HEALTH AND SPORT COMMITTEE

AGENDA

38th Meeting, 2010 (Session 3)

Wednesday 15 December 2010

The Committee will meet at 10.00 am in Committee Room 4.

1. **Certification of Death (Scotland) Bill:** The Committee will take evidence on the Bill at Stage 1 from—
   
   Leah Granat, Deputy Director, Scottish Council of Jewish Communities;
   
   Dr Salah Beltagui, Convenor, Muslim Council of Scotland;
   
   and then from—
   
   Shona Robison MSP, Minister for Public Health and Sport, Mike Palmer, Deputy Director for Public Health, Dr Mini Mishra, Senior Medical Officer, and Frauke Sinclair, Bill Team Leader, Certification of Death (Scotland) Bill, Scottish Government.

2. **Subordinate legislation:** The Committee will take evidence on the draft Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010 from—

   Shona Robison MSP, Minister for Public Health and Sport, Mary Cuthbert, Head of Tobacco, Sexual Health and HIV Team, Chief Medical Officer and Public Health Directorate, and Rosemary Lindsay, Principal Legal Officer, Solicitors Health and Community Care Division, Legal Directorate, Scottish Government.

3. **Subordinate legislation:** Shona Robison MSP (Minister for Public Health and Sport) to move S3M-7511—

   That the Health and Sport Committee recommends that the Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010 be approved.
4. **Subordinate legislation:** The Committee will consider the following negative instruments—

- The Sale of Tobacco (Prescribed Document) Regulations 2010 (SSI 2010/406);
- The Sale of Tobacco (Register of Tobacco Retailers) Regulations 2010 (SSI 2010/407); and
- The Community Health Partnerships (Scotland) Amendment Regulations 2010 (SSI 2010/422).

5. **Draft Budget Scrutiny 2011-12 (in private):** The Committee will consider a draft report to the Finance Committee on the Scottish Government's Draft Budget 2011-12.

Douglas Wands
Clerk to the Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
Tel: 0131 348 5210
Email: douglas.wands@scottish.parliament.uk
The papers for this meeting are as follows—

**Agenda Item 1**

Submission from the Scottish Government  
Letter from the Finance Committee  
Report by the Subordinate Legislation Committee  
Submission from the Scottish Council of Jewish Communities  
Submission from the Muslim Council of Scotland

**Agenda Item 2**

Paper from the clerk  
The Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010

**Agenda Item 4**

Paper from the Clerk

**Agenda Item 5**

Letter from the Cabinet Secretary for Health and Wellbeing  
Submission from Age Scotland  
PRIVATE PAPER
I am writing to the Committee to provide the further information that the Bill Team agreed to supply during the evidence session held on 24 November 2010 as part of the Stage 1 deliberations of the above Bill.

Firstly, you asked whether contributory factors relating to the death of a person would appear on the medical certificate of the cause of death:

The MCCD has two parts. Part 1 starts with the immediate and direct cause of death, followed by the sequence of events or conditions that led to the death, including the condition that started the fatal sequence and the additional conditions arising as a result of this underlying condition.

The initiating condition is the underlying cause of death as defined by the WHO as follows:

- the disease or injury which initiated the train of morbid events leading directly to death; or
- the circumstances of the accident or violence which produced the fatal injury.

From a public health perspective, the greatest health gain can be achieved from preventing this initial disease or injury, which may be a long term condition, and routine mortality statistics usually use the ‘underlying cause of death’.

Part 2 of the MCCD requires the entry of any other diseases, injuries, conditions or events that contributed to the death but were not part of the direct sequence leading to death.
I have included a link below to the Chief Medical Officer’s letter to Health Boards and all registered (and licensed to practise) medical practitioners. This letter asks them to take the necessary steps to implement the Guidance For Medical Staff Completing Medical Certificates of the Cause of Death. This advice was published in September 2009: [www.sehd.scot.nhs.uk/cmo/CMO(2009)10.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2009)10.pdf).

Secondly, you asked us to confirm the number of doctors in Scotland currently eligible to sign a death certificate and I can now update the Committee on this issue. The General Medical Council (GMC) advise there are some 19,224 licensed doctors with a registered address in Scotland. Any one of these practitioners would be eligible to sign a death certificate.

Thirdly, you asked for information on how medical reviewers would oversee/undertake the revalidation and training process for doctors and I have discussed the issue further with workforce planning colleagues. There is no direct link between the proposed role of the medical reviewer and that of the Responsible Officer (RO) under medical revalidation (see following paragraph for an explanation of the RO’s role). They are distinctly separate roles with different duties and responsibilities. RO regulations are reserved and have recently been approved by the UK Parliament. Under the proposed new system, medical reviewers would have no direct role in the revalidation process. However, medical reviewers, particularly the senior medical reviewer, would have a key role in promoting education and training on death certification.

Recommendations on a doctor’s fitness to practice will be made by an RO in each health board; this is a new statutory role and he/she will primarily base their recommendation on information gathered through the annual appraisal process, as augmented by clinical governance arrangements. Upon commencement of medical revalidation, scheduled for late 2012, each doctor’s Licence to Practice will be renewed every five years through the revalidation process, which is based predominantly upon five successful annual appraisals. In practice, the RO will rely on effective local appraisal and clinical governance systems providing sufficient information for him/her to make a recommendation to the GMC. It is through effective information exchange at local level that we expect a medical reviewer would highlight to an RO any concerns that may lead to considerations of individual doctor’s fitness to practice. However, only the GMC (as regulator of the profession) can suspend or withdraw a doctor’s licence.

Finally, we offered to update the Committee on discussions that have taken place with the Royal Colleges on the training programme for doctors. Undergraduate education and training is undertaken by Medical Schools to deliver the standards set by the GMC. The GMC is also responsible for the standards of postgraduate and speciality education and training of doctors. This is undertaken by NHS Education for Scotland (NES) through the Scottish Postgraduate Deans. Postgraduate Deans link with the Royal Colleges and the Academy of Royal Colleges and Faculties in Scotland to deliver appropriate training. The Deans have indicated that they are keen to emphasise the responsibilities of the educational supervisors and trainers of doctors in the area of death certification. One of the roles of the medical reviewers in Scotland would be to work with the Postgraduate Deans and educational supervisors and trainers to better embed death certification in the training and ongoing continuing professional development of doctors.

I also want to take the opportunity to address another issue raised by the Committee, concerning organ and tissue donors. We have had early discussions with relevant stakeholders to ensure that the new system will not adversely impact on organ and tissue...
donation. Specifically, we have spoken to the Tissue and Cells Medical Director at the Scottish National Blood Transfusion Service and concluded scrutiny would not affect organ and tissue donation because by the point at which scrutiny is flagged up (when the MCCD is presented to the registrar) tissues or organs would already have been removed. Equally, it would be of no concern for the purposes of scrutiny that some parts of the body had been removed.

Incidentally, we have also considered the issue of bodies donated for medical research to gauge whether scrutiny would cause a delay which would impact on whether or not a bequest could be accepted. We have had early discussions with university anatomy departments and will be continuing these to consider the need to develop guidance. In the meantime, we have noted that these cases would be justifiable reasons for the expedited procedure (section 6 of the Bill) to prevent any delay and deterioration of the body.

Response to Written evidence to Finance Committee
We also want to respond to a couple of points to the BMA's written evidence to the Finance Committee. Firstly, we note the BMA's concerns about the cost estimates but believe that our estimates are robust.

Secondly, in relation to the BMA's concern about medical reviewers' powers to require the provision of documents, we believe it is necessary to have an offence provision in place because without access to the relevant documents, the review system could not operate, or it might operate at a far, far slower rate than anticipated which would lead to lengthy delays for families. There is therefore a need for a power to require documents which carries the threat of imprisonment in order to compel persons to comply with a request by the medical reviewer. The offence provision also deals with the situation where a person deliberately alters or destroys documents.

It is a defence to a charge of refusing or failing to produce a document following a request under section 14 to prove that there was a reasonable excuse for the refusal or failure. So if there was some form of emergency in a hospital context, for example, and documents could not be produced within the deadline set by the medical reviewer, it would be possible to avoid prosecution if the doctor could persuade the court that the circumstances justified the failure to produce the documents within the timescale. Saying that, the notes requested by the medical reviewer are likely to be handled by administrative staff at the practice and the medical records department or ward/department administrative staff in a hospital setting.

We note the BMA's concerns and are of course happy to work with them to ensure implementation is proportionate.

Lastly, we would like to take the opportunity to explain our intelligence-led quality approach to scrutiny tied to quality improvement and clinical governance. This proportionate approach which delivers value for money comprises:

- a random sample of real-time reviews (annual audit cycle) to provide Scotland level data of the proportion of inaccurate MCCDs - this will give a benchmark against which to measure changes against, as well as of course providing outcomes from the actual reviews, which would be followed up where necessary
- interested person reviews - which will for the first time empower individuals to request reviews where they have concerns e.g. to raise the issue of health related problems or contributory factors that have not been included in the MCCD forms, with the outcomes again being followed up where necessary
targeted (retrospective/prospective) reviews - carried out on basis of intelligence gathered from a number of ISD / GROS data sources, with the work by the national statistician crucial.

The scrutiny outcomes will be linked to the education and training activities. The senior medical reviewer will have a key role in taking a leadership role for these. Medical reviewers will also directly support, through being available by phone, certifying doctors in filling out MCCD forms. Together, the elements of scrutiny are primarily aimed at improving the quality of death certification while also providing a level of deterrence, both from the scrutiny and legislative requirements. Other key benefits of the proposals include a uniform death certification system and better public health data.

I hope that this information is helpful and clarifies matters. If the Committee requires further information on any aspects, we would be happy to provide this to you.

FRAUKE SINCLAIR
Bill Team Leader
Dear Christine

Finance Committee – consideration of the Financial Memorandum of the Health (Certification of Death) Bill

As you are aware, the Finance Committee examines the financial implications of all legislation, through the scrutiny of Financial Memoranda. The Committee agreed to adopt level one scrutiny in relation to the Health (Certification of Death) Bill. Applying this level of scrutiny means that the Committee does not take oral evidence or produce a report, but it does seek written evidence from affected organisations.

The Committee received one submission, from the British Medical Association, which is attached to this letter. If you have any questions about the Committee’s scrutiny of the FM, please contact the clerks to the Committee via the contact details above.

Yours sincerely

Andrew Welsh MSP, Convener
Submission from the British Medical Association

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 doctors representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 15,500 doctors.

BMA Scotland is grateful for the opportunity to provide comment on the Certification of Death (Scotland) Bill. BMA Scotland took part in the consultation exercise for the Bill. We also provided a written response to the Health and Sport Committee detailing the following concerns regarding financial assumptions made.

- Although the system detailed in the Bill may appear to be reasonably priced, we believe it does not provide the best value for money since it does not offer adequate or effective protection levels to society. We highlighted this in the Scottish Government’s initial consultation.
- We have concerns that the level of costs detailed in the Financial Memorandum is seriously underestimated. This could have severe implications as any lack of funding or staff shortages could cause delays to funerals causing distress to families at a particularly difficult time. Any pilots taking place should be examined carefully to provide more accurate costs and Scotland’s rural nature should also be taken into consideration when considering costs.
- With regard to cost, additional workload for doctors would need to be considered. We acknowledge that all reviews can be suspended during times of an epidemic, however doctors in primary and secondary care settings constantly work under very tight timescales juggling patients in both planned and emergency situations. If an unrealistic timescale is set, or an emergency arises, or due to pressures from staff absence, a doctor will be required to decide whether to let patient care suffer or to be imprisoned.
- Finally, with regard to providing the information to the medical reviewer, confidentiality is paramount in preserving trust between patients and doctors. Doctors must have guarantees that all documents provided to the medical reviewer are secure in transit, be that electronically or by other means, to avoid any distress to relatives and preserve the dignity of the dead. Resources for the cost of this would also need to be sufficient.

Conclusion
The BMA has real concerns regarding whether this Bill would provide improved public protection given the lack of real-time scrutiny, and the minimal level of that scrutiny, despite the fact that one aim of the Bill is to provide improved safeguards and increased public confidence in the system.

We have concerns about cost and believe the medical reviewer system is less robust and not as comprehensive as the current system or the scheme being introduced in England and Wales. Indeed, there will in fact be a two tier
system in the UK, and it is doubtful that this would reassure the Scottish public. We are by no means saying the current system is perfect, however we should take this chance to change the certification of death for the better and not implement inadequate and unsafe changes to save money.

Dr Charles Saunders
Deputy Chairman of BMA Scotland
Subordinate Legislation Committee

Remit and membership

Remit:

1. The remit of the Subordinate Legislation Committee is to consider and report on-

   (a) any-

      (i) subordinate legislation laid before the Parliament;

      (ii) Scottish Statutory Instrument not laid before the Parliament but classified as general according to its subject matter;

      (iii) Pension or grants motion as described in Rule 8.11A.1;

   and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;

   (b) proposed powers to make subordinate legislation in particular Bills or other proposed legislation;

   (c) general questions relating to powers to make subordinate legislation; and

   (d) whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation.

   *(Standing Orders of the Scottish Parliament, Rule 6.11)*

Membership:

Bob Doris
Helen Eadie
Rhoda Grant
Alex Johnstone
Ian McKee (Deputy Convener)
Elaine Smith
Jamie Stone (Convener)
Committee Clerking Team:

Clerk to the Committee
Irene Fleming

Assistant Clerk
Jake Thomas

Support Manager
Lori Gray
The Committee reports to the Parliament as follows—

INTRODUCTION

1. At its meetings on 23 November and 7 December 2010, the Subordinate Legislation Committee considered the delegated powers provisions in the Certification of Death (Scotland) Bill at Stage 1. The Committee submits this report to the Health and Sport Committee as the lead committee for the Bill under Rule 9.6.2 of Standing Orders.

OVERVIEW OF THE BILL

2. The Certification of Death (Scotland) Bill (“the Bill”) was introduced in the Parliament on 7 October 2010 by the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon MSP.

3. The Scottish Government provided the Parliament with a memorandum on the delegated powers provisions in the Bill (“the DPM”).

4. Correspondence between the Committee and the Scottish Government is reproduced in the Annexe.

5. The Committee determined that it did not need to draw the attention of the Parliament to the delegated powers in sections: 2 (Power of Scottish Ministers to give directions to the Registrar General), 4(5)(e), 4(8), 8(5), 17(4), 18(4), 22(3), 24, 25(1), 25(2), 27 and 31(3) and the power to be inserted in paragraph 7A of Schedule 5A to the National Health Service (Scotland) Act 1978 by paragraph 2 of schedule 1 to the Bill.
Delegated powers provisions

Section 2: Suspension of referral of certificates for review during emergencies

Power conferred on: Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Negative resolution

6. Section 2 inserts section 24A(7) into the 1965 Act. This allows the Scottish Ministers to suspend by order the referral to medical reviewers of medical certificates of cause of death during an epidemic, or when it is considered on reasonable grounds that it is necessary to do so to prevent (or to prevent the spread of) infectious diseases or contamination. Such orders can also make ancillary provisions, as necessary or expedient.

7. The DPM explains that it may be necessary to suspend the referral of the certificates to medical reviewers during an epidemic, or other situation where an infectious disease or contamination is spreading rapidly, if there are large numbers of deaths. This could place a significant burden on the registration system and doctors. In some circumstances funerals may need to take place straightaway to prevent the development of a danger to public health. This power is designed to allow these rare but extreme circumstances to be catered for.

8. On the choice of procedure, the DPM states that negative procedure has been chosen “as this power will be required in emergency situations where there is a serious risk to public health that has to be addressed urgently. Negative procedure will allow such an order to be brought into force almost immediately, whereas if the emergency took place at the beginning of a long parliamentary recess, it would be impossible for the order to be made quickly enough to deal with the situation using affirmative procedure.”

9. The Committee accepts that it may be necessary to suspend the operation of the proposed scheme for review of medical certificates for the reasons given in the DPM. It therefore accepts the need for this order-making power in principle. On the choice of procedure, the Committee notes that there is a specific form of affirmative procedure which is designed for emergencies. This would allow the instrument to be made and brought into force immediately, but for the order to remain in force beyond a specified period (whatever period the Parliament considers appropriate) it must be approved by resolution of the Parliament.

10. The choice of negative procedure here would mean that it would be likely that the “21 day rule” would be breached in every case, given the circumstances in which the power is to be used. The Committee does not consider it sensible to select a form of procedure which it is clear the Government would find it difficult to comply with in practice. It therefore suggested to the Government that emergency affirmative procedure would be more appropriate.

11. The Government’s reply indicates that it did not initially select emergency affirmative procedure since it thought that the intervention of a long period of recess would be problematic. However, the Committee notes
that periods of recess need not count for the purposes of calculating the specified period. The Government has indicated that it intends to amend the power to adopt emergency affirmative procedure discounting periods of recess. The Committee is content with this.

Section 4(7): Suspension of applications under section 4 during emergencies

Power conferred on: the Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Negative resolution

12. Section 4(7) contains a power to suspend applications under section 4, just as section 24A(7) of the 1965 Act (added by section 2) contains a power to suspend the referral of certificates under that section. That is, during an epidemic or when it is necessary to do so to prevent the spread of infectious diseases or contamination.

13. The DPM explains that this power, and the choice of procedure, are taken for the same reasons as for the power taken under section 24A(7) of the 1965 Act (inserted by section 2).

14. The Committee considered that the same arguments against adoption of negative procedure applied here as are described in relation to section 2. The Government has agreed to amend the procedure for this power to emergency affirmative and the Committee is content with this approach for the reasons given above.

Section 23(3): Fees

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: Affirmative resolution

15. Section 23(3) permits the Scottish Ministers to make regulations about the charging of a fee (a) in respect of the review functions of medical reviewers and (b) for an application to cremate a person who has died outwith Scotland. The regulations can set out the amount of fees, arrangements for fee collection, including who will collect them for the Scottish Ministers, and the circumstances where there may be no fee.

16. Section 23(2) provides that the cost of medical reviewers is to be shared universally by a new separate fee payable in respect of every death registered (whether the cause of death is reviewed or not). The personal representatives of the deceased are liable to pay the fee which is to be treated as an administrative expense of the deceased’s estate.

17. By section 23(5), in setting the amount of fees, Ministers must have regard to the reasonable costs of the exercise of the functions in respect of which the fee is charged. They must consult such persons as they consider appropriate.
18. The Committee is content that a power to specify different fee levels over time is appropriate in principle, and that subordinate legislation is also appropriate for the specification of more detail on the collection arrangements.

19. However, the Committee queried whether draft affirmative procedure was the appropriate level of scrutiny for the setting of application fees, and arrangements for collection. Such arrangements would more usually be subject to negative resolution procedure. The DPM does not expand on why draft affirmative procedure rather than negative was adopted. The Committee therefore asked for clarification of this, particularly since the power cannot modify the basis of liability for the fee.

20. The Scottish Government responded that it had originally considered that the subject matter of the manner of collection of the fee could be rather sensitive. However it proposes to amend the Bill to apply negative procedure in light of the Committee’s comments. The Committee is content with this and notes that the principle that a new fee is to be payable in respect of the registration of every death, and liability for it, are both matters set out on the face of the Bill and therefore subject to full scrutiny by the Parliament.
ANNEXE

Correspondence with the Scottish Government

Section 2: Suspension of referral of certificates for review during emergencies

The Committee asks:

• **Q** – Given that this power is designed for an emergency situation, why has it been considered appropriate to propose negative procedure in place of the “Class 3” emergency affirmative procedure?

The Scottish Government notes the Committee’s comment that the “Class 3” procedure could be used to bring an order into force immediately without breaching the 21 day rule, allowing it to remain in force for a sufficiently long period (including that of a long Parliamentary recess) before requiring approval.

Whilst the Scottish Government had considered the application of “Class 3” emergency procedure, it understood that it would be an unusual use of that procedure to allow an order to remain in force for longer than 28 to 40 days without being approved by the Scottish Parliament (indeed it is understood that orders using this procedure are often referred to as “28 day orders” because, in most cases, they stipulate a period of 28 days).

As the objective here was to ensure that an order could be made and come into force at any time without requiring Parliamentary approval, including during a long period of recess, the Scottish Government considered that Class 3 procedure might not be suitable as the order might have to be made at the beginning of the summer Parliamentary recess (it is noted, for example, that the most recent summer recess lasted 62 days).

However, it appears that the Committee would consider the use of Class 3 procedure appropriate in these circumstances and the Scottish Government therefore plans to amend subsection (9) of section 24A (as inserted by section 2 of the Bill) accordingly (discounting periods of recess from the period before approval).

Section 4(7): Suspension of applications under section 4 during emergencies

The Committee asks:

• **Q** – Given that this power is designed for an emergency situation, why has it been considered appropriate to propose negative procedure in place of the “Class 3” emergency affirmative procedure?

For the same reasons as set out above in relation to section 2, the Scottish Government intends to amend the procedure applicable to the exercise of the power in section 4(7) from negative to “Class 3” emergency procedure.
Section 23(3): Fees

The Committee asks:

- Q - Why has affirmative procedure been applied to the power to make regulations to set the amount of fees and prescribe arrangements for collection of those fees, rather than negative procedure?

The Scottish Government had considered that affirmative procedure might be appropriate here as there may be particular sensitivities for bereaved families regarding the manner in which the fee is to be collected (for example, one of the options is for registrars to collect the fee from the person seeking to register a death; but the Association of Registrars of Scotland has commented that the recently bereaved may find it difficult to take on board the necessary information relating to payment of the fee at the point of registration).

However, the Scottish Government notes the Committee’s comment that the prescription of fee levels and collection arrangements are more usually subject to negative procedure and in the light of this, it intends to amend section 28 of the Bill accordingly.
Subordinate Legislation Briefing

Affirmative Instrument

Overview

There is one affirmative instrument for consideration. This relate to the registration of tobacco retailers using moveable structures, as well as Fixed Penalty Notices introduced by Part 1 of the Tobacco and Primary Medical Services (Scotland) Act 2010.

An explanation of the affirmative instrument, along with the comments of the Subordinate Legislation Committee, is attached to this paper. If members have any queries or points of clarification on the instrument which they wish to have raised with the Scottish Government in advance of the meeting, please could these be passed to the Clerk to the Committee as soon as possible.

<table>
<thead>
<tr>
<th>Name</th>
<th>Deadline</th>
<th>Motion to Approve</th>
<th>Purpose</th>
<th>Drawn to attention by Subordinate Legislation Committee (SLC)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010 (SSI 2010/draft)</td>
<td>17 Jan</td>
<td>Yes</td>
<td>See the attached Explanatory Note (pages 2 and 3)</td>
<td>See paragraphs 19 to 22 of the report from the SLC (pages 5 and 6)</td>
</tr>
</tbody>
</table>
EXECUTIVE NOTE

Draft SSI: The Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010

The above instrument was made in exercise of the powers conferred by sections 24 and 40(2) of, and paragraphs 3 and 4 of Schedule 1 to, the Tobacco and Primary Medical Services (Scotland) Act 2010 (“the Act”). This instrument is subject to affirmative procedure.

Policy Objectives

The Act establishes a tobacco sales registration scheme. This scheme allows retailers to be clearly identified, enabling trading standards officers and others to offer advice and support to them to avoid illegal sales. The Act also introduces a fixed penalty notice scheme.

Regulations 2, 3 and 4 set out information required on any application by a person seeking to sell tobacco from moveable premises to register for the tobacco sales registration scheme. These regulations are in line with other schemes relating to street traders.

Regulation 5 prescribes that a fixed penalty notice can be issued up to seven days after the day on which an offence was committed. This is in line with other fixed penalty schemes operational in Scotland, including the smoking ban fixed penalty notice scheme.

Regulations 6 and 7 set the fixed penalty amount for businesses and individuals found to be in breach of offences under Part 1 of the Act. Regulation 6 sets the fixed penalty level at £50, with the discounted amount at £30, for persons found to be buying, or attempting to buy, tobacco under the age of 18 and for persons under 18 who do not, on request from a constable, surrender tobacco products or provide information set out in the Act. Regulation 7 sets the amount of the fixed penalty notice at £200, with the discounted amount at £150, for all other offences in Part 1 of the Act. This regulation sets out that the level of fixed penalty will increase by £200 for every offence committed within a two year period. It should be noted that a fixed penalty cannot be issued to any person under 16.

These regulations will come into force on 1 April 2011

Consultation

The Act has a number of regulation-making powers. A consultation on five sets of draft regulations to be made under the Act began on 27 April and ran through until 20 July 2010. The Scottish Government received nearly 500 responses to the consultation from individuals and organisations.
Financial effects

A Regulatory Impact Assessment was carried out in relation to the tobacco sales registration scheme. It was deemed that these regulations would put no additional burden on business. A copy of the RIA can be accessed at: http://www.scotland.gov.uk/Publications/2009/02/27120518/0

REPORT FROM THE SUBORDINATE LEGISLATION COMMITTEE

The Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010 (SSI 2010/draft) (Health and Sport Committee)

1. The Regulations apply Chapter 2 of Part 1 of the Tobacco and Primary Medical Services (Scotland) Act 2010 to moveable premises, with some resulting modifications to Chapter 2 which are set out in regulations 3 and 4. Chapter 2 concerns applications to the register of tobacco retailers. Part 1 of the Act, generally concerns tobacco products; and prescribes further details of the fixed penalty notice scheme in relation to offences under Part 1 of the Act. (It is prescribed that a fixed penalty notice can be issued up to 7 days after the date of the offence (regulation 5)).

2. Regulation 6 sets the fixed penalty level at £50, with the discounted amount of £30, for persons buying or attempting to buy tobacco under the age of 18, and for persons under 18 who do not surrender tobacco products or provide required information under the Act.

3. Regulation 7 sets the fixed penalty amount of £200, with a discounted amount of £150, for all other offences in Part 1 of the Act. The £200 level will increase by £200 for every offence committed within a 2 year period. (The details are in the Schedule to the Regulations). A fixed penalty cannot be issued to anyone under 16 years old.

4. If approved, the Regulations will come into force on 1 April 2011.

5. Correspondence between the Scottish Government and the Committee is reproduced in the Appendix.

6. The Committee asked the Scottish Government whether the meaning or effect of the definition of “moveable premises” could be clearer. “Moveable premises” are defined in regulation 1(2) as premises consisting of a vehicle or other moveable structure from which the applicant proposes to carry on a tobacco business, but excluding a vessel. The Committee’s query related to the definition, as it appears that sections 13, 14, 15, 16, 19, 20 and 21 in Chapter 2 of Part 1 extend to premises at which a tobacco business may be carried on, rather than proposed to be carried on.
7. The Scottish Government in its response argued that the definition is correct, because “these Regulations relate to the application process provided for in section 11 of the Act. The definition reflects the wording in section 11(2)(b), 11(2)(c), 11(4)(b) and 11(5) that the applicant “proposes to carry on a tobacco business”.

8. The Committee considers that this response does not fully address the point raised in the question. Regulation 2 applies the whole of Chapter 2 of Part 1 of the Act to “moveable premises”, subject to the modifications to section 11 made by regulations 3 and 4. The application of Chapter 2 made by regulation 2 does not only apply to section 11.

9. Sections 13 to 16 and 19 to 21 in Chapter 2 broadly concern changes to the Register of Tobacco Retailers, banning orders, offences relating to the Register, and public inspection of the Register. In referring to (non moveable) “premises”, the Committee considers that those provisions are not restricted to those from which the applicant proposes to carry on a tobacco business. They relate to where a person carries on such a business from the premises (section 21 refers to both “tobacco businesses carried on or proposed to be carried on”).

10. It therefore appears in the Committee’s view, in relation to the application of sections 13 to 16 and 19 to 21, that the meaning and effect of regulation 2 could be clearer, as it appears that for those sections the definition should not incorporate the limitation that the moveable premises are those from which the applicant proposes to carry on a tobacco business.

11. Regulation 7 and the Schedule prescribe amounts of fixed penalty for any offences under Chapters 1 and 2 of Part 1 of the Act (other than sections 5 and 7) which continue after five contraventions within a 2 year period. This is in increments of £200 for each additional previous enforcement action, and without any maximum amount. However, the offences to which the fixed penalty scheme applies, in sections 1, 3, 4, 6, and 20, all have a maximum level of fine with reference to the standard scale.

12. It is possible therefore (depending on the number of contraventions over the 2 year period) for the level of the fixed penalty to exceed the maximum level of fine, per the standard scale of fines set out in the Act for a particular offence. The Committee considered that this effect of the provisions could be drawn to the attention of the lead committee considering the draft Regulations.

13. The Committee also queried the intention behind regulation 7(4) with the Scottish Government. That paragraph defines previous “enforcement action” for the purpose of increases in the level of fixed penalties as set out in the Schedule. The Committee asked whether it is intended (as paragraph (4) provides) that “enforcement action” includes the conviction of any offence under Chapter 1 or 2 of Part 1 of the Act, or is it intended that this should exclude any conviction for offences under sections 5 or 7 of the Act.

14. Sections 5 and 7 concern the offences of purchase or attempted purchase of tobacco products by persons under 18; and refusing to comply with a confiscation of tobacco products from a person under 18. The nature of this offence is quite
Agenda Item 2  
15 December 2010

different from the tobacco retailing offences. It is not clear why they are related for enforcement purposes.

15. The Scottish Government confirmed that it would be highly unusual in practice for circumstances to arise where a person is being given a fixed penalty notice for one of the tobacco retailing offences to which the escalated fixed penalty applies, and to have a conviction for an offence under sections 5 or 7 within the previous two years.

16. If however those circumstances did arise, “the policy view at present is that given the person has again offended, any convictions for the offences under sections 5 and 7 in the previous two years are to count towards the escalation of the penalty for the offence which he or she has now committed.”

17. The Committee notes the response and also that, while under section 27(2) of the Act a fixed penalty notice cannot be issued to anyone under 16 years of age, the tobacco retailing provisions and offences in Chapter 2 appear to have no restrictions in relation to the age at which a retailer can be registered.

18. The Committee therefore reports the following—

19. It considers that the meaning and effect of the definition of “moveable premises” in regulation 1(2) when read with regulation 2 could have been clearer. This is in the respect that—

- regulation 2 applies the whole of Chapter 2, Part 1 of the Act to “moveable premises” (subject to modifications in regulation 3 and 4 concerning section 11),

- “moveable premises” are defined as restricted to premises “from which the applicant proposes to carry on a tobacco business”, but

- sections 13 to 16 and 19 to 21 of the Act extend to premises where such a business is carried on, rather than proposed to be carried on;

20. The Committee also draws to the attention of the lead committee considering the instrument the effect of regulation 7 and the Schedule to the Regulations. Regulation 7 and the Schedule prescribe amounts of fixed penalty for any offences under Chapters 1 and 2 of Part 1 of the Act (other than sections 5 and 7) which continue after five contraventions within a 2 year period. This is in increments of £200 for each additional previous enforcement action, and without any maximum amount. However, the offences to which the fixed penalty scheme applies in sections 1, 3, 4, 6, and 20 all have a maximum level of fine with reference to the standard scale of fines. This could result in a fixed penalty that is greater than the limit set by the Parliament for the criminal offence.
21. It draws to the attention of the lead committee the effect of regulation 7(4), as explained in the response from the Government. “Enforcement action” for the purpose of the escalating amounts of fixed penalties in the Schedule for tobacco retailing offences under Part 1 of the Act shall include any convictions for the offences under sections 5 and 7 of the Act (purchase of tobacco by a person under 18; confiscation of tobacco products from persons under 18), in the previous 2 years.

22. The Committee also notes in that respect that it appears, while section 27(2) of the Act prevents a fixed penalty notice being issued to anyone under 16 years of age, that the tobacco retailing provisions and offences in Chapter 2 appear have no restrictions in relation to age.
APPENDIX

The Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010 (SSI 2010/draft)

On 26 November 2010, the Scottish Government was asked:

Questions
(1) Regulation 2 applies Chapter 2 of Part 1 of the Act to “moveable premises”, which are defined in regulation 1(2) as premises consisting of a vehicle or other moveable structure from which the applicant proposes to carry on a tobacco business, but excluding a vessel.

Could the meaning or effect of this definition be clearer, so far as it appears that sections 13, 14, 15, 16, 19, 20 and 21 in Chapter 2 extend to premises at which a tobacco business may be carried on, rather than proposed to be carried on?

(2) Regulation 7(4) defines previous “enforcement action” for the purpose of increases in the level of fixed penalties as set out in the Schedule. Is it intended (as paragraph (4) provides) that enforcement action includes the conviction of any offence under Chapter 1 or 2 of Part I of the Act, or is it intended that this should exclude any conviction for offences under sections 5 or 7 of the Act?

(3) Should the removal of the words in regulation 3(1) also remove “the” where it first occurs in section 11(2)(b) and (c) of the Act? What is the effect of this apparent error considered to be?

(4) In regulation 4(ii), is it intended to make the provision that “address” in section 13(1)(a) is to be read in accordance with the substitutions in regulation 3, so far as those substitutions refer to addresses of premises where a tobacco business is carried on or proposed, but the reference in that paragraph (a) (when read with the references to “name and address” in section 11) appear to refer to a registered person’s home address?

The Scottish Government responded as follows:

Question 1
“In our view the definition of “moveable premises” as those from which the applicant “proposes to carry on a tobacco business” is appropriate.

While Regulations made under section 24 of the 2010 Act may modify any part of Chapter 2 to apply to moveable structures, these Regulations relate to the application process provided for in section 11 of the Act. The definition reflects the wording in section 11(2)(b), 11(2)(c), 11(4)(b) and 11(5) that the applicant “proposes to carry on a tobacco business”.

7
Question 2
Regulation 7 provides for the amount of the fixed penalty for offences under Chapter 1 and 2 of the Act other than offences under section 5 (purchase of tobacco by a person under 18) and section 7 (confiscation of tobacco products from persons under 18). Other than the purchase of tobacco on behalf of under 18s these are the tobacco retailing offences. It is only in respect of these fixed penalties for these offences that the escalator applies. The other limitation is in section 27(2) which provides that a person may only be given a fixed penalty if aged 16 or over.

In view of this we consider it would be highly unusual in practice for circumstances to arise where a person is being given a fixed penalty notice for one of these offences and to have a conviction for an offence under sections 5 or 7 within the previous two years.

If however those unusual circumstances did arise, we can confirm that the policy view at present is that given the person has again offended, any convictions for the offences under sections 5 and 7 in the previous two years are to count towards the escalation of the penalty for the offence which he or she has now committed.

Question 3
We agree that the word “the” where it first occurs should also be substituted out of section 11(2)(b) and (c).

Whilst our view is that the error does not impact on the effect of the regulations (the meaning and effect is still clear), we intend to withdraw the instrument and re-lay it in the light of your Question 4, and we will therefore take the opportunity to substitute the word “the” out of section 11(2)(b) and (c) in regulation 3.

Question 4
We agree that the reference in section 13(1)(a) of the Act is to a person’s personal address rather than the address of the premises from which they conduct their tobacco business. Accordingly this reference should not be read subject to the substitution in Regulation 3.

As noted above, we intend to withdraw this instrument and re-lay it so that we can remove the reference to section 13(1)(a) in regulation 4. Our intention is to re-lay this instrument on 1st December. As the changes outlined above are the only substantive changes which will appear in the re-laid version, we hope it is possible for the re-laid version of the Regulations to be considered by the Committee as originally planned on 7 December.”
The Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010

Made - - - -

Coming into force - - 1st April 2011

The Scottish Ministers make the following Regulations in exercise of the powers conferred by sections 24 and 40(2) of and paragraphs 3 and 4 of schedule 1 to the Tobacco and Primary Medical Services (Scotland) Act 2010(a) and all other powers enabling them to do so.

In accordance with section 40(4) of that Act, a draft of this instrument has been laid before and approved by resolution of the Scottish Parliament.

Citation, commencement and interpretation

1.—(1) These Regulations may be cited as the Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010 and come into force on 1st April 2011.

(2) In these Regulations—

“the Act” means the Tobacco and Primary Medical Services (Scotland) Act 2010;

“moveable premises” means premises consisting of a vehicle or other moveable structure from which the applicant proposes to carry on a tobacco business but excluding a vessel.

Application of Chapter 2 of the Act (Register of Tobacco Retailers) to vehicles and other moveable structures (excluding vessels)

2. If premises are moveable premises, Chapter 2 of Part 1 of the Act applies subject to the modifications in regulations 3 and 4.

3. —(1) For—

(a) “the addresses of all premises at which the applicant proposes to carry on a tobacco business” in section 11(2)(b) of the Act; and

(a) 2010 asp 3. Section 35 of the 2010 Act contains a definition of “prescribed” which is relevant to the making of these Regulations.
(b) “the address of the further premises at which the applicant proposes to carry on a tobacco business” in section 11(2)(c) of the Act,

substitute in accordance with paragraph (2).

(2) Where it is proposed to carry on business from moveable premises—

(a) in a fixed location substitute—

“:— (i) a description which identifies the location of all premises at which; and

(ii) the type and registration number of the vehicle or a description and dimensions of the moveable structure being the premises from which,

the applicant proposes to carry on a tobacco business”.

(b) in a location which is not fixed substitute—

“:— (i) a description which identifies each street or area at which; and

(ii) the type and registration number of the vehicle or a description and dimensions of the moveable structure being the premises from which,

the applicant proposes to carry on a tobacco business”.

4. The references in the Act to—

(i) “addresses” in section 11(4)(b); and

(ii) “address” in sections 11(5), and 13(1)(b)

are to be read in accordance with the substitutions in regulation 3.

Time after which a fixed penalty notice may not be given

5. The time prescribed for the purpose of paragraph 3 of schedule 1 to the Act is 7 days after the day on which the offence took place.

Amount of fixed penalty and discounted amount for offences under sections 5 and 7 of the Act

6. The amount prescribed for the purposes of paragraph 4(1)(a) and (b) of schedule 1 to the Act for offences under sections 5 and 7 of the Act are respectively—

(a) £50 (fixed penalty); and

(b) £30 (discounted amount).

Amount of fixed penalty and discounted amount for all other offences under Chapters 1 and 2 of Part 1 of the Act

7.—(1) Subject to paragraph (2), the amounts prescribed for the purposes of paragraph 4(1)(a) and (b) of schedule 1 to the Act for offences under Chapters 1 and 2 of Part 1 of the Act other than sections 5 and 7 are respectively—

(a) £200 (fixed penalty); and

(b) £150 (discounted amount).

(2) Where a person is issued with a fixed penalty notice (“the fixed penalty notice”) and that person has been the subject of previous enforcement action within the prescribed period the amounts prescribed for the purposes of paragraph 4(1)(a) and (b) of schedule 1 to the Act are set out in the table in the Schedule to these Regulations.

(3) The prescribed period is two years ending on the date the fixed penalty notice is issued.
(4) In this regulation, “enforcement action” means the issue of a fixed penalty notice which is not subsequently withdrawn or the conviction of an offence under Chapter 1 or 2 of Part 1 of the Act.

Name

Authorised to sign by the Scottish Ministers

St Andrew’s House,
Edinburgh
Date
<table>
<thead>
<tr>
<th>Number of previous enforcement actions within prescribed period</th>
<th>Amount of fixed penalty £</th>
<th>Discounted amount £</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>400</td>
<td>350</td>
</tr>
<tr>
<td>Two</td>
<td>600</td>
<td>550</td>
</tr>
<tr>
<td>Three</td>
<td>800</td>
<td>750</td>
</tr>
<tr>
<td>Four</td>
<td>1000</td>
<td>950</td>
</tr>
<tr>
<td>Five</td>
<td>1200</td>
<td>1150</td>
</tr>
</tbody>
</table>

Amounts continuing in increments of £200 for each additional previous enforcement action.
EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations make provision in relation to the application to moveable structures of Chapter 2 of Part 1 (Register of Tobacco Retailers) of the Tobacco and Primary Medical Services (Scotland) Act 2010 (“the Act”). They also provide in relation to the fixed penalty notice scheme under section 27 and schedule 1 to the Act.

Regulations 2, 3 and 4 make provision in relation to the application of Chapter 2 to moveable premises.

Chapter 2 of Part 1 of the Act makes provision in relation to a Register of Tobacco Retailers which is to be established in accordance with section 10 of the Act. Section 11 of the Act provides in relation to applications to be put on this Register.

These Regulations are made under section 24 of the Act which allows Scottish Ministers to modify Chapter 2 to apply its provisions to moveable structures. Regulations 3 and 4 modify section 11 of the Act to take account of the fact that tobacco businesses carried on from moveable premises will not have a fixed address as is envisaged by section 11.

Regulation 3(2) provides that if the business is carried on from moveable premises in a fixed location then, in the application for registration, it will be necessary to give the following details in relation to those premises:—

(i) a description which identifies the location of the premises; and
(ii) the type and registration number of the vehicle or a description and dimensions of the moveable structure.

If the business is carried on from moveable premises which are not in a fixed location then, in the application for registration, it will be necessary to give the following details in relation to those premises:—

(i) a description which identifies each street or area at which the business is carried on; and
(ii) the type and registration number of the vehicle or a description and dimensions of the moveable structure.

Regulations 5, 6 and 7 and the Schedule provide in relation to the fixed penalty notice scheme.

Section 27(1) of the Act provides that a council officer or a constable may issue a fixed penalty notice if they have reason to believe that the person has committed an offence under Chapters 1 or 2 of Part 1 of the Act which provide in relation to tobacco.

Regulation 5 provides that a fixed penalty notice cannot be given after 7 days from the date of the offence.

Regulation 6 prescribes the amount of the fixed penalty for offences under sections 5 (purchase of tobacco products by persons under 18) and 7 (confiscation of tobacco products from persons under 18) of the Act as £50. The discounted amount for these offences is £30. This is the amount which will be due provided the penalty is paid within the discounted payment deadline. The deadline will be stated on the fixed penalty notice.

Regulation 7 prescribes the amount and the discounted amount for all other offences under Chapters 1 and 2 of Part 1 of the Act. The amount is £200 and the discounted amount is £150.

If the person receiving the fixed penalty notice has already had a fixed penalty or a conviction for a tobacco offence under the Act within the previous two years, the amounts are escalated in accordance with the Schedule to these Regulations.
Overview

There are three negative instruments for consideration. Two instruments relate to amendments being made to the sale of tobacco products and the establishment of a register of tobacco retailers under Part 1 of the Tobacco and Primary Medical Services (Scotland) Act 2010. The final instrument updates community health partnership regulations.

A brief explanation of each instrument, along with the comments of the Subordinate Legislation Committee, is set out below. If members have any queries or points of clarification on the instrument which they wish to have raised with the Scottish Government in advance of the meeting, please could these be passed to the Clerk to the Committee as soon as possible.

<table>
<thead>
<tr>
<th>Name</th>
<th>Deadline</th>
<th>Motion to Annull</th>
<th>Purpose</th>
<th>Drawn to attention by Subordinate Legislation Committee (SLC)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Sale of Tobacco (Prescribed Document) Regulations 2010 (SSI 2010/406)</td>
<td>10 Jan 11</td>
<td>No</td>
<td>Section 4 of the Tobacco and Primary Medical Services (Scotland) Act 2010 provides that it is an offence to sell a tobacco product or cigarette papers to a person under the age of 18. These Regulations specify the types of personal identification which will be acceptable in establishing proof of age at the point of sale for a person seeking to purchase tobacco or tobacco related products.</td>
<td>The SLC had no comments to make on this instrument</td>
</tr>
<tr>
<td>The Sale of Tobacco (Register of Tobacco Retailers) Regulations 2010 (SSI 2010/407)</td>
<td>10 Jan 11</td>
<td>No</td>
<td>Section 10 of the Tobacco and Primary Medical Services (Scotland) Act 2010 requires the Scottish Ministers to keep a register of persons carrying on a tobacco business. Section 11(2) of the Act sets out what must be contained in an application to be registered or to add premises to a person’s existing entry in the register.</td>
<td>The SLC had no comments to make on this instrument</td>
</tr>
<tr>
<td>The Community Health Partnerships (Scotland) Amendment Regulations 2010 (SSI/2010/422)</td>
<td>17 Jan 11</td>
<td>No</td>
<td>These Regulations set out other information required by Ministers in order to register a tobacconist on the tobacco sales register.</td>
<td>The SLC had no comments to make on this instrument</td>
</tr>
</tbody>
</table>
Submission from Age Scotland

Key Messages

- Generally Age Scotland believes that this is a fair deal for older people although we remain of the opinion that there is more the Government could do to support vulnerable older people in Scotland, including greater investment in community transport.
- We welcome the announcement that key policies such as Free Personal and Nursing Care and the Concessionary Travel Scheme have been retained and that the Scottish Government recognises the preventative nature of these public services.
- The new ‘Change Fund’ of £70m and pooling of social care budget between health boards and local authorities has the potential to shift the balance of care for older people towards prevention through primary and community care. However more answers are needed about the mechanisms for operating these budgets.
- We are concerned that the reduced local authority settlement might lead to reductions in funding third sector projects that support older people in their communities and homes and help keep them out of hospital and institutional care.

Foreword

Age Scotland’s report on the draft Scottish Budget for 2011/12 examines if and how the Scottish Government is taking the necessary steps to prepare for an ageing population.

It is widely known that Scotland’s population has been ageing as a result of higher life expectancy and lower fertility rates. In October 2009, the General Register Office for Scotland published new 25 year population projections. These show that the population of Scotland is likely to increase by 7% by 2033, and that there will be a greater proportion of older people. The number of people aged 75 and over is now projected to increase by 23% between 2008 and 2018, and by 84% between 2008 and 2033. In the same 25 year period, the number of people aged 60 – 74 is projected to increase by 33%.

NESTA estimate that over the next 15 years Scotland’s public services will need an additional £27bn to cope with the increased demands in health, social care and justice alone due to the consequences of an ageing society and ill health. There is much in this budget that Age Scotland welcomes most notably a commitment, in principle, to retaining Free Personal and Nursing Care, no restriction on eligibility criteria for the concessionary travel scheme and a £70m Change Fund to invest in community-based health and social care services for older people. However unfortunately the Scottish Budget does not go far enough in addressing the long terms issues prevalent with an ageing population with no new investment for community transport and no emphasis on how the Government can invest in more preventative services and encourage independent living for as long as possible.
Free Personal and Nursing Care  
Age Scotland was delighted to see unanimous Parliamentary support expressed in June 2010 for the principle of free personal and nursing care in particular the motion noting that the Parliament “reaffirms its commitment to free personal and nursing care for the long term so that Scotland’s elderly population can continue to receive the care to which it is entitled”. We commend the Scottish Government and the COSLA leadership for detailing in their draft budget that agreement was reached that the local authority settlement includes monies to “continue to fund free personal care.”

Age Scotland recognises there have been a number of problems associated with the policy since its implementation in 2002. In particular there are questions about the future sustainability of the policy, raised by senior local government leaders, given the ageing demographics of the Scottish population and the pressure this will put on budgets. Between 2006-07 and 2008-09, the cost of free personal care for older people increased from £321.5 million to £376.5 million and while these monies are significant we would ask MSPs to consider the significant savings that Free Personal Care deliver across other budget lines.

Currently there are 44,600 people receiving Free Personal Care in their own homes in Scotland at an average cost of £5,750 per year. By contrast, the average cost of a residential care home place is £23,000 a year. There is also evidence from studies by the Joseph Rowntree Foundation and the Policy Exchange that indicate that for every extra £1 spent on a range of services to promote health, well-being and independence in older people, there is approximately a £1.20 additional benefit in preventing or delaying the need for higher intensity (and more expensive) care. The Policy Exchange evaluation found that overnight hospital stays were reduced by 47% and use of A&E departments by 29%. Restricting free personal care would not save money in the long run as many people who currently receive it at home would move into care homes, costing the public purse far more than free personal care does.

To meet the growing demand the answer is not for central government to restrict one of the most successful and popular policies enacted since devolution, but instead to work with partners across the public and third sector to develop wider planning for an ageing population that goes beyond just looking at care. Age Scotland are working with the Scottish Government on their ’Reshaping the care of older people’ programme, which is a much needed step in the right direction, but there needs to be a stronger emphasis on looking how Government can invest in more preventative services and encourage independent living for as long as possible.

Local Government Settlement  
The Local Government settlement will fall by 2.6% for those that implement a council freeze and 6.4% for those that do not. While we recognise that local Government has to take it share of the cuts and we recognise that (presuming all authorities freeze their council tax) the budget does not fall below the 34.5% share allocated in 2010/11, the cuts to local authority budget lines will
have major implications for the delivery of public services that older people rely on. While we are pleased that the Scottish Government and COSLA’s leadership recognise the importance of the social care system and highlight in the budget document priorities including

- Free Personal Care payments will continue to be uprated by inflation in 2011/12
- Delivering on the carers and young carers strategy.
- Pooling of resources between health boards and local authorities to redesign services that focus on community based care.

We are concerned about local government’s ability to deliver on these challenging targets. Many vital public services are already underfunded and the council tax freeze over the last three years (which we recognise that helped many older people on fixed incomes), has squeezed out much of the real efficiency savings that were possible. Any future efficiency savings will undoubtedly impact on front line services such as home care and supporting people budgets; and low level preventative services and resources that older people value and depend on.

**Health and Social Care Settlement**

Age Scotland welcome the ‘Change Fund’ of £70m in 2011/12 which will be managed by Health Boards to enable the redesign of services that support shifting the balance of care for older people towards prevention through primary and community care. By investing in the ‘Change Fund’ and involving third sector organisations as partners alongside the NHS and local authorities the Government are tapping into an expertise that will tackle delayed discharges, reduce unplanned emergency admissions to hospital, and make more innovative use of care home placements alongside improvements in care-at-home provision and housing-related support.

The potential joint working between local government, the third sector and the NHS is particularly welcome. The pooling of health and social care budgets between health board and local authorities previously announced by the Health Minister Shona Robison, coupled with the new change fund will allow public bodies to focus on improvements in older people’s services. Age Scotland believes this pooling of budgets could be a catalyst for change in promoting more effective joint planning and delivery of services across the health, social care and housing spectrum if the obvious bureaucratic hurdles can be overcome swiftly. We hope this change, in conjunction with the Government’s on-going ‘Re-shaping Care for Older People’ agenda, can drive forward progress and provide better support to older people in their own homes and communities, but we consider that structural change might be necessary for the most efficient delivery and seamless service to older people, and an end to postcode variations in the standards of social care.

Age Scotland recognises the Scottish Government priority to ensure that the Health Budget in Scotland receives the full Barnett consequential of £280m towards its resource budget with level 2 spending falling from 11.18bn in 2010/11 to £11.15bn in 2011/12. Our ageing population means that the NHS will still be subject to budgetary pressures therefore the focus of health
spending must shift from acute hospital based care to more preventative interventions.

Two-thirds of patients cared for in hospitals are people aged 65 and over. Three principal reasons for unplanned readmission within 28 days of discharge have been identified: a relapse of, or complications with, the original condition; the development of a new problem; and unaddressed medical or social problems. Support and referrals at discharge from GPs, ward/A&E staff, paramedics, carers, service users and others, including third sector organisation and the appropriate through care once back in their own home can have very positive outcomes for older people and offer excellent value for money.

Fuel Poverty
The latest fuel poverty figures show a huge jump in fuel poor households across Scotland: 65% of single pensioner households (242,000) and 49% of older smaller households (190,000) are fuel poor, while 23% of single pensioner household (87,000) and 20% of older smaller households (77,000) are in extreme fuel poverty. These figures are much higher than for any other demographic group demonstrating older people are more likely than any other household types to experience fuel poverty. These figures are up from the previous year where 54% of single pensioner households (190,000) and 42% of older smaller households (151,000) were in fuel poverty and 18% of single pensioner household (68,000) and 9% of older smaller households (36,000) were in extreme fuel poverty.

Despite these figures the recently announced Housing budget shows a reduction of £20.7 million, in cash terms, for the budget area (Supporting Sustainability) that tackles fuel poverty.

With a recent record high 770,000 households (33% of households) now in fuel poverty and older households still the worst affected by fuel poverty (432,000) it is unthinkable that the Scottish Government should consider reducing support for their flagship fuel poverty programmes when they should be consolidating spending in this area.

The Energy Assistance Package addresses this problem through being more closely focussed on vulnerable fuel poor households than the Central Heating and Warm Deal Programmes and this should ensure that a greater number of fuel poor households receive help than was the case previously. The interventions delivered by the EAP also offer greater benefits than those available under the CHP, particularly for rural and hard-to-treat houses. Indeed we note preventative spend nature of fuel poverty programmes that shows that £1 spent on fuel poverty will not only reduce the cost to the NHS by 42p, but also shift spending from fuel and towards the high street economy, however, if the budget of £60 million is decimated, the EAP will not eliminate fuel poverty in Scotland.

While we welcome the continuation of the Energy Assistance Package and the Home Insulation package, programmes which are vital in tackling the fuel
poverty Age Scotland is calling for the Scottish Government to provide greater clarity about future monies to tackle fuel poverty and provide assurances that the EAP will not have its funding decimated despite the reductions announced to the Housing budget.

Third Sector Budget
We welcome the increase in the core Third Sector Budget from £20.7m this year to £24m in 2011/12 – an increase of 16%. Given Scottish Government intention to legislate to increase the take up of self-directed support so that users of care services can choose to purchase their own services instead of using local authority services, this investment is crucial in helping build the size and scope of the independent community care sector in Scotland.

Age Scotland believe that Self-Directed support will only become a reality if there is a developed market for care users to purchase service from the third sector and private sector otherwise local authority are provision will remain the norm across the country.

Further we welcome the commitment through the budget to include the third sector more closely in the public service re-design and delivery. Where Third Sector organisations are working with public sector purchasers to design and deliver public services - collaboration across the public sector has the potential to achieve better results with regard to both quality and cost. For example ROAR is a consortium of voluntary and social economy organisations, based in Renfrewshire; working together to offer low level care and befriending services for older adult. However central to this aspiration is building up the capacity of the sector through grant and local funding.

Conclusion
There is much in this budget that Age Scotland can commend, including the continuation of the National Concessionary Travel Scheme, support for Free personal and an increase in money to support and develop the third sector.

Age Scotland welcomes the Scottish Government’s support for these key policy areas in the draft budget and also recognises the potential effect that the £70m change fund and pooling and health and social care budge could have on the delivery of social care services in Scotland. Age Scotland believes this pooling of budgets could be a catalyst for change in promoting more effective joint planning and delivery of services across the health, social care and housing spectrum but it may need to be accompanied by structural change to enable seamless services to older people, and an end to postcode variation in social care.

To affect lasting change for Scotland’s older people these programmes must go hand in hand with better support for older people to live in their own homes and communities and a recognition of the preventative spend measures of key social programmes such as the Energy Assistance Programme and a greater investment in community transport to support older people living in rural and remote areas.
Glasgow Council Leader Gordon Matheson says "What I am saying is that these kind of issues must be on the table. We look at the challenges we know face and that includes universal free personal care." Scotland on Sunday 22nd August 2010

Douglas Yates, an SNP councillor in East Renfrewshire and Cosla spokesman on health and social care, told the Sunday Herald free personal care was now clearly "unsustainable" given shrinking budgets and rising demand.

Shona Robison MSP, Scottish Older People’s Assembly, Glasgow, November 7th 2011

2009 Scottish House Condition Survey

http://www.communiesscotland.gov.uk/stellent/groups/public/documents/webpages/cs_021319.hcsp
2011-12 Draft Budget

At the meeting of the Health and Sport Committee yesterday, I undertook to provide additional information to support the Committee's scrutiny of the 2011-12 Draft Budget. The information is provided below under each of the headings helpfully provided by your support team.

NICOLA STURGEON
1. Information on ISD figures raised by Mary Scanlon on an £95 million increase in administration costs between 2007 and 2010 (comprising £32 million increase in hospital sector admin and £63 million increase in community sector admin costs).

Since 2007, a number of changes have been made to the way that administration costs are reported, which means that costs previously excluded, have now been added to the report and therefore figures between 2007 and 2010 are not directly comparable. For example, it was agreed that administration costs reported in note 6 of the annual accounts would be included for which brought in the following costs for the first time:

- Administration of Board Meetings and Committees
- Corporate Governance and Statutory Reporting
- Health Planning, Commissioning and Performance Reporting
- Treasury Management and Financial Planning

In the 2009-10 annual accounts of NHS Boards, the total note 6 costs for Boards included in the costs book was £86 million. In addition to these changes, some costs associated with the items below have been reclassified as administration costs

- health promotion and health education
- a number of other functions such as pharmacy, catering, property maintenance and transport

2. A detailed breakdown of the £47 million increase in the levels of resource transfers from health boards to local authorities for Free Personal Care (FPC).

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>2009-10</th>
<th>2006-07</th>
<th>Increase / (Decrease)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>27.3</td>
<td>23.6</td>
<td>3.7</td>
</tr>
<tr>
<td>Borders</td>
<td>2.5</td>
<td>-</td>
<td>2.5</td>
</tr>
<tr>
<td>Fife</td>
<td>15.9</td>
<td>13.6</td>
<td>2.3</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>121.2</td>
<td>106.8</td>
<td>14.4</td>
</tr>
<tr>
<td>Highland</td>
<td>15.0</td>
<td>4.1</td>
<td>10.9</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>33.6</td>
<td>27.8</td>
<td>5.7</td>
</tr>
<tr>
<td>Grampian</td>
<td>31.9</td>
<td>29.6</td>
<td>2.3</td>
</tr>
<tr>
<td>Orkney</td>
<td>2.6</td>
<td>2.6</td>
<td>0.1</td>
</tr>
<tr>
<td>Lothian</td>
<td>36.0</td>
<td>31.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Tayside</td>
<td>18.8</td>
<td>18.9</td>
<td>(0.2)</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>17.6</td>
<td>17.1</td>
<td>0.5</td>
</tr>
<tr>
<td>Western Isles</td>
<td>1.9</td>
<td>0.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>8.1</td>
<td>8.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Shetland</td>
<td>0.2</td>
<td>0.7</td>
<td>(0.5)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>332.6</strong></td>
<td><strong>284.7</strong></td>
<td><strong>47.9</strong></td>
</tr>
</tbody>
</table>

Notes

- The £47.9 million increase reported in the 2009-10 Cost Book reflects additional expenditure by Boards to Local Authorities in respect of resource transfer – see section 4 below.
- Plans are being developed to further improve the quality of resource transfer information with ISD, also recognising the introduction of the Change Fund from 2011.

3. Details of the integrated resource network pilots undertaken by health boards as part of the £70 million Change Fund, and the outcomes of those pilots.
Change Fund

The Scottish Government is allocating £70 million from within the NHS Budget to a Change Fund in 2011-12 to enable NHS Boards and partner local authorities, together with the third and independent sectors, to redesign services to support the delivery of improved care outcomes for the growing older population.

Access to the fund will be contingent on local Partnerships – NHS, local authorities and third and independent sector representation – drawing up joint plans for its use. Local change plans will be prepared and submitted through local Community Planning Partnership processes, and it will up to each Partnership to agree how to achieve this through local delegated and devolved arrangements.

Guidance is under development with key partners from the above sectors and will issue by the end of this year. Key outcomes and measures of success for use of the Change Fund will include, amongst others, the role of unpaid carers and their support needs.

The shared/Partnership nature of the Change Fund builds on the principles of integrated resourcing currently being explored within the Integrated Resource Framework test sites, further details of which are provided below.

Integrated Resource Framework (IRF)

The IRF has been developed jointly by the Scottish Government, NHS Scotland and COSLA, through the Shifting the Balance of Care Delivery Group, in response to the shared strategic objective to shift the balance of care by working in a more integrated way, both within the NHS and also across health and social care.

The objective of the programme is to enable partners to make investment choices informed by a comprehensive understanding of current resource and activity patterns, across the whole health and social care system at locality/CHP level. By providing Boards and their local authority partners with the information required to plan strategically and review services more effectively, partners will be able to realign their resources accordingly to support shifts in clinical/care activity within and across health and social care systems.

More effective integration will improve people's experience of services, and enable better models of care to be provided without necessarily incurring additional cost.

The IRF development process has two main components:

- **Phase 1**: Explicit mapping of patient and locality level cost and activity information for health and adult social care, to provide a detailed understanding of existing resource profiles for partnership populations;

- **Phase 2**: Implementation of agreed and transparent mechanisms that allow resource to flow between partners, following the patient to the care setting that delivers the best outcomes.

Four test sites are taking forward the second phase of the IRF, which will develop and implement mechanisms for shifting resources both within the NHS, and between the NHS and local authority partners.
The test sites (4 Health Boards and 12 Councils) are:

- NHS Highland with Argyll & Bute Council and Highland Council;
- NHS Tayside with Angus Council, Dundee City Council and Perth and Kinross Council;
- NHS Ayrshire and Arran with East Ayrshire Council, North Ayrshire Council and South Ayrshire Council;

The work undertaken by all NHS Boards under phase 1 will help inform partnership decisions as part of their Delivery Plans for the Change Fund. Learning from the test sites is also being shared with other partnerships on an on-going basis.

4. Information on the progress of targets agreed between the Government and local authorities in return for the additional £47 million for FPC.

The £47.9 million increase reflects additional expenditure by Boards to Local Authorities on resource transfer primarily relating to:

- provision of community based services as an alternative to long-stay inpatient care and respite beds.
- delayed discharge funding for local authority services that support discharge from in-patient beds.

In terms of Free Personal Nursing Care (FPNC), the allocation to Local Authorities is made through the local government block grant mechanism and is separate from Health Board funding. I set out in my statements to Parliament on 7 and 15 May 2008 the Scottish Government’s response to Lord Sutherland’s independent review of FPNC. I confirmed that all the recommendations made by Lord Sutherland had been accepted by the Scottish Government and would form part of a wider package of measures being developed with local government:

These commitments, all of which have been implemented, included:

- the provision of £40 million in additional funding to local authorities from 2009-10 to stabilise the policy.
- developing proposals to establish a common eligibility framework and consistent approach to waiting lists.
- accelerating implementation of the Single Shared Assessment model.
- active monitoring of care needs.
- legislation to clarify the issue of food preparation.
- improving the understanding of service users and carers about access to care services.
- enhancing financial and performance monitoring systems.

Over the last six years there has been an increase in Local Authority expenditure on FPNC for self-funding residents in care homes of 23.4% from £83.3 million in 2003-04 to £102.8 million in 2008-09. This is new expenditure arising as a result of the FPC policy.

Over the last six years there has been an increase in Local Authority expenditure on personal care at home of 112.6% from £128.8 million in 2003-04 to £273.7 million in 2008-09.
Expenditure on home care clients is not all new expenditure attributable to the free personal care policy as it is estimated that local authorities were spending at least £64.5 million on personal care services in 2001-02.

This increase in expenditure is due to:

- increase in number of clients receiving personal care at home – increase of 34% between 2003-04 and 2008-09.
- a continuing shift in the balance of care towards more care at home, resulting in larger packages of care at home and increasing proportion of home care clients requiring personal care.
- introduction of equal pay provision in many local authorities resulting in higher wage costs.
- re-imbursement of charges for meal preparation in a small number of local authorities.

Free Personal and Nursing Care has been one of the most high profile and defining policies introduced since devolution. It currently touches and improves the lives of over 50,000 older vulnerable people in Scotland.

5. Information on shared service collaboration, and the role the Third Sector might play in service delivery, as part of the delivery of the £70 million Change Fund.

The purpose of the Fund is not simply to plug gaps in current patterns of delivery. Partnerships’ plans will need to demonstrate that systems and relationships are in place locally to deliver significant changes in service planning and provision with a focus on innovation and development in community settings. The Fund is to be used to support partnership ambitions and as such is distinct from Resource Transfer or aligned budget approaches.

Developments undertaken using the Change Fund will build on the wide range of innovative work already underway across Scotland, including the Integrated Resource Framework (IRF, the Long Term Conditions Action Plan, the Rehabilitation Framework, Self Directed Support, Dementia and Carers Strategies and the development of improved Local Housing Strategies with better links to Shifting the Balance of Care and related service redesign initiatives such as re-ablement, telecare and intermediate care.

Key measures of success or outputs from use of the Change Fund are likely to include:

- Reduction in unplanned acute bed-days in the over 75 population;
- Reduction in bed-days lost to delayed discharge;
- Remodelled care home use;
- Increase in proportion of older people living at home;
- Improved support for unpaid carers; and
- Increases in housing related support.

Guidance on the use of the Change Fund will make it very clear that the third sector should be involved as an equal partner in the planning, development and delivery of changes to be made to service provision.

6. Information on the delivery of the Government’s eHealth / telehealth targets for 2010-11. £100 million was spent from an allocated budget of £134 million. Where were the efficiencies savings made that allowed the Government to deliver its 2010-11 eHealth targets for £100m?

St Andrew's House, Regent Road, Edinburgh  EH1 3DG

www.scotland.gov.uk
What efficiencies is the Government basing its decision on to allocate a budget of £90 million for its eHealth / telehealth targets for 2011-12.

The eHealth baseline going into SR10 was £100m. 2010-11 out-turn is likely to be around £120m. This reflects the fact that the budget was set over the three year period of the eHealth Strategy which ends in 2011. 2010-11 is a planned peak of year of expenditure as the final year of the strategy but was not intended to set a new baseline.

The reduction from £134 million reflects the phasing of the programme over the three year period and more efficient procurement and implementation of services. Total revenue expenditure over the three years approaches £300m.

Around 80% of the baseline budget pays for existing services such as the NHS broadband contract, the national PACS service, IT for GPs and depreciation on nationally held assets like software licences. The remaining budget represents investment funds aimed at the objectives set out in the Government’s eHealth Strategy. Over the last three years this has focused on improving IT assets that enable improvements in healthcare. In particular:

- a new national contract for IT supporting GPs across Scotland;
- a new national contract for a hospital patient management system that will cover around 70% of Scotland over the next few years;
- a national systems integration capability, roll out of a new systems supporting sexual health clinicians, national PACS;
- a new Theatres system;
- a chemotherapy prescribing system; and
- investment in the telecare programme.

On a smaller scale or where more significant expenditure is still expected this year:

- pilot projects around long term conditions management;
- an efficiency programme focused on replacing the use of paper; and
- a range of investments supporting the development of the clinical portal programme.

The focus of the last three years on asset procurement will be followed by an improvement based approach with less capital investment and a shift from implementation of new functionality to maximising the benefits arising from these new assets. NHS Boards have agreed through the eHealth Strategy Board that we now have enough new capability available to us to support service improvement in Boards. The next strategy will, therefore, be based on improvement outcomes rather than technology purchase or implementation.

The revenue fund of £90m for 2011-12 is sufficient to provide support for Boards to take forward such an improvement based agenda. Over the course of this financial year NHS Boards have worked closely with the Scottish Government to agree efficiency improvements in existing expenditure to further focus on the improvement agenda. The target for 2011-12 is £6m in efficiency savings that will contribute to a £16m improvement fund allocated to territorial boards to improve patient care through the use of the substantial assets that have been procured.
7. Information on the NHS has been performing on HEAT targets, especially those targets focussing on health inequalities [relates to the second recommendation on page 4 of the submission from Andrew Walker on HEAT targets – see meeting paper HS/S3/10/36/5];

Performance against HEAT targets is reported through Scotland Performs: http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance

Whilst a range of HEAT targets contribute to reducing health inequalities (for example alcohol brief interventions, suicide prevention, CAMHS, and access to drug and alcohol misuse services), however, specifically the ‘H – health improvement’ targets make a direct contribution to tackling health inequalities. Furthermore, within the suite of H targets, the number of targets that explicitly focus on inequalities has increased year on year, and are set out below.

HEAT 2009/10 Targets

The following target explicitly focused on inequalities:

- Achieve an agreed number of inequalities targeted cardiovascular Health Checks during 2009/10.

In 2009/10 NHSScotland delivered 29,433 inequalities targeted cardiovascular health checks against a target of 28,455.

HEAT 2010/11 Targets

The following targets explicitly focused on inequalities:

- Achieve an agreed number of inequalities targeted cardiovascular Health Checks during 2010/11.
- At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.

HEAT 2011/12 Targets

The following targets explicitly focused on inequalities:
• Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2011/12.
• Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014.
• NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.
• At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.

The expected impact of the budget, with respect to inequalities is:

• Reducing inequalities in health is critical for achieving our aim of making Scotland a better, healthier place for everyone. The aim of the Keep Well programme of inequalities targeted health checks, delivered through enhanced primary care services is to increase the healthy life expectancy of our most deprived populations and thereby have a significant impact on unequal health outcomes.

• Maintaining a healthy weight during childhood is important for both physical health and mental wellbeing. The best start in maintaining a healthy weight is through breastfeeding. Being overweight or obese during childhood is a health concern in itself, but when it continues into adulthood it can lead to physical and mental health problems, such as heart disease, diabetes, osteoarthritis, increased risk of certain cancers, low self-esteem and depression.

• The Scottish Government remains committed to driving down smoking levels further. NHS Boards will continue to deliver a universal smoking cessation service, and there is an emphasis on helping people in deprived areas.

• To increase the number of children who are decay free at age 5 years, particularly addressing inequalities. Dental decay is almost totally preventable but is the single most common reason to admit children to hospital in Scotland and accounts for significant pain and discomfort to the child and to absence from school.

8. Information on the main HEAT targets and identify the 2 or 3 main budget lines which feed into supporting the delivery of each target.

There is not a 1-to-1 relationship between the HEAT targets and budget lines.

The NHS and Special Health Board budget line supports delivery of all HEAT targets and accordingly we have not separately identified any component of this budget line for any specific target.

The Improvement and Support of the NHS budget line supports the delivery of HEAT targets and other priorities through a combination of improvement programmes and more tailored performance support for NHS Boards. During 2011/12, the team will deploy its resources in support of cancer and elective waiting times, access to mental health services, the NHS Efficiency & Productivity Programme and performance support to NHS boards where the need for additional support is identified or requested.
<table>
<thead>
<tr>
<th>HEAT Target 2011/12</th>
<th>2011/12 Budget line (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines during 2011/12.</td>
<td>Alcohol Misuse [42.3]</td>
</tr>
<tr>
<td>Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2011/12.</td>
<td>Health Improvement and Health Inequalities [58.5]</td>
</tr>
<tr>
<td>Reduce suicide rate between 2002 and 2013 by 20%</td>
<td>Mental Wellbeing [6.0]</td>
</tr>
<tr>
<td>Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014.</td>
<td>Health Improvement and Health Inequalities [58.5]</td>
</tr>
<tr>
<td>NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.</td>
<td>Tobacco Control [12.3]</td>
</tr>
<tr>
<td>At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.</td>
<td>Health Improvement and Health Inequalities [58.5]</td>
</tr>
<tr>
<td>NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.</td>
<td></td>
</tr>
<tr>
<td>NHS Boards to deliver a 3% efficiency saving to reinvest in frontline services</td>
<td></td>
</tr>
<tr>
<td>NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.</td>
<td>Capital [488.2]</td>
</tr>
<tr>
<td>From the quarter ending December 2011, 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.</td>
<td>Access Support for the NHS [101.3]</td>
</tr>
<tr>
<td>Deliver 18 weeks referral to treatment from 31 December 2011.</td>
<td>Access Support for the NHS [101.3]</td>
</tr>
<tr>
<td>By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</td>
<td>Alcohol Misuse [42.3]</td>
</tr>
<tr>
<td>Drug Misuse [31.9]</td>
<td></td>
</tr>
<tr>
<td>Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; and 18 weeks referral to treatment for Psychological Therapies from December 2014.</td>
<td>Mental Health Legislation and Services [15.3]</td>
</tr>
<tr>
<td>Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors.</td>
<td>Local Partnerships should use Health and Social care change fund for older people [70.0] to support delivery.</td>
</tr>
<tr>
<td>To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.</td>
<td></td>
</tr>
<tr>
<td>Further reduce healthcare associated infections</td>
<td>Clean Hospitals / MRSA Screening Programme</td>
</tr>
<tr>
<td>HEAT Target 2011/12</td>
<td>2011/12 Budget line [£m]</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.</td>
<td>[28.4]</td>
</tr>
<tr>
<td>To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&amp;E between 2009/10 and 2013/14.</td>
<td>Miscellaneous Other Services [152.3]</td>
</tr>
</tbody>
</table>
9. Publication of (or notification if already published) of the list of legally committed capital projects which will require funding from the capital budget.

**Legally Committed Capital Projects 2011-12**

<table>
<thead>
<tr>
<th>NHS Dumfries and Galloway</th>
<th>Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Dumfries and Galloway</td>
<td>North West Dumfries Primary Care Centre</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>General Hospital and Maternity Services</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>Cupar Community Health</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>Equipping of New Acute Hospital</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>Aberdeen Emergency Care Centre</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>Forresterhill Energy Centre</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>Chalmers Hospital/ Health Centre</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td>Clyde Mental Health Strategy</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td>Possilpark Medical Centre</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td>Alexandria Medical Centre</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>Mull &amp; Iona</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>Migdale Community Hospital</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>Airdrie Resource Centre</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>Royal Victoria Hospital</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>Musselburgh</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>Nuclear Medicine, Ninewells</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>Equipment - Tayside Mental Health NPD Project</td>
</tr>
<tr>
<td>National Commitment</td>
<td>Primary Care Modernisation Programme</td>
</tr>
<tr>
<td>National Commitment</td>
<td>IFRS reversionary interest on PFI projects</td>
</tr>
<tr>
<td>National Services Scotland</td>
<td>Accommodation (Glasgow - Meridian)</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>Vehicle Replacement</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>Defibrillator Replacement</td>
</tr>
<tr>
<td>State Hospital</td>
<td>State Hospital Refurbishment</td>
</tr>
</tbody>
</table>

**Notes**

The legally committed element of the New South Glasgow Hospitals Project represents Phase 1 covering the development of laboratories, facilities management building, new city mortuary and electrical supply for the Southern General site and enabling works. This forms part of the £842 million project to which the Scottish Government is fully committed.

Approval of full business cases in respect of North West Dumfries Primary Care Centre, Possilpark Medical Centre and Alexandria Medical Centre were scheduled to fall into financial year 2010-11. Financial close was predicated on such approval.