHARGES

NHS Charges

Section 150: Liability to pay NHS charges

310. *Section 150* sets out the circumstances in which NHS costs can be recovered. *Subsections (1)* and *(2)* provide that any person who makes a compensation payment in consequence of an injury, whether physical or psychological, will also be liable to pay NHS charges for treatment received by the injured person at a health service hospital as a result of the injury and/or for the provision of NHS ambulance services provided to the injured person as a result of the injury. The effect of *subsection (2)* is that there will be two separate recovery schemes – one for England and Wales under which money will be payable to the Secretary of State and one for Scotland under which money will be payable to the Scottish Ministers. References in this section of the notes to "the authority" are to be taken as referring to both the Secretary of State and the Scottish Ministers. The regulation making powers in Part 3 are, by virtue of section 167(1), exercisable by the Secretary of State (in relation to England and Wales) and the Scottish Ministers (in relation to Scotland). Before making any regulations the Secretary of State must, by virtue of section 195(3), consult the National Assembly for Wales.

311. *Subsection (3)* defines compensation payment. The definition is a broad one which covers payments made by the person liable, or alleged to be liable, for the injury or by his representative such as an insurance company or the Financial Services Compensation Scheme[11]. The definition catches not only a final payment of damages but also an interim payment or a payment of costs only. The subsection also provides that the term "compensation payment" includes not just payments of money but payment in money's worth which might include, for example, provision of free rehabilitation services. It does not, however, capture *ex gratia* payments where there can be no legal liability to make a payment.

312. *Subsections (3)(b)* and *(11)* specifically extend the scheme to payments made by the Motor Insurers Bureau which operates schemes to make compensation payments where drivers are uninsured or untraceable.

313. *Subsection (3)* also introduces *Schedule 10,* which lists a number of payments which are not to count as compensation payments. These include compensation orders made by the criminal courts (*paragraph 1*), payments under the Fatal Accidents Act 1976 or its Scottish or Northern Irish equivalent (*paragraphs 6 and 7)* and payments made by trusts prescribed in regulations (*paragraph 3*). The intention is that this power would be used to prescribe trusts such as those that are set up to compensate haemophiliacs infected with HIV from blood products. *Paragraph 5* of *Schedule 10* provides that the scheme will not apply where the compensator is the same hospital or ambulance service as the one which would receive NHS charges under the scheme.

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[11] The Financial Services Compensation Scheme is a scheme set up under the Financial Services and Markets Act 2000 to provide compensation when the insurance company can not for example because the business has failed.

This might arise for example if an employee of an NHS trust was injured at work, received treatment at their employing hospital and later made a successful claim for compensation against their employer. *Paragraph 8* provides that additional items can be added to the Schedule by regulations. It is envisaged that this power will be used to prescribe items such as payments under the Criminal Injuries Compensation Scheme or the Vaccine Damage Payments Act 1979. *Subsection (12)* of *section 150* enables items already in the Schedule to be omitted or modified by regulations.

314. *Subsection (4)* applies the scheme to all types of payment including those made voluntarily.

315. *Subsection (5)* clarifies the meaning of the term injury, providing that it does not include disease. However, where the injured person suffers a disease attributable to the original injury for which compensation has been paid, *subsection (6)* clarifies that treatment received or ambulance services provided as a result of that disease will be received or provided as a result of the injury and would therefore fall within the scheme. Thus, treatment received as a result of a free-standing disease, such as asbestosis would be outside the scheme whereas treatment received as a result of a disease linked specifically to the injury suffered - for example, septicaemia resulting from a broken leg – would be within it.

316. *Subsections (7)* to *(9)* exclude from the definition of NHS treatment, private treatment provided at health service hospitals or treatment provided at such hospitals as part of primary medical or dental services (under Part 4 of this Act) or personal or general medical or dental services.

317. *Subsection (13)* makes clear that the scheme will apply only to injuries which take place after these provisions have been brought into force. *Subsection (14)* confirms that for the purposes of the scheme it is irrelevant whether an admission of liability is made when making the compensation payment.

Certificates of NHS charges

Section 151: Applications for certificates of NHS charges, section 152: section 151: supplementary, and section 153: Information contained in certificates

318. *Section 151* deals with applications for certificates. *Subsection (1)* provides that a person (for example, an insurance company) may apply to the Secretary of State or the Scottish Ministers for a certificate before a compensation payment is made to an injured person. Under *subsections (7)* and *(8),* a compensator must apply for a certificate if, at the time of making a compensation payment, he has not already been issued with a certificate or any previously issued certificate has expired. These obligations do not arise if the compensator has applied for a certificate within a period before making payment set out in regulations. It is envisaged that this would be a short period such as 28 days.

319. When the authority receives an application for a certificate, it must, under *subsection (2),* issue such a certificate as soon as is "reasonably practicable". A time limit is not prescribed as the authority will have to gather information from one or more NHS trusts which can take some time.

320. *Subsection (3)* deals with the length of time for which a certificate is to remain in force. This can be until a specified date which might be appropriate for example where there was ongoing treatment; until the occurrence of a specific event – for example any further admission to hospital; or indefinitely which would be appropriate for example where there was a nil certificate of charges, a certificate where the maximum charge recoverable (i.e. the cap set in regulations under *subsection (2)* of *section 153*) had already been reached, or an out patient charge and/or ambulance charge only was recorded.

321. *Section 152* makes provision in cross-border cases. *Subsections (1)* and *(2)* enable applications wrongly made to the Secretary of State or the Scottish Ministers to be referred to the other authority. *Subsections (3)* and *(4)* enable applications sent to one authority which are relevant to both to be referred to the other as well. *Subsections (5)* and *(6)* allow for a single certificate to be issued to cover liability under both the English/Welsh and the Scottish schemes.

322. *Section 153* deals with the information to be included in certificates. *Subsections (1)* and *(2)* provide that the certificate must state the amount or amounts, determined in accordance with regulations, that the compensator must pay in NHS charges.

323. *Subsection (3)* provides that where the damages awarded to an injured person have been reduced to reflect a finding of contributory negligence either made by a court under the Law Reform (Contributory Negligence) Act 1945 or its equivalent outside Great Britain or set out in an agreed judgement or order entered or sealed by a court in England and Wales or Northern Ireland or in a joint minute executed by the parties in Scotland (or equivalent documents elsewhere), the amount due in NHS charges will also be reduced by the same proportion.

324. *Subsection (4)* provides that where it is ascertained that no NHS charges are due because the injured person did not receive NHS treatment at a health service hospital and was not provided with NHS ambulance services as a result of the injury then the authority must issue a nil certificate of charges to show that no payments are due.

325. *Subsection (5)* sets out particular matters which may be covered by regulations. These include a cap on the overall amount payable *(subsection (5)(a));* different amounts for different circumstances – for example out-patient or in-patient treatment and/or ambulance services, and different amounts for different areas *(subsection (5)(b));* provision for cases where a person receives treatment at more than one hospital *(subsection (5)(c)*; and provision for cases where a fresh certificate is issued or a certificate revoked as a result of a review or appeal *(subsection (5)(f)).* Under *subsection (5)(e),* regulations may also provide for apportionment of liability for NHS costs in cases where there is more than one person paying compensation to the same injured person. This may occur for example in a multiple road traffic accident where several compensators are involved. *Subsection (5)(g)* deals with the situation where a person has received treatment or ambulance services in both England/Wales and in Scotland and the compensator therefore has liability for NHS charges under both the English/Welsh and the Scottish schemes. It enables regulations to be made to allow liability under the English scheme to be reduced in

recognition of liability in respect of the same injury arising under the Scottish scheme and vice versa. This is to ensure that a compensator is not penalised just because a person's treatment has taken place in two separate parts of Great Britain.

326. *Subsection (6)* makes clear that the amounts which regulations under *subsection (5)(a)* and *(b)* prescribe to be specified on certificates will be before any reduction for contributory negligence. This means that any reduction resulting from a finding of contributory negligence will be applied to the amounts set in regulations and not, for example, to the full treatment costs which may have exceeded the prescribed maximum recoverable.

327. *Subsections (7)* and *(8)* provide that regulations relating to apportionment or to fresh certificates issued or certificates revoked after a review or appeal can include provisions giving credit for amounts already paid, for the payment of balances and the recovery of excesses. These situations might arise, for example, where a fresh certificate was issued for a higher amount and the original lower amount had already been paid – in such cases it is envisaged that credit would be given for the amount already paid and only the outstanding balance would be due. Conversely, if a person had already paid more than was due it is envisaged that the excess payment would be recouped from the hospital or ambulance trust to which it had been passed and returned to the compensator.

328. *Subsections (9)* and *(10*) relate to cases where a claim by an injured person has been settled by a prescribed mediation process and the damages payable under the settlement are to be reduced to reflect the injured person's contributory negligence. Regulations may provide that in specified circumstances the amount due in NHS charges will be reduced by the same proportion. Regulations may also specify acceptable mediation processes. This might include, for example, prescribing the qualifications of the independent mediator or specifying that the outcome of the mediation should be a full and final settlement of the compensation claim.

329. *Subsection (11)* provides for regulations to specify the information that a compensator can, on receipt of a certificate of charges, request from the authority as to how it has arrived at the amount specified.

330. *Subsection (12)* provides that regulations setting out the amounts due may apply to any certificates issued after the date on which the regulations come into force except where a certificate is issued after settlement of a case and the compensation payment to which it relates was made before the date of coming into force of the regulations. This is to provide for cases where, for example the tariff is revised on say 1 April, a claim has settled on 30 March but the compensator doesn't apply for a certificate until after 1 April when the tariff has changed. This makes it clear that the tariff rate before the revision will apply.

Recovery of NHS charges

Section 154: Payment of NHS charges

331. *Section 154* sets out the time limits for payment of NHS charges. *Subsection (1)* provides that where a certificate is issued before settlement of a claim, payment must be made within 14 days of settlement. *Subsection (2)* provides that, where a

certificate is issued on or after settlement, payment must be made within 14 days of issue of the certificate.

Section 155: Recovery of NHS charges

332. *Section 155* makes provision for the recovery of unpaid NHS charges. If the person paying compensation either has not applied for a certificate under *Section 151* or has not paid the amount due under a certificate, *subsections (1)* and *(2)* provide for the authority to issue a new or duplicate certificate and a demand for immediate payment. *Subsections (3)* to *(5)* enable joint certificates and demands to be issued by the Secretary of State and the Scottish Ministers. *Subsections (6)* to *(8)* set out the procedures to be used to enforce payment. *Subsections (9)* and *(10)* make clear that a document stating the amount due, signed by an authorised person, is the only proof required that an amount is recoverable.

Review and appeal

Section 156: Review of certificates

333. *Section 156* provides for internal review of certificates. *Subsection (1)* requires the authority to review a certificate if, after it has been issued, a finding of contributory negligence is either made by a court under the Law Reform (Contributory Negligence) Act 1945 or its equivalent outside Great Britain or set out in an agreed judgement or order entered or sealed by a court in England and Wales or Northern Ireland or in a joint minute executed by the parties in Scotland (or equivalent documents elsewhere). This reflects the fact that such a finding reduces the liability for NHS charges as provided in s*ection 153*. *Subsection (2)* provides for regulations to be made to deal with cases where a claim becomes a qualifying claim as defined in *section 153(9)*, that is where a claim has been settled by a prescribed mediation process and the damages payable under the settlement are to be reduced to reflect the injured person's contributory negligence. *Subsection (3)* provides for cases where a certificate relating to the same injury has been issued in relation to the same injured person by both the Secretary of State and the Scottish Ministers or where a joint certificate has been issued to reflect liability under both schemes. It provides that, where the amounts due under one of these certificates (or parts of a certificate) have been adjusted following review or appeal, then the other authority must review its certificate (or part of a certificate) if it is satisfied that consequential adjustments are necessary or expedient. In addition to these two cases, *subsection (4)* enables a review of a certificate to be carried out by the authority either on its own initiative or on application by the compensator. *Subsection (4)(a)* provides for regulations to be made relating to the timing of such reviews and the circumstances or cases in which they may take place.

334. *Subsection (5)* provides that, following review, the authority may verify that the existing certificate is correct, make appropriate variations and issue a new certificate or revoke the old certificate. *Subsection (6)* prevents the authority from issuing a fresh certificate for a higher amount than a previous one unless satisfied that the previous certificate was based on incorrect or insufficient information supplied by the person to whom the certificate was issued. *Subsection (7)* enables a single

certificate to be issued following a review to cover liability under both the English/Welsh and Scottish schemes.

Sections 157 to 159: Appeal against a certificate or a waiver decision; Appeal tribunals; and Appeal to Social Security Commissioner

335. *Sections 157* to *159* provide for appeals against certificates of charges and waiver decisions to an independent body.

336. *Subsection (1)* of *section 157* sets out the circumstances in which an appeal against a certificate may be made and *subsection (2)* provides that no appeal may be made until the claim to which the compensation payment relates has finally been disposed of and the amounts set out in the certificate of NHS charges have been paid. *Subsections (4)* and *(5)* enable compensators to apply for the requirement for prior payment in *subsection (2)* to be waived, and allow the Secretary of State or the Scottish Ministers to grant such a waiver only where it appears to him or them that requiring payment would cause exceptional financial hardship. *Subsection (6)* provides compensators with a right of appeal against a waiver decision using the same mechanisms as for an appeal against a certificate. It is envisaged that the waiver would only be granted in truly exceptional cases, such as where the raising of money which might later fall to be refunded might, for example, put an individual's home at risk or bankrupt a single-handed business.

337. *Subsection (7)* provides for regulations to be made as to the timing, manner and procedure for appeals and for enabling an appeal against a certificate to be treated as a review. *Section 167(2)* provides that regulations made by Scottish Ministers under this subsection may only be made with the consent of the Secretary of State.

338. *Section 158* provides that appeals against both certificates and waiver decisions will be heard by appeals tribunals set up under social security legislation ('the Appeals Service'). *Subsection (3)* sets out the powers available to tribunals on an appeal against a certificate and *subsection (4)* requires the authority to act in accordance with any tribunal decision. *Subsection (5)* enables a single certificate to be issued following appeal to cover liability under both the English/Welsh and Scottish schemes. *Subsection (6)* sets out the powers available to tribunals on an appeal against a waiver decision. *Subsection (7)* enables regulations to be made to set out the circumstances in which medical evidence submitted for an appeal does not have to be disclosed. This might be appropriate for example in cases in which it was thought that disclosure of such evidence to the injured person or their representatives might be harmful to the person's health.

339. *Section 159* provides for onward appeal, by either the authority or the compensator, on a point of law only, to a Social Security Commissioner. *Subsection (3)* applies to hearings by the Commissioner under this Section those subsections of section 14 of the Social Security Act 1998 which set out the Commissioner's powers in dealing with cases. The effect is that he may either determine a case himself or refer it back to a tribunal for decision with directions. *Subsections (4)* and *(5)* provide that, where the Commissioner refers a case back for decision, the tribunal will have the same powers as on an appeal under s*ection 158* and that in the case of an appeal against a certificate the authority must, as under that Section, act in accordance with

the tribunal's decision. *Subsection (6)* provides that where a Commissioner determines himself a case relating to an appeal against a certificate, the authority must act in accordance with his decision.

Information

Section 160: Provision of information

340. The system for recovery of NHS charges is reliant upon information being exchanged by the various parties involved in the chain of events from accident to payment of compensation. *Subsections (1)* and *(2)* of this Section provide that a person against whom a claim for compensation is made and other persons set out in *paragraphs (b)* to *(g)* of *subsection (1)* must provide the authority with such information about the case as is required by regulations and that such information must be provided within the timescales and in the manner required by regulations. S*ubsection (3)* makes clear that the information required may include information about NHS treatment or ambulance services provided to an injured person. It is envisaged that the only information which would be needed about the injured person's NHS treatment would be the category of treatment - treatment without admission, for example in accident and emergency or at an out-patient clinic, or treatment given as an in-patient plus the number of days' admission and in some instances the type of treatment provided.

Section 161: Use of information held by the Secretary of State or the Scottish Ministers etc.

341. This section allows information obtained for the purposes of the benefit recovery scheme, as set out in the Social Security (Recovery of Benefits) Act 1997, to be used for the purposes of the scheme relating to recovery of NHS costs and vice versa. This will mean, for example, that in cases involving both NHS and benefit recovery a single set of information can be used for both purposes. *Subsections (1)* to *(3)* enable information held for the purposes of the social security scheme to be supplied to those responsible for the NHS costs recovery scheme. *Subsections (4)* to *(6)* enable information held for the purposes of the NHS costs recovery scheme to be supplied to those responsible for the social security scheme.

Payments to hospitals or ambulance trusts

Section 162: Payment of NHS charges to hospitals or ambulance trusts

342. *Section 162* requires the authority to pay NHS charges which it has recovered (other than, under *subsection (2)*, overpayments which they are required to repay following a review or appeal) to:

- the body responsible for the hospital which provided treatment to the injured person; and/or
- the NHS trust or NHS foundation trust or, in Scotland, Special Health Board, designated by the Secretary of State or Scottish Ministers as the relevant ambulance trust in relation to the hospital to which the injured person was taken for treatment.

343. Where treatment has been received at more than one health service hospital or both treatment and ambulance services have been provided, *subsection (1)(c)* and *(d)* enables the authority to divide the money received between the bodies concerned as it thinks appropriate. *Subsection (3)* enables regulations to be made as to how and when the authority will make payments of the amounts due (*paragraph (a));* and to deal with the situation where the body which provided the treatment or ambulance services no longer exists *(paragraph (b))*. Regulations could for example enable payments to be passed to the new trust taking over from the former NHS trust or ambulance trust. *Subsections (4)* and *(5)* provide that the income received by hospitals should be used to provide goods and services for patients receiving NHS treatment at those hospitals and that received by ambulance trusts to provide NHS ambulance services.

Miscellaneous and general

Section 163: Regulations governing lump sums, periodical payments etc.

344. As explained above in relation to *Section 150,* liability for payment of NHS charges is triggered by any payment of compensation, whether it is a single payment, an interim payment or a second or subsequent payment of compensation. *Subsection (1)* enables regulations to be made as to the application of the scheme to particular types of payments which are made in personal injury cases. These are:

- multiple payments *(subsection (1)(a)).*
- structured settlements *(subsection (1)(b)).* In such cases it is envisaged that regulations might allow for the settlement agreement to count as a single payment of compensation and for no further liability in respect of NHS costs to arise when payments are made in accordance with the agreement;
- interim payments of damages which are ordered to be repaid by a court *(subsection (1)(c)).* In such cases, it is envisaged that regulations might provide for repayment to the compensator of any payment of NHS costs made as a result of the interim payment.

345. Under *subsection (2),* regulations relating to multiple payments may give credit for amounts already paid or provide for the payment of balances or recovery of excesses. For example, regulations might allow the amount of NHS charges due in respect of a later payment to be reduced to take account of earlier payments; or if, as a result of a finding of contributory negligence, the final sum due was less than an earlier payment, they might provide for refund of the overpayment.

346. *Subsection (3)* enables regulations to be made to deal with the particular situation of payments into court and the circumstances in which such payments – which are made to the court rather than to the injured person – are to count as compensation payments. It allows regulations to modify the scheme as it applies in such cases – for example by providing that the period within which a compensator must apply for a certificate under *section 151* runs from the date on which any payment is accepted rather than the date on which it is made or that the date of acceptance of the payment is to count as the settlement date for the purposes of *Section 154*. Under *section 202(3)(b)*, *section 163(3)* does not extend to Scotland.

Section 164: Liability of insurers

347. *Section 164* provides that where an insurance policy covers, to any extent, a compensation payment made by an insured person in consequence of an injury, that policy will also cover any NHS costs for which the insured person is liable in respect of that injury and that this cover cannot be restricted or excluded. *Subsection (4)* enables regulations to be made limiting an insurer's liability in circumstances set out in the regulations. It is envisaged that this might be appropriate, for example, to enable a reduction in the NHS costs payable in cases where an insurer has only covered a proportion of the total compensation due as a result of a cap on the amount payable under the insurance policy.

Section 165: Power to apply Part 3 to treatment at non-health service hospitals

348. *Section 165* enables regulations to be made extending the scheme for recovery of NHS costs to cases in which treatment has been provided at a non-health service hospital under an arrangement with one of the NHS bodies listed in *subsection (3)(b).* This would cover, for example, treatment at private or voluntary hospitals paid for by the NHS. The regulations could also extend the scheme to cases in which an injured person has been provided with ambulance services to take him to such a hospital for treatment. The regulations could cover such issues as the bodies who would receive any payments recovered under the extended scheme. *Subsection (2)* excludes from any such extension treatment which, had it taken place at an NHS hospital, would have been private treatment or treatment under arrangements for primary dental services or general or personal medical or dental services. This mirrors the exclusions from the main scheme set out in *section 150(7).*

Section 166: The Crown

349. This section provides that the scheme for recovery of NHS costs will extend to the Crown (i.e. the Queen and Government Departments) except, as a result of the definition of compensation payment in *section 150(3)(a),* in circumstances where the person concerned can have no legal liability. This applies, for example, to *ex gratia* payments made by or on behalf of the Queen in her personal capacity.

PART 4 – DENTAL AND MEDICAL SERVICES

Primary dental services

Section 170: Provision of primary dental services

350. *Section 170* inserts a new *section 16CA* into the 1977 Act. The new *section 16CA* directly confers on each PCT and LHB a duty to provide or secure the provision of primary dental services in its area to the extent it considers necessary to meet all reasonable requirements *(16CA(1)).* This new duty replaces the duty in section 35 of the 1977 Act (arrangements for general dental services) which requires a PCT to make arrangements with dental practitioners and dental corporations for the provision of dental services where a dental practitioner has agreed to provide dental treatment and appliances to a patient.

351. *Section 16CA(2)* confers a power for PCTs and LHBs to provide dental

services themselves. This will enable a PCT or LHB to employ dentists to provide primary dental services.

352. *Section 16CA(3)* places a duty on PCTs and LHBs to publish information about the services they commission or provide. This will assist patients in identifying providers of NHS dental care in the PCT's or LHB's area and the range of services offered. The duty is in response to the recommendations in *Options for Change* for "improving the patient experience".

353. *Section 16CA(4)* imposes a duty on PCTs and LHBs to co-operate with other PCTs and LHBs in making arrangements for primary dental services. In particular, PCTs will need to co-operate with LHBs where practices straddle the England and Wales border.

354. *Section 16CA(5)* and *(6)* provide regulation making powers to define what should, or should not, be considered as primary dental services. This would allow for services in care homes, for example, to be provided not as primary dental services, but under section 3 of the 1977 Act.

Section 171: Dental public health

355. *Section 171* inserts a new *section 16CB* into the 1977 Act. *Section 16CB* gives power to confer on PCTs, LHBs and the Assembly dental public health functions. Under *section 171(2),* the existing duty on the Secretary of State under section 5(1A) of the 1977 Act to provide dental treatment and dental education in schools is repealed. PCTs and LHBs may involve other agencies in discharging dental public health functions, such as independent contractors or dental practices. For example, a PCT or LHB might wish to involve a dental practice in providing an oral health promotion or smoking cessation programme.

Section 172: General dental services contracts

356. *Section 172* inserts six new *sections 28K* to *28P* into the 1977 Act.

357. New *section 28K(1)* and *(2)* provide for a PCT or LHB to enter into a general dental services contract ("GDS contract"). A general dental services contract is a contract for primary dental services, but it may also include services which are not primary dental services, for example, specialised services such as orthodontics. The general dental service contract replaces the arrangements for the provision of general dental services under sections 35 of the 1977 and the National Health Service (General Dental Services) Regulations 1992 (S.I. 1992/661). *Section 28K(3)* provides for PCTs and LHBs to negotiate the terms of a GDS contract with individual practices seeking to provide dental services under a GDS contract.

358. *Section 28L(1)* provides regulation-making power for the Secretary of State or the Assembly to prescribe the services that must be provided under a GDS contract. *Section 28L(2)* would allow the services to be prescribed by reference to the manner or circumstances in which they are provided. So, for example, the regulations could provide for certain services to be provided on weekdays only between 9am and 6pm.

359. *Section 28M* provides for the PCT or LHB to enter into a GDS contract either

with a dental practitioner, dental corporation[12] or a group of individuals practising in partnership. Where the contract is to be with a partnership at least one member of the partnership must be a dental practitioner. *Section 28M(2)(b)* provides that where any partner is not a dental practitioner, that person must be either a health care professional or individual who is engaged in the provision of services under the NHS Act or the health services of Scotland and Northern Ireland. This will enable persons who are not dentists to be a party to a GDS contract. *Section 28M(1)* provides that regulations may place conditions on the persons who may enter into GDS contracts.

360. *Section 28M(3)* will allow regulations to make provision about the effect on a GDS contract of a change of partnership.

361. New *sections 28K* and *28N* replace the system of remuneration for dentists providing general dental services under section 35 of the 1977 Act.

362. *Section 28N(1)* allows the Secretary of State or the Assembly to give directions regarding payments to be made under the new contract. Where directions are made, the GDS contract must require that payments are made under the contract in accordance with the directions *(subsection (2)).* In this way, payments in respect of any particular matter under the contract can be set on a national basis. Directions may relate to payments to be made by a PCT to a GDS provider or by a GDS provider to a PCT. Where there are no applicable directions, the parties to the GDS contract are free to determine the remuneration to be paid under the contract *(section 28K(3)(b)).*

363. *Section 28N(3)* sets out how the power to make directions may be exercised. It will enable directions to provide for payments to be determined by reference to the meeting of particular standards for example. Directions may also be made in respect of individual practitioners and so would enable, for example, payments to be made in respect of a dental practitioner's maternity.

364. *Section 28N(4)* recreates the requirement in section 43B of the 1977 Act for the Secretary of State or the Assembly to consult representative bodies on remuneration matters. Under the new multi-professional GDS contract this extends consultation rights to other groups whose members can become GDS providers, for example representatives of other groups of dental health care professionals whose remuneration might also be affected.

365. *Section 28N(5)* provides for directions to be made by regulations or by an instrument in writing and provides for directions to be revoked or varied where they are made by an instrument in writing. Where directions are made by regulations the Interpretation Act 1978 makes equivalent provision.

366. *Section 28N(6)* sets out some examples of what payments under this section will include, namely fees, allowances, reimbursements, loans and repayments.

367. *Section 28O(1)* provides for the Secretary of State or the Assembly to make regulations to determine terms which the contract must include or the contract must

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[12] A dental corporation is a limited company permitted to carry on the business of dentistry under s40 of the Dentists Act 1984

make provision about. *Section 28O(2)* gives examples of what the regulations under *section 28O(1)* may cover, such as, the circumstances as to the variation of contracts, details about rights of entry to, and inspection of, practice premises in connection with, for example health and safety legislation, and the dispute resolution procedure. *Section 28O(4)* requires regulations to make provision as to the right of patients to choose from whom they are to receive services.

368. *Section 28P(1)* and *(2)* provide for regulations concerning the resolution of pre-contractual disputes to be made. In particular, the regulations may provide for the Secretary of State or the Assembly or a person appointed by him or it to determine the terms on which any GDS contract may be entered into. Section 4(4) of the National Health Service and Community Care Act 1990 makes similar provision in relation to NHS contracts to be entered into by health service bodies[13].

369. *Section 28P(3)* to *(5)* allows GDS contractors to be treated as health service bodies for contracting purposes. The effect is that the contract is treated as a health service contract under section 4 of the 1990 Act, and any disputes arising under the GDS contract once it has been entered into will be determined by the Secretary of State or his appointee. *Subsection (5)* provides for regulations to make payments relating to NHS contracts enforceable through the courts. No GDS contractor will be forced to have health service body status (and therefore an NHS contract). If a contractor is not a health service body, then the contract is enforceable as an ordinary legal contract before the courts unless the contract itself sets out an alternative route for resolution of disputes.

370. *Section 28P(4)* allows regulations under *subsection (3)* to make provision about the effect of a change in the partnership of a GDS contractor. The purpose would be to ensure that a change in the partnership should not affect the health service status of the contractor.

371. *Section 172(2)* provides for the repeal of sections 35 and 36 of the 1977 Act. As stated above the new GDS contract will replace the existing statutory arrangements for the provision of general dental services.

Section 173: General dental services: transitional

372. *Subsection (1)* requires the Secretary of State or the Assembly to make an Order in respect of dentists who are providing GDS under section 35 of the 1977 Act immediately prior to the coming into force of *section 173*. An Order may require a PCT to enter into a new GDS contract with such a person *(subsection (2)).* Alternatively, it may require a PCT to enter into some other kind of contract for the provision of dental services *(subsection (3)),* which may be appropriate where it has not been possible to enter into a GDS contract before the coming into force of *section 172*. An Order may prescribe the circumstances in which a PCT or LHB must enter into a contract, the terms of the contract, remuneration and the resolution of any disputes.

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[13] Section 4(1) of the 1990 Act defines an "NHS contract" and section 4(2) defines by way of a list "health service body".

Primary Medical Services

Section 174: Provision of Primary Medical Services

373. *Section 174* inserts new *section 16CC* into the 1977 Act. The new *section 16CC* directly confers on each PCT and LHB a duty to provide or secure the provision of primary medical services within its area to the extent that it considers necessary to meet all reasonable requirements (new *section 16CC*(*1*)). This is modelled on the Secretary of State's duty in section 3 of the 1977 Act. This new duty replaces the duty in section 29 of the 1977 Act (arrangements and regulations for general medical services) which requires a PCT to make arrangements with medical practitioners for the provision of general medical services for all persons in the area who wish to take advantage of the arrangements.

374. *Section 16CC(2)* allows a PCT or LHB to provide primary medical services itself. This will enable the PCT/LHB to employ general practitioners. Alternatively, it can make other arrangements as it sees fit, for example, through contractual arrangements with voluntary organisations or a commercial provider.

375. *Section 16CC(3)* places a duty on PCTs and LHBs to publish information about the primary medical services that they commission or provide. This will assist patients in identifying providers of primary medical services in the PCT's or LHB's area and the range of services they offer.

376. *Section 16CC(4)* imposes a duty on PCTs and LHBs to co-operate with other PCTs and LHBs and each other in making arrangements for primary medical services. In particular they will need to co-operate where practices straddle PCT and/or LHB boundaries, including practices that straddle the England/Wales border.

377. *Section 16CC(5)* and *(6)* provide regulation powers to clarify what should, or should not, be considered as primary medical services for which PCTs and LHBs have the duty to secure provision.

Section 175: General Medical Services contracts

378. *Section 175* inserts seven new *sections 28Q to 28W*, into the 1977 Act providing for new general medical services contracts ("GMS contracts") to replace arrangements made under section 29 of the 1977 Act.

379. *Section 28Q(1)* gives a power for PCTs and LHBs to enter into GMS contracts. A GMS contract is a contract for primary medical services, but it may also include services which are not primary medical services, for example, enhanced services that are on the boundaries of primary and secondary care such as certain more specialised services in areas like drug and alcohol misuse, sexual health or depression. The GMS contract replaces the arrangements for the provision of general medical services in sections 29 to 34A of the 1977 Act and the National Health Service (General Medical Services) Regulations 1992 (S.I. 1992/635). *Section 28Q(3)* provides for PCTs and LHBs to negotiate the terms of a GMS contract with individual practices seeking to provide medical services under a GMS contract.

380. *Section 28R* provides a regulation-making power for the Secretary of State or the Assembly to prescribe the services that must be provided under a GMS contract.

381. *Section 28R(2)* would allow the services to be prescribed by reference to the manner or circumstances in which they are provided. So, for example, the regulations could provide for certain services provided outside certain times (say, before 8 am and after 6:30 pm on weekdays) not to count as prescribed services that must be provided under a GMS contract.

382. *Section 28S* provides for the PCT or LHB to enter into a GMS contract either with a medical practitioner, a group of individuals practising in partnership or a company. Where the contract is with members of a partnership at least one member of the partnership must be a medical practitioner. *Section 28S* provides that regulations may place conditions on persons who may enter into GMS contracts. *Section 28S(1)* and *(3)* provides that limited companies can hold a GMS contract subject to at least one share being legally and beneficially owned by a medical practitioner and secondly, that any shares not so owned by medical practitioners must be legally and beneficially owned by an individual who could otherwise enter into a GMS contract, for example a health care professional.

383. *Section 28S(2)(b)* provides that where any partner is not a medical practitioner that person must either be a health care professional as defined in *section 28M* who is engaged in the provision of NHS services, an NHS employee as defined in *section 28D*, a person employed by a provider of primary medical or primary dental services under *section 28C* (or Scottish and Northern Irish equivalents) or an individual who is (or within a prescribed period, was) providing services under a general medical services contract, a general dental services contract, under a PMS arrangement or under a PDS arrangement (or Scottish and Northern Irish equivalents). This will enable persons who are not medical practitioners to be a party to a GMS contract.

384. *Section 28S(4)* allows for the Secretary of State or the Assembly to make regulations to make provision about the effect on a GMS contract of a change in the membership of the partnership. For example, such provision may allow a partnership to continue where over time partners come and go due to routine events such as a career change or retirement.

385. *Sections 28Q(3) and 28T* replaces the system of remuneration for medical practitioners providing general medical services under section 29 of the 1977 Act.

386. *Section 28T(1)* will allow the Secretary of State or the Assembly to give directions regarding payments to be made under the new contract. Where directions are made, the GMS contract must require that payments are made under the contract in accordance with the directions (*subsection (2)*). In this way, payments in respect of any particular matter under the contract can be set on a national basis. Directions may relate to payments to be made by a PCT to a GMS provider or by a GMS provider to a PCT.

387. *Section 28T(3)* sets out how the power to make directions may be exercised. It will enable directions to provide for payments to be determined by reference, for example, to the meeting of standards. Directions may also be made in respect of individual practitioners and so would enable, for example, payments to be made that relate to the seniority of a medical practitioner.

388. *Section 28T(4)* recreates the requirement in section 43B of the 1977 Act for the Secretary of State or the Assembly to consult representative bodies on remuneration matters. Given that other health care professionals will be able to become GMS providers, *section 28T(4)(a)* does not confine the duty to consult only to bodies representative of medical practitioners.

389. *Section 28T* provides for directions to be made by regulation or by instruments in writing and provides for them to be revoked or varied where directions are made by an instrument in writing. Where directions are made by regulations the Interpretation Act 1978 makes equivalent provision.

390. *Section 28T(6)* sets out some examples of what payments under this section include, namely fees, allowances, reimbursements, loans and repayments.

391. *Section 28U* provides that a GMS contract must require the contractor to comply with any directions given by the Secretary of State or the Assembly as to the drugs, medicines or other substances which may or may not be prescribed for patients being treated under the terms of the contract. This allows the new contractual provisions to replicate the controls on prescribing set out in *paragraph 44* of *Schedule 2* and *Schedules 10* and *11* to, the National Health Service (General Medical Services) Regulations 1992. Directions under this section will normally be made by regulations but may be made by instrument in writing following a request by a holder of a marketing authorisation.

392. *Section 28V* provides for the Secretary of State or the Assembly to make regulations to determine terms, which the contract must include, or what the contract must make provision about. *Section 28V(2)* gives examples of what the regulations *may* cover, such as the persons who perform services, the circumstances in which, and the manner in which, the contract may be terminated and the dispute resolution procedure.

393. *Section 28V(3)* provides that the regulations must make provisions setting out the circumstances under which a contractor may or must accept a person as a patient for whom services are to be provided under the contract, the circumstances in which they can decline to accept such a person and how the contractor can terminate their responsibility for a patient.

394. *Section 28V(4)* and *(5)* provide for the regulations to set out the circumstances under which a PCT or LHB may impose a variation to a GMS contract and the circumstances under which any duty under the contract may be suspended or terminated. This will, for example, allow GMS contractors to seek to opt out of providing certain services, such as minor surgery, child health surveillance and contraceptive services in accordance with a prescribed procedure.

395. *Section 28W(1)* provides for regulations concerning the resolution of pre-contract disputes. In particular, the regulations may provide for the Secretary of State or the Assembly or a person appointed by him or it to determine the terms on which any GMS contract may be entered into. Section 4(4) of the National Health Service and Community Care Act 1990 makes similar provision in relation to NHS contracts

entered into by health service bodies.

396. *Section 28W(3)* allows contractors to elect to be treated as a health service body for contracting purposes. The effect is that any contract is treated as a health service contract under section 4 of the 1990 Act, and any dispute arising under the GMS contract once it has been entered into will be determined by the Secretary of State or the Assembly or his or their appointee. *Section 28W(5)* provides for regulations to make payments relating to NHS contracts enforceable through the courts. No GMS contractor will be forced to have health service body status (and therefore an NHS contract). If a contractor does not have the status of a health service body, then the contract is enforceable as an ordinary legal contract before the courts unless the contract itself sets out an alternative route for the resolution of disputes.

397. *Section 28W(4)* allows regulations under *section 28W(3)* to make provision about the effect of a change in the partnership of a GMS contractor. The purpose would be, for example, to ensure that a routine change in the partnership should not affect the health service body status of the contractor.

398. *Section 175(2)* repeals the GMS provisions contained in sections 29 to 34A of the 1977 Act.

Section 176: General medical services: transitional

399. *Subsection (1)* requires the Secretary of State or the Assembly to make an Order in respect of medical practitioners who are providing GMS under section 29 of the 1977 Act immediately prior to the coming into force of *section 175*. An Order may require a PCT to enter into a new GMS contract with such a person. An Order under *section 176(3)* may also require a PCT to enter into a different sort of contract for the provision of medical services. A contract under *subsection (3)* may be appropriate where it has not been possible to enter into a GMS contract before the coming into force of *section 175* to ensure continuity of service. An Order may prescribe the circumstances in which a PCT or LHB must enter into a contract, the terms of the contract, remuneration and the resolution of any disputes.

Primary dental and medical services: supplementary

Section 177: Arrangements under section 28C of the NHS Act 1977

400. *Section 177* amends the existing provisions in section 28D of the 1977 Act which set out who can enter into primary medical services or primary dental services arrangements. *Section 177(2)* substitutes section 28D(1)(b) and (c) with new *section 28D(1) (b)* to *(bc)*. These paragraphs include a number of changes to the categories of persons who may enter into PMS or PDS arrangements. For example, a dentist will be able to enter into a PMS contract and a medical practitioner will be able to enter into a PDS contract. In such cases, the services under these contracts will have to be performed by appropriately qualified individuals.

401. New regulation making powers set out in *section 28D(1)* provide that the Secretary of State or the Assembly may set conditions that prospective providers of PMS or PDS must meet before they can enter into PMS or PDS arrangements. They are intended to ensure that the conditions that are to be prescribed in respect of GMS

contractors under *section 28S* and GDS contractors under *section 28M* may be applied, where appropriate, to providers of PMS and PDS under section 28C arrangements.

402. *Subsection (5)* provides a new definition of NHS employee, that will apply equally to PMS and PDS, to replace that in section 28D(2) of the 1977 Act.

403. *Subsection (7)* inserts new *subsection (3)(ca)* into section 28E of the 1977 Act. This provides that the Secretary of State or the Assembly may set out conditions that apply to persons performing primary dental or primary medical services under section 28C of the 1977 Act. For example, conditions may set out the qualifications and experience required of healthcare professionals performing PMS or PDS.

404. *Subsection (8)* inserts new *subsections (3A)* and *(3B)* into section 28E of the 1977 Act which allows for regulations under section 28E(1) to require payments under PMS or PDS arrangements to be made in accordance with any directions given by the Secretary of State or the Assembly. The amendment allows the Secretary of State or the Assembly to require certain payments to be provided for within the contractual terms, for example to ensure that maternity payments made to dentists under a PDS agreement are the same as those under a GDS contract or that seniority payments are made to PMS general practitioners in the same way as to a GMS practitioner.

405. *Subsection (9)* introduces new *section 28E(3C)* which allows the Secretary of State or the Assembly to make regulations as to the circumstances under which a PCT or LHB must enter into a GMS or GDS contract with an existing provider of PMS or PDS when asked to do so. This replaces the regulation making powers in section 28E (3)(g) and (7) of the 1977 Act that permit a PMS medical practitioner to have a preferential right of return to the PCT or LHB medical list. The preferential right of return provides an assurance to a GMS GP who moves to become a PMS medical practitioner that should they, in the future, wish to revert to providing services under GMS they will, in most cases, be able to do so as of right.

406. *Subsection (10)* provides for regulations concerning the resolution of pre-contract disputes. In particular, the regulations may provide for the Secretary of State or the Assembly or a person appointed by him or it to determine the terms on which any PMS contract or PDS contract may be entered into.

407. *Subsection (11)* inserts into section 28E new *subsections (3E)* and *(3F)*. *Subsection (3E)* requires for regulations to make provisions that set out the circumstances under which a person providing PMS may or must accept a person as a patient for whom services are to be provided under a PMS arrangement, the circumstances in which he can decline to accept such a person and how he can terminate his responsibility for a patient.

408. New *section 28E (3F)* requires for regulations to provide for the right of a patient of a PMS or PDS provider to exercise choice as to the person from whom they will receive services.

409. *Subsection (12)* repeals sections 28F and 28G of the 1977 Act. These sections relate to the choice of medical practitioner and choice of dental practitioner; matters

now covered in the new GMS/GDS contracts and PMS/PDS arrangements. Section 28H is also repealed. Section 28H requires the Secretary of State to ensure that every person providing or performing PMS has the opportunity to participate in arrangements for vaccinations and immunisations. In future, PMS arrangements might not be for the full range of primary medical services, for example a PCT might choose to enter into a PMS contract where an existing GMS practice has decided not to deliver certain services, such as vaccinations and immunisations or contraceptive services, as being the most appropriate way of ensuring that patients still have access to those services. Consequent to the repeal of section 28H, immunisation services will be a matter for both GMS contracts and PMS arrangements.

Section 178: Abolition of pilot schemes

410. *Section 178* repeals the power in Part 1 of the National Health Service (Primary Care) Act 1997 concerning pilot schemes for the provision of personal medical and personal dental services in England and Wales.

411. PMS and PDS will however continue under the arrangements (frequently referred to as PMS and PDS permanence) set out in sections 28C, 28D, 28E and 28EE of the NHS Act 1977 (which are amended by *section 177*).

Section 179: Persons performing primary medical and dental services

412. *Section 179(1)* inserts new *section 28X* in the 1977 Act to allow regulations to provide that healthcare professionals (including medical and dental practitioners) may not perform primary or medical or dental services unless they are on an appropriate PCT/LHB list.

413. In relation to medical practitioners, for example, the new single medical list will replace the medical list (section 29A of the 1977 Act), the medical supplementary list (section 43D of the 1977 Act) and services lists in PMS (sections 8ZA of the Primary Care Act and 28DA of the 1977 Act). Under the new arrangements a medical practitioner performing primary medical services need only be included in one appropriate PCT list – normally that of the PCT with whom he holds a contract.

414. In relation to dental practitioners, the new single dental list will replace the dental list (section 36 of the 1977 Act), supplementary list (section 43D of the 1977 Act) and services lists in PDS (sections 8ZA of the Primary Care Act, and 28DA of the 1977 Act). Under the new arrangements a dentist who is performing primary dental services need only be on one PCT list – normally that of the PCT with whom he holds a contract.

415. *Section 28X(4)* provides for the regulations to make provision about eligibility for inclusion in a list, grounds for refusal for inclusion in a list and the procedure to be followed. It allows provision to be made corresponding to sections 49F to 49N of the 1977 Act, thereby providing for suspension and removal from the PCT/LHB's list and appeals to the Family Health Service Appeals Authority. Further, *section 28X(4)(e)* allows for the regulations to make provision about requirements that a person who is included in a list must comply with if their name is to remain in the list. *Section 28X(4)(g)* allows for regulations to make provision about the circumstances in which

a person included in a list may not withdraw from it. *Section 28X(7)* makes clear that information about applications, refusals, suspensions or removals may be shared with the NHS authorities which need the information.

416. Section 49M(7) of the 1977 Act enables regulations to be made about payments to practitioners who have been removed from lists by primary care organisations, whose appeals to the appeals body (the Family Health Services Appeals Authority) have been unsuccessful, but have been successful on further appeal to the Courts. *Section 179(2)* provides that the regulations may also include provision for the amount of any payment or the method of calculating the amount to be determined by the Secretary of State or someone appointed by the Secretary of State.

Section 180: Assistance and support

417. *Section 180* inserts a new *section 28Y* in the 1977 Act. This new section gives PCTs and LHBs a power to assist and support providers and prospective providers of primary dental services and primary medical services who do so through GDS, PDS, GMS or PMS arrangements. Support and assistance includes financial support.

418. For dentistry, this will enable PCTs or LHBs, for example, to increase primary dental services capacity by giving financial assistance to establish or extend dental practice premises. In respect of medical services, the PCT/LHB might employ a practice manager who would then work, for example, for two small practices who might not otherwise be able to avail themselves of such services. Equally the PCT/LHB might employ a general practitioner to support a practice temporarily to avoid the practice opting out of certain service provision. A PCT/LHB will be able to charge for the support given.

Dental services: miscellaneous

Section 181: Abolition of Dental Practice Board

419. *Section 181* provides for the abolition of the Dental Practice Board. A Special Health Authority is to be established under section 11 of the 1977 Act by the Secretary of State and the Assembly. The new Special Health Authority will be a cross border Special Health Authority undertaking functions in relation to both England and Wales. The assets, liabilities and staff (subject to consultation) of the DPB will be transferred under section 11 powers to the new Special Health Authority.

Section 182: Special Health Authorities

420. *Subsection (1)* amends section 16B of the 1977 Act in relation to the exercise of functions by PCTs. An Order may provide for the transfer to a Special Health Authority of the rights and liabilities of a PCT under a GDS contract where the Special Health Authority is to exercise functions on its behalf, and for transfer back should that function cease. *Subsection (2)* makes similar provisions in relation to LHBs in Wales.

421. For example, a GDS contract may provide for payments to dentists under such a contract to be made by the new Special Health Authority rather than PCTs. This section would allow an Order to provide for the Special Health Authority to take on

the PCT's contractual responsibility for the payments it makes under the contract.

Section 183: Charges for dental services

422. *Section* 183 inserts a new *section 79* and a new *Schedule 12ZA* to the 1977 Act replacing sections 78A, 79 and 79A which linked the calculation of dental charges to the remuneration of a dental practitioner. *Section 183(3)* provides that the first regulations made under new *section 79* shall be subject to approval by resolution of each House of Parliament.

423. New *section 79(1)* provides for regulations to prescribe the way in which patient charges can be made and recovered for dental services. New *section 79(2)* provides that regulations made under new *section 79(1),* may for example, set a maximum charge and exempt certain treatments from a charge. New *section 79(5)* ensures that charges apply to all primary dental services whether provided under a GDS contract, PDS or by the PCT/LHB, and to dental appliances under other Part 1 services. New *section 79(3)* enables regulations made under new *section 79(1)* to provide for the amount that PCTs, LHBs or Special Health Authorities recompense dental clinics or practices and that this amount may be reduced by the amount that has been collected in patient charges by that clinic or practice.

424. *Schedule 12ZA* maintains the same exemptions from dental charges as under the provisions previously set out in old section 79 and Schedule 12 of the 1977 Act**.** *Paragraphs 1, 2, 4* and *6* of new *Schedule 12ZA* set out the circumstances in which dental charges will not apply. *Paragraph 2* makes it clear that, normally, charges will not apply to the replacement or repair of appliances. *Paragraph 3* provides that charges will, however, apply to the repair or replacement either of prescribed appliances, or of appliances which need to be repaired or replaced because of something that person supplied with the appliance has done (or where that person is under 16, something that their parent or guardian has done). Dental appliances will be free of charge when provided by a hospital for its in-patients (*paragraph 4*). However, if dental appliances are provided for a hospital in-patient under GDS or PDS contracts or by a PCT as part of Primary Care Trust Dental Services, then the normal charges will apply *(paragraph 5).*

425. *Paragraph 7* of new *Schedule 12ZA* enables regulations to prescribe the evidence that must be provided when a patient claims an exemption from charge. For example, a patient may be required to provide a birth certificate or FP92 Maternity Exemption Certificate issued through the Prescription Pricing Authority in England.

426. *Section 183(4)* provides for charges to apply to dentures and dental appliances provided in accordance with PDS pilot schemes following the coming into force of new *section 79* of the 1977 Act, but before the abolition of PDS piloting under *section 178* above.

General

Section 184: Minor and consequential amendments

427. This section introduces *Schedule 11,* which provides for minor and consequential amendments. *Paragraph 23* inserts *sections 45A* and *45B* into the 1977

Act. These sections cover the recognition of Local Medical Committees ("LMCs") and Local Dental Committees ("LDCs"). *Sections 45A(7)* to *(9)* and *45B(7)* to *(9)* allow the Secretary of State to make regulations that require PCTs/LHBs or Strategic Health Authorities to consult LMCs and LDCs and to prescribe other functions of these Committees. *Sections 45A* and *45B* separate out the roles of these committees from the provisions in sections 44 and 45 of the 1977 Act and the new regulation making powers simply replace those in section 45(1) in respect of LMCs and LDCs.

PART 5 - MISCELLANEOUS

Welfare Food Scheme

Section 185: Replacement of the Welfare Food Schemes

428. The Welfare Food Scheme was established in 1940 to protect the health of mothers and children at a time of food shortages and price rises. The scheme currently provides tokens for milk (in both liquid and dried form) and vitamins to expectant mothers and children up to the age of 5. It also provides non means-tested milk to children up to age 5 in nurseries and day care and to a very few disabled children.

429. The consultation document, '*Healthy Start: proposals for reform of the Welfare Food Scheme'*[14], outlined the government's intention to set up a new scheme or schemes in 2004 with the aims of ensuring that children in low income families have access to a healthy diet and giving increased support for breastfeeding. '*Healthy Start, The Results of the Consultation Exercise'*[1] summarised responses to that consultation.

430. *Section 185* replaces section 13 of the Social Security Act 1988 ("the 1988 Act"), which provided powers for a scheme or a number of schemes to be set up to distribute welfare food. The new *section 13* provides powers for regulations to establish a new scheme or schemes, to help certain pregnant women, mothers and children to have access to and incorporate in their diets, food of a prescribed description.

431. It is intended that the nutritional basis of the existing scheme will be extended under the first new scheme to include a broader range of foods in addition to milk and infant formula. It is likely that the only additional foods in the first instance will be fruit and vegetables, and that their role in the scheme will be evaluated before the range of foods is modified further. The aim is to use a voucher bearing a fixed value to enable beneficiaries to access these foods. It is also intended that the new scheme should be integrated with, and consistent with, the NHS and health policies so that beneficiaries can receive appropriate advice on nutrition to complement the prescribed food benefit.

432. *Subsection (1)* supplies powers for regulations to establish one or more schemes to provide benefits for specified categories of pregnant women, mothers and

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[14] For copies of these documents contact postal address: PO Box 777, London SE1 6XH. Website address: www.doh.gov.uk/healthystart

children to have access to food of a prescribed description. The first set of regulations will be subject to the affirmative resolution procedure. Thereafter, regulations will be subject to negative procedure. It is intended that the new scheme, like the existing scheme, will continue to be targeted primarily at low income families in receipt of specified benefits such as Income Support, Income Based Jobseekers Allowance and Tax Credits, and that the nursery element of the scheme will remain non means-tested.

433. *Subsection (2)* obliges the Secretary of State to consult the Assembly and Scottish Ministers on the establishment or variation of a scheme. The scheme in Northern Ireland will be governed by separate legislation (See *section 186*).

434. *Subsection (3)* makes it clear that a scheme may impose requirements that must be met before pregnant women, mothers and children can become entitled to benefits under the scheme or remain entitled to continuing benefits.

435. The current section 13 of the 1988 Act enables regulations to provide for the distribution or disposal of welfare food. *Subsection (4)(a)* of the new *section 13* specifies on the face of the Act the categories of providers who may supply food under the scheme. This could include food suppliers, providers of day care, and health service bodies. It is intended that retailers will supply the majority of foods in exchange for a voucher as they do presently with the current milk token and that nursery or day care institutions will provide the non-means-tested element of the scheme. Other suppliers, such as food co-operatives or voluntary and community organisations will also be encouraged to participate. As set out in the consultation document, 'Healthy Start', the government intends to shift the supply of dried milk (infant formula) to retail outlets and to end distribution via NHS clinics in order to remove a potential barrier to the promotion of breastfeeding. It is not intended that a provider be required to provide the full range of foods available under the scheme in order to participate. This means, for example, that milk deliverers could participate and provide only milk, greengrocers or farmers' markets could participate and provide only fruit and vegetables, and pharmacies could participate and provide only infant formula.

436. *Subsection (4)(b)* makes it clear that a scheme may provide for beneficiaries to gain access to the prescribed food benefit by means of a voucher or other arrangement. The existing scheme is based primarily upon the use of tokens that are exchangeable for specified quantities of liquid or formula milk. As it is the intention to provide a wider range of foods under a new scheme or schemes, different mechanisms for enabling access to the foods may be required. These may include, for example, a system based on vouchers of a fixed value which will enable parents or beneficiaries to obtain food of a prescribed description from a wide variety of retailers.

437. *Paragraphs (d)* and *(e)* of *subsection (4)* provide powers for the recompense of registered providers and the payment of beneficiaries, for example, those who fail to receive the benefit for whatever reason. These provisions, amongst other things, replace respectively subsections (4)(c) and (3)(b) of the current section 13.

438. *Paragraphs (f)* and *(g)* of *subsection (4)* make it clear that a scheme may provide for the Secretary of State to arrange for the operation of all or part of a

scheme, to be delegated to health service or other bodies described in the scheme. The Department of Health, for example, may wish to contract-out elements of the scheme which relate to the distribution of vouchers to beneficiaries and reimbursement of suppliers.

439. *Subsections (4)(h)* and *(5)* largely replace and update subsections (4)(d) and (5) of the current section 13 and make it clear that a scheme may provide for prescribed persons to be required to supply information to assist in the administration of the scheme. For instance, suppliers may be required to provide information to verify that vouchers have been properly exchanged in accordance with the provisions of the scheme. *Subsection (5)(a)* provides for a requirement that information be provided in legible form. Such a provision could, for example, ensure that computerised records are made available in printed form.

440. *Subsection (6)* provides a new power for the Assembly to prescribe the range of foods to be available under a scheme in relation to the operation of the scheme in Wales. Although the existing scheme is primarily based upon social security benefits, and is therefore reserved, it is recognised that the potential range of foods links closely to the devolved health policies of the Assembly. This power has therefore been transferred to the Assembly, with agreement that the scheme will be uniform across Great Britain at the outset.

441. Powers to prescribe the range of foods will be transferred to Scottish Ministers by means of an order under section 63 of the Scotland Act 1998.

442. *Subsection (7)* provides power for the Secretary of State to give directions to bodies, such as a health body or contracted service provider, in relation to the operation of the scheme. *Subsection (8)* provides a power for the Assembly to direct bodies administering the scheme in relation to matters relating to the operation of the scheme (or that part of the scheme) in Wales. The subsection also requires the Assembly to gain the prior agreement of the Secretary of State to ensure that any proposed changes will not adversely affect the operation of the scheme throughout Great Britain, beyond the boundaries of devolved responsibilities. This qualified power will also be transferred to Scottish Ministers by section 63 Order. Section 63 of the Scotland Act 1998 (c.46) enables Her Majesty, by Order in Council, to provide for the transfer to the Scottish Ministers of functions of a Minister of the Crown which are exercisable in or as regards Scotland. The Order will be subject to the affirmative procedure in both the Westminster Parliament and the Scottish Parliament.

443. *Subsection (9)* replaces and updates the current power in section 13(4)(e) of the 1988 Act relating to the prosecution of some offences.

444. *Subsection (11)* contains, among other definitions, a definition of "enactment" which takes account of changes made by the Scotland Act 1988 to the Interpretation Act 1978. It also contains a definition of "women" that includes persons under the age of 18.

445. The amendment in *subsection (2)* of the Section to section 15A of the 1988 Act ensures that the Assembly's procedures regarding subordinate legislation are reflected in the primary legislation.

Section 186: Replacement of the Welfare Food Schemes: Northern Ireland

446. *Section 186* will enable Northern Ireland to replicate the provisions in *Section 185* of the Act by way of Order in Council subject to negative resolution procedure. This will ensure that women and children in Northern Ireland have the same access to the reformed welfare food scheme as women and children in England, Scotland and Wales. Currently women and children in Northern Ireland, under the separate Northern Ireland Welfare Food Scheme, have access to the same benefits as those in the rest of the UK. This has been the position since the Scheme's inception in 1940 and we would wish to maintain this position.

447. During suspension of the Northern Ireland Assembly, Northern Ireland legislation may be made by Order in Council under the Northern Ireland Act 2000. Such Orders are normally subject to the affirmative resolution procedure. However, if there is a requirement for immediate parity in legislative provisions between Northern Ireland and Great Britain, the Northern Ireland Act 2000 provides for Orders to be made subject to the negative resolution procedure. This is permitted only if the provisions of the Order will correspond in their purpose to the relevant provisions of the GB Act.

Appointments and employment

Section 187: Appointments to certain health and social care bodies

448. *Section 187* makes provision in respect of appointments to certain health and social care bodies. The Secretary of State currently has the power, under section 16D of the 1977 Act, to direct a Special Health Authority to undertake any of his functions relating to the health service that he specifies in directions. Pursuant to this power, the Secretary of State currently directs the National Health Service Appointments Commission ("the NHSAC"), a Special Health Authority established under section 11 of the 1977 Act, to exercise his powers of appointment in relation to many bodies that have functions within the health service.

449. The power to direct the NHSAC to undertake a function of the Secretary of State of making appointments is currently limited to bodies whose functions fall within the meaning of the 'health service' in the 1977 Act. Because of this limitation, specific provision was made in the 2002 Act for the Secretary of State to direct a Special Health Authority to exercise his function of appointing members to certain bodies, including, for example, the Council for the Regulation of Health Care Professionals.

450. *Subsections (1), (2)* and *(3)* enable the Secretary of State to direct a Special Health Authority to exercise the function of appointing persons to any body (whether or not established in legislation) that has functions relating to health, social care, or the regulation of professions associated with health or social care. The Government's intention is for this role to be delegated to the NHSAC.

451. *Subsections (4)* and *(5)* make provision for the extent of the relevant provisions of the 1977 Act where the Secretary of State delegates an appointments function to the Special Health Authority in respect of appointments to a body that has

functions in the United Kingdom.

452. *Subsection (6)* provides for what is meant by 'appointments function', and *subsection (7)* provides that if a body has other functions falling outside those specified in *subsection (1),* this does not prevent the Secretary of State from delegating the appointments function to the Special Health Authority.

453. *Subsection (8)* introduces *Schedule 12* which amends the Pharmacy Act 1954, the Medical Act 1983, the Dentists Act 1984, the Opticians Act 1989, the Osteopaths Act 1993, the Chiropractors Act 1994, the Nursing and Midwifery Order 2001 and the Health Professions Order 2001. The effect of these amendments is to allow the Privy Council to direct a Special Health Authority to undertake its function of appointing members to the regulatory bodies established by those enactments, together with any function that the Privy Council has in removing members. The Privy Council may, in particular cases, decide instead to delegate only certain parts of these functions, retaining the rest itself. The Privy Council may only so direct a Special Health Authority if the Secretary of State has exercised his power of direction under the section.

454. In respect of the Medical Act 1983 and the Dentists Act 1984, further provision is made for the appointments functions currently made by Her Majesty, on the advice of Her Privy Council, to be conferred on the Privy Council: this is consistent with provision made in the Pharmacy Act 1954, the Opticians Act 1989, the Osteopaths Act 1993, the Chiropractors Act 1994, the Nursing and Midwifery Order 2001 and the Health Professions Order 2001.

455. *Subsection (10)* provides that "nothing in this section applies in relation to CHAI or CSCI". The reason for this is that *schedules 6 and 7* provide that chair and non-executive appointments to CHAI and CSCI should in future automatically fall to a Special Health Authority to make rather than Ministers. For all other appointments it will be a matter for Ministers to determine whether or not they should be delegated. The Government's intention is that the Special Health Authority involved will be the NHS Appointments Commission.

Section 188: Appointments to certain health and social care bodies: joint functions

456. Where there is a requirement for a Minister of the Crown to make appointments to certain health and social care bodies jointly or concurrently with another person, for example with the Northern Ireland Ministers or the Assembly, *subsections (1)* and *(2)* together provide that the Secretary of State may in these circumstances direct a Special Health Authority to undertake the appointments function, but only if he first consults the other person. *Subsection (3)* provides that if a direction is given in respect of an appointments function that has to be exercised jointly or concurrently, that function is exercisable by the Special Health Authority acting alone.

457. *Subsection (4)* provides that *subsections (2)* and *(3)* do not apply to any appointments to be made jointly or concurrently with the Scottish Ministers: the Secretary of State may, in these circumstances, only give a direction to the Special

Health Authority in relation to any function he has. *Subsection (5)* provides that "appointments function" has the same meaning as in *section 187.*

Section 189: Validity of clearance for employment in certain NHS posts

458. Section 7 of the Protection of Children Act 1999 requires that before a person can be appointed to a child-care position, a check must be made against the Protection of Children Act List. The list is maintained by the Secretary of State and checks against it are made through the Criminal Records Bureau, which will make a charge for such a check. These checks will include a check against the POCA list wherever appropriate.

459. The Act provides for an easement to this rule in cases where the person was supplied by an employment agency or business. In such cases, it is sufficient for the employer to satisfy himself that the List has been checked within the last 12 months by the employment agency or business. This provision was included to avoid the need for checks against the List for the same person to be repeated at very frequent intervals. Normally, once a check has been made on appointment to a child-care position, there is no requirement for it to be repeated while the person remains in that child-care position.

460. The majority of persons supplied for temporary work by agencies supplying staff in the health care sector are also employed permanently in the NHS - often in the same Trust where they do the agency work. Increasingly, temporary workers will be supplied by NHS Professionals, the NHS's own "in-house" agency, which is set to become the main provider of temporary staff of all kinds in the NHS. In circumstances where a person is supplied by an agency (which may include NHS Professionals) and has substantive employment with the NHS and has previously been checked against the List, it is felt that an annual check, while being a costly overhead on the operations of NHS Professionals and other agencies, will add nothing to the safety of children.

461. Thus *subsection (1)* of *section 189* inserts new *subsections (3A), (3B)* and *(3C)* into section 7 of the Protection of Children Act 1999 which have the effect of disapplying the requirement to check against the Protection of Children Act List where a person is offered employment in a child care position and certain conditions are met. These conditions are that at the time the offer of employment is made, the person concerned is already employed by an NHS body (as defined) and that NHS body (or another NHS body or an employment agency or business) has ascertained that he is not on the List. In addition, he must not have been placed on the list subsequently and, if he accepts the offer of employment, he must not be placed on the List for the duration of the employment to which the offer relates.

462. Part VII of the CSA 2000 provides for the Secretary of State to maintain a List of persons who are considered unsuitable to work with vulnerable adults (the POVA List). Once the POVA List is introduced, before a person can be appointed to a position caring for vulnerable adults, a check will need to be made against the POVA List. Checks against this POVA List will again be carried out through the mechanism of the CRB. The POVA List will (when it is introduced) work in a very similar way to the Protection of Children Act List referred to above. For this reason, the

amendments made by *subsection (2)* to section 89 of the CSA 2000 mirror those made to the Protection of Children Act 1999.

463. *Subsection (3)* is a transitory provision and is needed because the amendments made to the Protection of Children Act 1999 by paragraph 121 of schedule 21 to the Education Act 2002 are not yet in force.

464. *Subsection (4)* is intended to put beyond doubt the ability to use the provisions of the Regulatory Reform Act 2001 in order to make an Order under section 1 of that Act which would further amend the provisions relating to checks against the POCA and POVA Lists in both the Protection of Children Act 1999 and the Care Standards Act 2000. Without such an amendment it might be argued that it is not possible to make such an Order until a period of 2 years had elapsed from the passing of this Act.

Public Health Laboratory Service

Section 190: Abolition of the Public Health Laboratory Service Board

465. This section abolishes the Public Health Laboratory Service Board ('PHLS'). The intention to do so was announced in Health Protection Agency ('HPA') Newsletter Number 10 on 15 November 2002[15].

466. The PHLS was established in 1946 and its statutory powers are broadly defined by the 1977 Act (as amended by the Public Health Laboratory Service Act 1979). Section 5(2)(c) of that Act, as amended, provides for "a microbiological service.… for the control of the spread of infectious diseases and carry[ing] on such other activities as in his [the Secretary of State's] opinion can conveniently be carried on in conjunction with that service".

467. The PHLS's corporate purpose, as described in its Business Plan for 2001-2, was to protect the population from infection by maintaining a national capability of the highest quality for the detection, diagnosis, surveillance, prevention and control of infectious and communicable diseases in England and Wales. From 1 April 2003, all but one of the functions of the PHLS transferred to the Health Protection Agency ("HPA") - a new Special Health Authority - or to other parts of the National Health Service. The only function remaining with the PHLS is provision of microbiological culture media for use in microbiology laboratories. It is not intended that this function should remain with the PHLS in the longer term. An independent appraisal of the options for the future of this service is being carried out, after which appropriate recommendations will be made to the Secretary of State. It is intended that the repeal of the PHLS provisions will be brought into force after the Secretary of State has transferred the remaining function.

PART 6 – FINAL PROVISIONS

Section 195: Orders and regulations

468. This section provides that all regulation and order making powers in the Act will be subject to the negative resolution procedure, unless provided for differently

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[15] A copy of the HPA letter is available in the Library.

under *subsection (5).* In England, this means that such regulations and orders will be laid before Parliament and may only be 'made' (i.e: be signed by the Minister and be commenced on the day stated on the document) if after forty days either House of Parliament does not decide to annul them. For Wales, it is different as all regulations and orders are debated by the National Assembly for Wales as a matter of course.

469. *Subsection (5)* lists those regulation-making powers which will be subject to more Parliamentary scrutiny than the negative resolution procedure provides for. The first set of regulations under *section 150(12)* (regulations to amend *Schedule 10* – exempted payments) and every set of regulations under *section 153(2)* (regulations about the amounts to be specified in certificates) will be subject to the affirmative resolution procedure. *Subsection (5)* also provides that all orders and regulations made under *sections 200* and *201* that amend or repeal any part of the text of an Act must also be subject to the affirmative procedure. For England, this means that these orders and regulations will have to be approved by Parliament before they can be made. For Wales, the Assembly's Standing Orders set down the procedures to be followed and all such instruments must be approved by the Assembly in Plenary or Cabinet. All such instruments are debated before they are made. In the case of regulations made for Scotland under *section 150(12)* and *153(2),* the Scottish Parliament will have to approve them.

COMMENCEMENT

Section 199: Commencement

470. *Section 199* provides that all of the Act provisions may come into force on such days as the appropriate authority in each case may appoint by order, except for those order or regulation making powers which will come into force on Royal Assent and the provisions in s*ections 167, 186* and *192* explained below. *Subsection (2)* gives the meaning of 'appropriate authority' in relation to the provisions of each Part of the Act.

471. *Section 167* will come into force on Royal Assent as it simply provides by whom the powers to make regulations under Part 3 may be exercised and provides that regulations under *section 157(7)* (appeals against a certificate or a waiver decision) may only be made by the Secretary of State with the consent of the Scottish Ministers.

472. *Section 186* provides that an Order in Council to replicate the Welfare Food Scheme provisions in *section 185* for Northern Ireland be made subject to the negative resolution procedure. To enable the corresponding Northern Ireland legislation to be made as soon as possible after the Act receives Royal Assent, *section 199* provides that *section 186* comes into force on Royal Assent.

473. *Section 192* comes into force on Royal Assent as it merely corrects an error in the Government of Wales Act 1998.

ANNEX A: OUTLINE OF THE EXISTING LAW RELATING TO THE NHS

474. This is a statement of the law relating to the NHS before the enactment of the Health and Social Care (Community Health and Standards) Act 2003.

475. The following paragraphs provide a brief description of the current legislative framework for the NHS. The legislative framework for the NHS in England and Wales is mostly set out in the National Health Service Act 1977 ("the 1977 Act"). This has been amended quite substantially by various enactments, notably by the National Health Service and Community Care Act 1990 ("the 1990 Act"), the Health Authorities Act 1995 ("the 1995 Act"), the National Health Service (Primary Care) Act 1997 ("the Primary Care Act"), the Health Act 1999 ("the Health Act"), the Health and Social Care Act 2001 and the National Health Service Reform and Health Care Professions Act 2002 ("the NHS Reform Act").

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

477. The other main part of the NHS structure is what might be described as "the NHS in the High Street" or "family health services". This is dealt with under Part 2 of the 1977 Act. The professionals in question are general practitioners ("GPs") (i.e. family doctors), general dental practitioners ("GDPs"), ophthalmic opticians and ophthalmic medical practitioners, and chemists.

478. The 1990 Act, the Primary Care Act, the Health Act, the Health and Social Care Act 2001 and the NHS Reform Act introduced a number of changes to these systems of health care. Broadly speaking, the changes introduced by these Acts were as follows -

- The 1990 Act introduced what is known as the internal market; by creating a divide between the planning and purchase of Part I services, on the one hand, and the provision of those services, on the other;
- the Primary Care Act in effect enabled medical and dental services to be delivered, not under Part 2, but under a more flexible system within Part I of the Act, known as 'PMS' and 'PDS';
- the Health Act made a number of changes, but in particular provided for the abolition of GP fund-holding (introduced by the 1990 Act), the establishment of PCTs and new arrangements to improve the quality of NHS services and co-operation between NHS bodies and local authorities;

- the Health and Social Care Act 2001 also made a number of different changes, but in particular provided for changes to the funding of NHS bodies, local authority scrutiny of NHS provision, changes to the system for filling vacancies for GPs, additional lists for Part II practitioners, the abolition of the NHS tribunal, the provision of "local pharmaceutical services" (similar to the Primary Care Act arrangements for PMS/PDS), and the establishment of "Care Trusts".
- Part 1 of the NHS Reform Act provided for HAs to be renamed, in England only, as Strategic Health Authorities; for the Secretary of State to be required to establish PCTs for the whole of England and to be able to delegate his functions directly to them; and for many of the service provision functions currently directly conferred on Health Authorities (including those relating to family health services under Part 2 of the 1977 Act) to be conferred on PCTs. In relation to Wales, the Act provides for the establishment and funding of Local Health Boards ("LHBs") and places a duty on each LHB and local authority in Wales to formulate and implement a health and well-being strategy for the area.

Part 1 System: hospital and community health services

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

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

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

482. Section 2 confers wide ranging powers for the Secretary of State to provide such services as are appropriate to discharge any duty imposed on him by the Act (including his general duty under section 1), and to do any other thing whatsoever which is calculated to facilitate, or is conducive or incidental to, the discharge of such a duty.

483. Sections 8 to 18 of the 1977 Act provide for the administration of the NHS. These sections have been substantially amended since 1977, most recently by the NHS Reform Act. As amended, they provide for the setting up of Strategic Health Authorities (section 8), Special Health Authorities (section 11) and PCTs (section

16A). HAs (Health Authorities)/Strategic Health Authorities, Special Health Authorities and PCTs are independent statutory bodies, although their membership is determined in accordance with regulations (and in the case of Special Health Authorities, the establishment order) and some of the appointments to their membership are made by the Secretary of State. HAs/Strategic Health Authorities and PCTs are established for territorial purposes. Each HA/Strategic Health Authority is established for such area of England and Wales as set out in the establishment order made under section 8; the entire area of England and Wales is covered by Strategic Health Authorities and PCTs in England and HAs in Wales. There are no PCTs in Wales. The NHS Reform Act provides for the establishment of LHBs in Wales. Special Health Authorities are established for specific functional purposes - they are established for the purpose of performing any functions of the Secretary of State which he may direct them to perform under section 16C.

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

485. Strategic Health Authorities may, in accordance with regulations and any relevant directions, delegate their functions (whether Part I or Part 2) to each other, or to committees or others: see section 16 of the 1977 Act. Similar provision is made for PCTs: see section 16B of the 1977 Act. Regulations have been made under both provisions.

486. Strategic Health Authorities, HAs and Special Health Authorities are currently funded under the provisions of section 97 of the 1977 Act Section 97(1) concerns the remuneration of persons providing Part 2 services and is not cash-limited (in other words the Secretary of State must pay whatever it has cost the HA, and he cannot impose a ceiling on the expenditure). Under section 97 an authority is paid money not exceeding the amount allotted to them by the Secretary of State. This amount is allotted towards meeting their "main expenditure" which includes all expenditure attributable to the performance of their Part I functions, and all their administrative costs. The money paid in respect of Part I services is therefore ultimately cash-limited. To enforce the cash-limits set by the Secretary of State, HAs have various financial duties imposed upon them by section 97A of the 1977 Act.

487. PCTs are funded under section 97C of the 1977 Act and LHBs under section 97F, inserted by the NHS Reform Act. There is a similar distinction between cash-limited and non-cash-limited funding. Section 97C was amended by section 3(3) of the Health and Social Care Act 2001 so that in addition to HA allotments, the Secretary of State may make supplementary payments direct to PCTs. PCTs are subject to a set of financial duties similar to those for HAs (see section 97D, as inserted by section 3 of the Health Act and amended by section 3 of the Health and Social Care Act 2001)

Part 2 System: family health services

488. The broad structure of the Part 2 system is similar for doctors, dentists,

persons providing ophthalmic services and persons providing pharmaceutical services.

General Medical Services

489. Under section 29 of the 1977 Act, it is the duty of each PCT (or HA in Wales) in accordance with regulations to arrange as respects their area with medical practitioners to provide "personal medical services" for all persons in the area who wish to take advantage of the arrangements. These services are described as "general medical services" ("GMS"). A principal feature of this system is that (apart from certain exceptional cases) it is not the PCT or HA which itself provides the GMS; instead, it enters into separate statutory arrangements with independent practitioners (often known as "GP principals") for the provision of those services. GPs are therefore not employees of the PCT or HA; they are independent professionals who undertake to provide GMS in accordance with the body of regulations governing that activity. Those Regulations are currently the National Health Service (General Medical Services) Regulations 1992 (S.I. 1992/635) as amended ("the GMS Regulations"). They incorporate (at Schedule 2) the Terms of Service of GP principals.

490. The remainder of section 29, as amended, sets out certain things which must or may appear in the Regulations. Section 29 is prospectively amended by section 23 Health and Social Care Act 2001. Section 29A prevents a PCT or HA making arrangements with a doctor unless he is on a medical list, and sets out certain restrictions on who is eligible to be on such a list. Section 29B gives a regulation-making power for the filling of vacancies for doctors which was also extended by section 20 of the Health and Social Care Act 2001. Sections 31 and 32 provide for regulations requiring that each GP must be "suitably experienced" as prescribed. Section 33 provides the Secretary of State with power to control GP numbers if necessary.

491. A new power for Regulations to enable PCTs or HAs to conditionally include doctors in the medical list is in section 43ZA, inserted into the 1977 Act by section 21 of the Health and Social Care Act 2001. Similar provision is made for all the professions. Section 43D inserted by section 24 of the Health and Social Care Act 2001 gives power in regulations for PCTs or HAs to keep lists of persons who assist in the provision of General Medical Services (in contrast to GP principals, who are included in the medical list) (see the National Health Service (Supplementary List) Regulations 2001 (SI 2001/3740) as amended). Similar provision is made for the other professions.

492. Section 28F inserted by the Primary Care Act gives power to make Regulations conferring a right to choose one's medical practitioner (see the Choice of Medical Practitioner Regulations 1998, SI 1998/3179 as amended).

493. GPs are required by the Terms of Service to provide patients with personal medical services in effect at all times, but some provision is made in respect of out of hours services (see paragraphs 12 and 18A of Schedule 2 to the General Medical Services Regulations). Section 18 of the Health and Social Care Act 2001 allows for further formalisation of out of hours arrangements.

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

Dentists

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

Common provisions

496. Sections 43A and 43B of the 1977 Act, as substituted by section 10 of the Health Act, provide a structure for the remuneration of persons providing Part 2 services. Section 10 of the Health Act has, however, not been brought into force. Neither have the original sections 43A and 43B inserted by the Health and Social Security Act 1984 (c.48) been commenced. In effect the original sections inserted by the 1984 Act must be complied with because of section 7 of that Act, which provides that a determination of remuneration made before the coming into force of those provisions is deemed to be validly made if regulations authorising it could have been made had that provision been in force at that time. It is therefore not open to the Secretary of State or anyone else to make a determination which is inconsistent with the provisions of sections 43A and 43B as inserted by the 1984 Act. What in fact happens is that the Secretary of State makes and publishes a determination for each of the professions, which takes the form of the separate document referred to in each of the sets of Regulations governing the four professions. These determinations therefore have the force of law, although they are not subject to any further degree of formality or Parliamentary procedure. In the case of General Medical Services, the determination is contained in a document known as the Red Book.

497. Each profession has in each HA area a local representative committee (called the Local Medical Committee, the Local Dental Committee, and so on). These represent local practitioners and are provided for under sections 44 and 45 of the 1977 Act as amended.

498. There are detailed provisions for the removal or suspension of practitioners from the list in which their names are included (see sections 49F to 49R in the 1977

Act). There is provision for review of decisions and for appeal to a new statutory body, the Family Health Services Appeal Authority ('the FHSAA'). The FHSAA is set up by section 49S of the 1977 Act, inserted by section 27 of the Health and Social Care Act 2001. It is constituted in accordance with new Schedule 9A. This new body may turn a local removal from a particular HA list into a national disqualification that prevents any HA from including them in their list.

Administration of Part 2 services

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

500. Whilst the duty to make arrangements for Part 2 services is conferred directly upon PCTs or HAs, rather than upon the Secretary of State, the exercise of those functions by PCTs and HAs may be the subject of directions issued by the Secretary of State under section 17 or the NAW under section 16BC of the 1977 Act.

Funding

501. The funding of Part 2 services by PCTs is currently effected through section 97C of the 1977 Act.

NHS trusts

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

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

504. This system resulted in the creation of what was known as the "internal

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

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

506. Paragraph 5A of Schedule 3 to the 1990 Act, as inserted by section 3 of the Health and Social Care Act 2001, now provides that the Secretary of State may make supplementary payments direct to NHS trusts. Most NHS trust income, however, continues to consist of payments by HAs/PCTs for the provision of services.

NHS contracts

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

The Primary Care Act

508. The Primary Care Act introduced a new method of delivery of family health services. Personal medical services ("PMS") and personal dental services ("PDS") may be provided under agreements known (in the initial stage at least) as "pilot schemes" (sections 1-3 of the Primary Care Act). These agreements are made between the Strategic Health Authority or PCT and one or more of the persons or bodies listed in section 3(2). Before a pilot scheme may be made, the proposals for the scheme must be submitted to, and approved by, the Secretary of State (sections 4 and 5).

509. Although the provider of personal medical services may be an NHS trust or other qualifying body, the services themselves must be *performed* by a "suitably experienced" medical practitioner. Section 26 of the Health and Social Care Act 2001 amends the Primary Care Act by inserting a new section 8ZA, that provides powers to require the HA to keep a list of all the performers of PMS. The regulations have yet to be made.

510. The system of pilot schemes is intended ultimately to be replaced by a permanent regime, which is in substance the same as the pilot scheme regime but instead of being provided for in free standing provisions of the Primary Care Act is provided for by way of amendments to the 1977 Act. See sections 21 and 22 of the Primary Care Act which insert, in relation to England and Wales, sections 28C, 28D and 28E, which are not yet in force. All these provisions are prospectively further amended by the section 4 of and Schedule 3 to the NHS Reform Bill which devolve

PMS and PDS functions from the Secretary of State and HAs to PCTs wherever practicable. Where the PCT is providing PMS or PDS rather than commissioning it, it is not considered compatible with maintaining a distinction between commissioner and provider to devolve certain functions to the PCT. In these cases, functions currently undertaken by the HA under the 1997 Act will remain at Strategic Health Authority level.

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

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

513. The PCT funds the services provided under a pilot scheme from its cash-limited allocation under section 97C. This means that in effect the remuneration of practitioners providing PMS or PDS under the Primary Care Act is cash-limited, in contrast to the remuneration of Part II practitioners.

The Health Act

514. Part I of the Health Act made further changes to both the Part I system and the Part 2 system.

PCTs

515. In England, PCTs are a tier of administrative body below Strategic Health Authorities. PCTs are established by the Secretary of State by orders under section 16A of the 1977 Act (as inserted by section 2(1) of the Health Act). Their functions are currently conferred, in the main, by directions given by the Secretary of State under section 17 of the 1977 Act.

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

Quality

517. Section 18 of the Health Act imposes a "duty of quality" on HAs, PCTs and NHS trusts. Sections 19 to 24 provide for the establishment and operation of the Commission for Health Improvement, which is responsible for monitoring the quality of care for which NHS bodies have responsibility. The Commission is able to conduct a variety of reviews and investigations: see section 20(1). Both of these provisions are amended by the NHS Reform Act.

The Health and Social Care Act 2001

518. The Health and Social Care Act 2001 made further changes. The following paragraphs summarise those changes, although the relevant provisions may already have been referred to in the general description above of the NHS system.

Health service funding

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

Terms of employment of health service employees

520. Section 6 of the Health and Social Care Act 2001 amends the 1977 and 1990 Acts so as to extend the Secretary of State's powers to direct as to the terms and conditions of staff of PCTs and NHS trusts.

Part 2 services and PMS/PDS

521. Sections 14 and 15 of the Health and Social Care Act 2001 made new provision for GP vacancies. Section 16 provides that HAs (now PCTs) will remove or suspend practitioners from Part II lists (section 25), subject to appeal to the Family Health Services Appeal Authority (FHSAA) (section 27). Sections 17 to 24 make provision for out of hours GP services, changes to the Part II list arrangements and for supplementary lists for persons assisting the provision of Part II services. Section 26 enables the Secretary of State to make regulations for PCTs to hold lists of persons who may perform PMS/PDS. Many of these provisions are not free-standing but proceed by way of amending or inserting new sections in the 1977 Act. For example, section 25 inserts new sections 49F to 49R and section 27 inserts section 49S and Schedule 9A.

Pharmaceutical services

522. Sections 28 to 41 of the Act provide for the provision of "local pharmaceutical services" under arrangements similar to those for PMS and PDS under the Primary Care Act 1997. Sections 42 to 44 makes a number of changes to the existing system

for the provision of pharmaceutical services under Part II of the 1977 Act.

Care Trusts

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

The NHS and Local Authorities

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

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

526. The Health Act makes further provision for co-operation between the NHS and local authorities. Most importantly, section 31 makes provision for NHS bodies and local authorities to enter arrangements under which an NHS body exercises LA functions or vice-versa. Provision is also made for arrangements to operate a "pooled fund" from which payments may be made towards expenditure on either NHS or local authority functions. In addition to section 31, section 28 provides for HAs, with the assistance of PCTs, NHS trusts and local authorities, to prepare plans setting out a strategy for improving both the health of the local population and the provision of health care to that population. Section 30 of the Health Act inserts a new section 28BB into the 1977 Act, which makes provision for local authorities to make payments towards expenditure incurred by NHS bodies: this provision mirrors section 28A of the 1977 Act.

527. The Health and Social Care Act 2001 makes further changes in relation to "partnership arrangements". Sections 45, 47 and 48 makes provision for NHS trusts and PCTs to be designated as "Care Trusts" where those trusts exercise local authority functions under arrangements under section 31 of the Health Act. Section 46

provides that the Secretary of State may, in certain circumstances, direct NHS bodies and local authorities to enter into such arrangements.

ANNEX B: CURRENT LAW RELATING TO SOCIAL CARE

The following paragraphs provide a brief description of the framework of social services law.

Community care services

528. Section 47 of the National Health Services and Community Care Act 1990 requires local authorities to assess the needs of any person who appears to them to be in need of community care services and decide in the light of that assessment whether any community care services should be provided to that person.

529. Community care services are defined in section 46(3) of the 1990 Act.

Children's services

530. The Children Act 1989 makes provision for local authority support to children and families including services for children in need, the provision of accommodation, and advice and assistance; provision relating to the protection of children, care and supervision orders; for the regulation and inspection of day care and child minding, and provision in relation children's homes and private fostering. The Adoption and Children Act 2002 makes provision in relation to the adoption of children, including provision about the role and duties of local authorities in relation to adoptions.

Care Standards

531. The Care Standards Act 2000 (as amended by this Act) makes provision relating to the registration and regulation of children's homes, independent hospitals and clinics, private and local authority care homes, residential family centres, independent medical agencies, domiciliary care agencies, fostering, nursing and voluntary adoption agencies.

532. Proprietors and managers of the establishments and agencies listed above are required to register with the appropriate registration authority, and to comply with regulatory requirements. The relevant registration authority has power to inspect, and may cancel registration or prosecute for non-compliance with specified regulations.

Direction making powers

533. Section 84 of the Children Act 1989 provides that, where the Secretary of Sate is satisfied that any local authority has failed, without reasonable excuse, to comply with duties imposed upon them under the Act, he may make an order declaring them to be in default with respect to that duty. The order must contain the Secretary of State's reasons for making it, and may contain directions for the purpose of ensuring that the duty is complied with.

534. Section 7A of the Local Authority Social Services Act 1970 provides that every local authority shall exercise social services functions in accordance with directions made by the Secretary of State. Section 7C makes provision for Secretary

of State to hold an inquiry. Section 7D empowers the Secretary of State to make specific directions where a local authority has failed to comply with duties which are social services functions.

Complaints

535. The current provisions relating to complaints against social services are set out in section 7B of the Local Authority Social Services Act 1970 and sections 24D and 26 of the Children Act 1989, and in the Complaints Procedure Directions 1990 and the Representations Procedure (Children) Regulations 1991. This Act repeals section 7B of the Local Authority Social Services Act 1970 and enables the Secretary of State to make regulations about the handling and consideration of complaints about social services provided to adults. Complaints will continue to be considered by the local authority whose actions are complained about, but the regulations may provide for a complaint to be further considered by the CSCI, an independent panel, or another person or body. The Act also provides that the Secretary of State may make regulations enabling complaints made under the Children Act procedure to be considered by the CSCI or an independent panel, and extends the duty to consider complaints under section 26 of the Children Act 1989 to complaints relating to special guardianship support services.

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

Provision	**Effect**
Part 2	
Section 47	Provides powers for the Assembly to prepare and publish its own statements of standards relating to health care provided by or for Welsh NHS bodies.
Section 54(4)	Provides that the CHAI must report to the Assembly where there are significant failings in health care provided by or for a Welsh NHS body or the running of such body or a person or body providing care for the Welsh NHS body.
Section 54(3)	Provides that the Assembly may request that the CHAI provide it with advice and information on health care provided for or by a Welsh NHS body.
Section 57	In carrying out reviews and investigations generally, the Assembly is required under *section 70* to be concerned with the efficiency of the provision of health care.

Section 58(3))	Provides that the Assembly must give agreement for any regulations made by the Secretary under Section 58(1) (prescribing additional functions for the CHAI) which functions relate specifically to the provision of health care by or for Welsh NHS bodies.
Section 59	The Assembly may, after consulting CHAI, require CHAI by regulations to publish statements of criteria to be used by CHAI relating to certain functions.
Section 62	Empowers the Assembly, by Regulations to specify functions in respect of which CHAI may charge a Welsh NHS body fees and to provide for the manner in which CHAI publish fees.
Section 70	Confers on the Assembly, and persons authorised by the Assembly, the function of conducting reviews of, and investigations into, the provision of health care by and for Welsh NHS bodies.
Section 71	Provides that if the Assembly, in carrying out reviews and investigations, discovers significant failings in the provision of health care on the part of English NHS bodies or cross-border NHS bodies, or the running of such bodies (or persons providing care for such bodies), it shall report its findings to the Secretary of State and further may make recommendations. Further where the Assembly discovers significant failings relating to NHS foundation trusts, it shall report them to the Independent Regulator and may make recommendations.
Section 72	Provides the Assembly with the power to inspect premises in furtherance of its review and inspection functions under Section 70.
Section 73	Provides the Assembly with supplementary powers to its right of entry: inspection, copying and removal of documents and records and other items and the right to interview person in private. Introduces an offence of obstructing the Assembly from exercising its powers of entry and inspection.
Section 74	Confers a regulation making power on the Assembly to require persons to produce specified information, documents and records.
Section 75	Confers a regulation making power on the Assembly to require persons to explain documents or matters relating to the exercise of the Assembly's functions.
Section 92	Gives the Assembly the general function of encouraging improvements in the provision of Welsh Local Authority social services.

Section 93	Enables the Assembly to review studies and research made by others on Welsh Local Authority social services and make and publish a report.
Section 94	Confers on the Assembly the function of conducting reviews of, and investigations into, the discharge of social services functions by local authorities in Wales. Subsection (6) provides for the Assembly, by regulations, to require a local authority in Wales to pay a fee to the Assembly in respect of the exercise of those functions.
Section 95	Enables the Assembly to undertake or promote comparative studies (for improving economy, efficiency and effectiveness in the provision of social services and for improving the management of social services).
Section 96	Enables the Assembly to make regulations to confer additional functions on itself but only where those functions correspond with functions conferred on the CSCI by the Act or by the Secretary of State.
Section 97	Sets out the matters with which the Assembly shall be concerned in the exercise of its functions.
Section 98	Confers on the Assembly, and persons authorised by the Assembly, the power to enter and inspect premises.
Section 99	Enables persons authorised by the Assembly to inspect and take copies of documents or records.
Section 100	Gives the Assembly the power to require information, documents or records from certain persons in relation to social services functions. Introduces an offence of obstructing the Assembly from exercising its powers of entry and inspection.
Section 101	Confers on the Assembly the power to make regulations to require persons to explain documents, or matters relating to the exercise of the Assembly's functions.
Section 109	Confers a duty on the Assembly to have particular regard to the need to safeguard and promote the rights and welfare of children in the exercise of its functions.
Section 113(2)	Provides that the Assembly may make regulations on the complaints procedure in relation to complaints made about Welsh NHS bodies' healthcare functions.
Section 114(3)	Provides that the Assembly may make regulations on the complaints procedure in relation to complaints made about Welsh local authorities' social services functions.

Section 142	Provides that the Assembly must make an annual report on the way it has exercised its health care and social services functions.
Section 143	Enables the Assembly to use any information it obtains in exercising its health and social care reviewing functions and other functions for the purposes of all of those functions.
Section 144	Enables the Assembly to hold an inquiry into any matter connected with its health care or social care functions.
Section 145	Provides that the Assembly and the CHAI must co-operate to ensure the efficient and effective discharge of any relevant functions.
Schedule 6, paragraph 9(2) and *(4)*	Enables the Assembly to make payments and/or loans to the CHAI on such terms and conditions as it may determine.
Schedule 9, paragraph 10(2)	Enables the Assembly to undertake duties alongside the Audit Commission.
Part 4	
Section 166	Gives the Assembly certain regulation making powers in respect of primary dental services.
Section 167	Inserts a new section 16CB into the 1977 Act which provides for the Assembly to prescribe functions for itself in relation to dental public health.
Section 168	Makes provision for the new general dental services contract and confers regulation and direction making powers on the Assembly in relation to GDS.
Section 169	Enables the Assembly to make an order to make transitional provision in respect of certain persons providing dental services.
Section 170	Gives the Assembly certain regulation making powers in respect of primary medical services.
Section 171	Makes provision for the new general medical services contract and confers regulation and direction making powers on the Assembly in relation to GMS.
Section 172	Enables the Assembly to make an order to make transitional provision in respect of certain persons providing medical services.
Section 173	Gives the Assembly certain regulation making powers in respect of arrangements under section 28C of the 1977 Act.

Section 174	Provides for the abolition of pilot schemes in England and Wales under the National Health Service (Primary Care) Act.
Section 175	Provides for regulations to specify who may perform any primary dental or medical service.
Section 178	Enables the Assembly to make provision for the rights and liabilities of a LHB under a general dental services contract to transfer to a Special Health Authority.
Section 179	Inserts new *section 79* in the 1977 Act and confers various regulation making powers on the Assembly in relation to dental charging.
Part 5	
Section 185(2)	Provides that the Secretary of State must consult the Assembly before establishing or varying a Welfare Food Scheme.
Section 185(7)	Confers powers on the Assembly to prescribe the descriptions of food in relation to the operation of the scheme in Wales.
Section 185(9)	Enables the Assembly, with the agreement of the Secretary of State, to give directions to a body administering a Welfare Food Scheme in relation to matters relating to the operation of a scheme or part of a scheme in Wales.
Section 188	Provides that the Secretary of State must first consult the Assembly before directing a Special Health Authority to undertake his appointments function to a body for which appointments are made jointly or concurrently with the Assembly.

ANNEX D: HANSARD REFERENCES

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

STAGE	DATE	HANSARD REFERENCE
A) HOUSE OF COMMONS		
Introduction	12 March 2003	Vol 401, Col 309
Second Reading	07 May 2003	Vol 404, Cols 696-808
Committee	13 May - 19 June 2003	Hansard Standing Committee E
Report and Third Reading	08 July 2003	Vol 408, Cols 904-1101
B) HOUSE OF LORDS		
Introduction	09 July 2003	Vol 651, Col 284
Second reading	08 September 2003	Vol 652, Cols 09-26 and 56-111
Committee	07 – 23 October 2003	Vol 653, Cols 148-223, 413-49, 458-523, 609-81, 697-754, 1053-92, 1102-66, 1322-6, 1271-80, 1293-322, 1326-39, 1356-450, 1451-490, 1726-760
Report	06, 10 and 11 November 2003	Vol 654, Cols 911-951, 962-1032, 1091-1164, 1174-1206 and 1319-1349
Third reading	18 November 2003	Vol 654, Cols 1858-1903
C) HOUSE OF COMMONS		
Commons consideration of Lords amendments	19 November 2003	Vol 413, Cols 813-876
D) HOUSE OF LORDS		
Lords consideration of Commons amendments	19 November 2003	Vol 654, Cols 2011-2035

E) HOUSE OF COMMONS		
Commons consideration of Lords amendments	20 November 2003	Vol 413, Cols 904-925
F) HOUSE OF LORDS		
Lords consideration of Commons amendments	20 November 2003	Vol 654, Cols 2084-2093

Royal Assent	20 November 2003	House of Commons Vol 413, Col 1037 House of Lords Vol 654, Col 2114

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Her Majesty's Stationery Office and Queen's Printer of Acts of Parliament.