HEALTH AND SPORT COMMITTEE

AGENDA

3rd Meeting, 2011 (Session 3)

Wednesday 23 February 2011

The Committee will meet at 10.00 am in Committee Room 1.

1. **Health and Social Care Bill (UK Parliament legislation):** The Committee will take evidence on legislative consent memorandum LCM (S3) 33.1 from—

   Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing, Alastair Pringle, Head of Patient Focus and Equalities, Directorate of Chief Nursing Officer, Patients, Public and Health Professions, Jenny Long, Policy Manager, Health and Healthcare Improvement Directorate, and Kathleen Preston, Health and Community Care Solicitor, Legal Directorate, Scottish Government.

2. **Subordinate legislation:** The Committee will take evidence on the Public Services Reform (Social Services Inspections) (Scotland) Regulations 2011; the Public Services Reform (Joint Inspections) (Scotland) Regulations 2011; the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011; the Healthcare Improvement Scotland (Inspections) Regulations 2011; the Public Services Reform (Scotland) Act 2010 (Consequential Modifications) Order 2011, and the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 from—

   Shona Robison MSP, Minister for Public Health and Sport, Anne Aitken, Head of Health Quality Branch, Quality Division, Adam Rennie, Deputy Director of Community Care, and Kirsty McGrath, Solicitor, Food, Health and Community Care Division, Scottish Government.

3. **Subordinate legislation:** Shona Robison MSP (Minister for Public Health and Sport) to move S3M-07795—

   That the Health and Sport Committee recommends that the Public Services Reform (Social Services Inspections) (Scotland) Regulations 2011 be approved.
4. **Subordinate legislation:** Shona Robison MSP (Minister for Public Health and Sport) to move S3M-07796—

   That the Health and Sport Committee recommends that the Public Services Reform (Joint Inspections) (Scotland) Regulations 2011 be approved.

5. **Subordinate legislation:** Shona Robison MSP (Minister for Public Health and Sport) to move S3M-07797—

   That the Parliament recommends that the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 be approved.

6. **Subordinate legislation:** Shona Robison MSP (Minister for Public Health and Sport) to move S3M-07798—

   That the Health and Sport Committee recommends that the Healthcare Improvement Scotland (Inspections) Regulations 2011 be approved.

7. **Subordinate legislation:** The Committee will consider the following negative instruments—

   the Social Care and Social Work Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI/2011/26);
   the Social Care and Social Work Improvement Scotland (Fees) Order 2011 (SSI/2011/27);
   the Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 (SSI/2011/28);
   the Social Care and Social Work Improvement Scotland (Applications) Order 2011 (SSI/2011/29);
   the Healthcare Improvement Scotland (Fees) Regulations 2011 (SSI/2011/33);
   the Healthcare Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI/2011/34); and
   the Healthcare Improvement Scotland (Applications and Registration) Regulations 2011 (SSI/2011/35).

8. **Health and Social Care Bill (UK Parliament legislation) (in private):** The Committee will consider its approach to its draft report on legislative consent memorandum LCM (S3) 33.1.

9. **Legacy paper (in private):** The Committee will consider a draft legacy paper.
The papers for this meeting are as follows—

**Agenda Item 1**

Note by the clerk  
Submission from Health Professions Council  
Submission from Health Protection Scotland  
Submission from NHS National Services Scotland  
Submission from RCGP Scotland  
Submission from NHS Tayside  
Submission from NHS Greater Glasgow and Clyde  
UNISON Health and Social Care Bill (UK) LCM response

**Agenda Item 2**

Letter from the Minister for Public Health and Sport  
Note by the clerk

*The Public Services Reform (Social Services Inspections) (Scotland) Regulations 2011*

*The Public Services Reform (Joint Inspections) (Scotland) Regulations 2011*

*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

*The Healthcare Improvement Scotland (Inspections) Regulations 2011*

*The Public Services Reform (Scotland) Act 2010 (Consequential Modifications) Order 2011*

*The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011*

**Agenda Item 7**

Note by the clerk

*The Social Care and Social Work Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI/2011/26)*
The Social Care and Social Work Improvement Scotland (Fees) Order 2011 (SSI/2011/27)

The Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 (SSI/2011/28)


The Healthcare Improvement Scotland (Fees) Regulations 2011 (SSI/2011/33)

The Healthcare Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI/2011/34)

The Healthcare Improvement Scotland (Applications and Registration) Regulations 2011 (SSI/2011/35)

Agenda Item 9

PRIVATE PAPER

HS/S3/11/3/11 (P)
Legislative Consent Memorandum – Health and Social Care Bill (UK Legislation)

Background

1. The Health and Social Care Bill was introduced in the House of Commons on 19 January 2011 and is available on the UK Parliament’s website.¹

2. The overarching stated aim of the Health and Social Care Bill is to establish a sustainable national framework for the NHS in England, create a Health Service more responsive to patients, and deliver on the commitment to reduce bureaucracy.

3. As it makes provisions for purposes that lie within the competence of the Scottish Parliament, or that will alter that legislative competence or the executive competence of the Scottish Ministers, a legislative consent memorandum (“LCM”), annexed at annexe A, has been lodged by the Scottish Government under chapter 9B of the Standing Orders. The Parliamentary Bureau has designated the Health and Sport Committee as lead committee in respect of the memorandum.

4. The Cabinet Secretary for Health and Wellbeing will attend the meeting of the Committee on to give evidence on the LCM.

5. The LCM must set out the background to the relevant bill and specify the extent to which the bill makes provision for any purpose within the legislative competence of the Parliament or alters that competence or the executive competence of the Scottish Ministers. The Parliamentary Bureau refers the memorandum to the relevant lead committee.

6. The lead committee must consider the LCM and make a report on its views to the Parliament, after which the Scottish Government is expected to lodge a legislative consent motion (a draft of which is set out in the LCM). The aim is for all of the parliamentary stages in the Scottish Parliament to be completed with due regard for the Westminster timetable for the Bill and, therefore, the Committee needs to produce its report promptly.

7. There is no set form for a committee’s report on an LCM and the report need not be long. However, in general terms, the Committee should bear in mind the following points—

   • the general merits of the relevant provisions contained within the bill identified within the LCM;

¹ http://services.parliament.uk/bills/2010-11/healthandsocialcare.html
• whether there is justification for use of the legislative consent procedure in respect of each of these provisions;
• whether there are any comments on the draft legislative consent motion contained within the LCM;
• whether to recommend to the Scottish Parliament to grant consent that the relevant provisions of the Bill be made.

8. At its meeting on 26 January 2011, the Committee agreed to invite Scottish health boards, and other relevant health bodies, to submit written comments they on the LCM. Six organisations took the opportunity to make a submission to the Committee: Health Protection Scotland; the Health Professionals Council; NHS National Services Scotland; RCGP Scotland; NHS Tayside; and NHS Greater Glasgow and Clyde. These submissions are included as papers for the meeting (HS/S3/11/3/2 – HS/S3/11/3/7).

9. Additionally, the following organisations responded to say that they had no substantive comments to make on the LCM: BMA Scotland; General Dental Council; GMC Scotland; NHS Ayrshire and Arran; NHS Shetland; and the Scottish Medicines Consortium.

For decision

10. Members are invited to agree either—

   a) to recommend, without further comment, to the Parliament that the motion on the LCM be agreed to; a report can be produced to this effect by the clerks, much in the manner of a report without comments on an affirmative instrument;

   b) to produce a report to the Parliament commenting on the LCM; if this option is preferred by the Committee, a report can be prepared by the clerks on the basis of today’s evidence session, for consideration at the next meeting of the Committee.

Dougie Wands
Clerk to the Committee
Draft Legislative Consent Motion

1. The draft motion, which will be lodged by the Cabinet Secretary for Health and Wellbeing, is:

   “That the Parliament agrees that the relevant provisions of the Health and Social Care Bill, introduced in the House of Commons on 19 January 2011, in respect of the establishment of the NHS Commissioning Board and GP commissioning consortia, abolition of the Health Protection Agency, duty of co-operation in relation to health protection functions, amendment of the Mental Health Act 1983, the Health and Social Care Information Centre, regulation of healthcare professions and health and social care workers, the National Institute for Health and Clinical Excellence and National Health Service /Health and Social Services contracts, so far as these matters fall within the legislative competence of the Parliament, or alter the executive competence of Scottish Ministers, should be considered by the UK Parliament.”

Background

2. This memorandum has been lodged by Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing, under Rule 9.B.3.1(a) of the Parliament’s standing orders. The Health and Social Care Bill was introduced in the House of Commons on 19 January 2011. The Bill can be found at:

   http://www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.int-v.html

3. It is appropriate that the Health and Social Care Bill makes provision for the matters detailed below that fall within the legislative competence of the Scottish Parliament, or alter the executive competence of the Scottish Ministers. There is no suitable Scottish Parliament Bill or statutory instrument in process that could be used to make the necessary changes in a timely manner, and therefore the most practical method to achieve these provisions is by means of the Health and Social Care Bill.

Content of the Health and Social Care Bill

4. The overarching stated aim of the Health and Social Care Bill is to establish a sustainable national framework for the NHS in England, create a Health Service more responsive to patients, and deliver on the commitment to reduce bureaucracy. These proposals flow from a number of commitments made in the Department of Health’s (DH) White Paper ‘Liberating the NHS’ (July 2010), and the Bill will include measures to:
• Establish an independent NHS Board to allocate resources and provide commissioning guidance, and to allow GPs to commission services on behalf of their patients
• Improve efficiency and outcomes by strengthening the role of the Care Quality Commission and developing Monitor into an economic regulator to oversee aspects of access and competition in the NHS
• Take forward proposals to significantly cut the number of health quangos, helping cut the cost of NHS administration by a third

5. There are seven areas where the Bill currently triggers the need for legislative consent, and these are discussed below:

- NHS Commissioning Board
- Abolition of the Health Protection Agency
- Mental Health Act 1983
- Health and Social Care Information Centre
- Regulation of healthcare professions and health and social care workers
- National Institute for Health and Clinical Excellence
- Non-consequential amendments

NHS Commissioning Board

Background

6. The Bill will establish the NHS Commissioning Board (NHSCB), which for England will:

- Provide national leadership on commissioning for quality improvement, for instance by developing commissioning guidelines based on quality standards and by designing tariffs and model NHS contracts
- Promote and extend public and patient involvement and choice
- Ensure the development of consortia and hold them to account for outcomes and financial performance
- Commission certain services that are not commissioned by GP consortia, such as the national and regional specialised services and primary care services
- Allocate and account for NHS resources

7. The NHSCB will be responsible for commissioning specialised and high secure services, which includes capacity for patients from the Devolved Administrations. The NHSCB will also be responsible for commissioning health care through GP consortia and for commissioning some primary care services.
Legislative consent

8. Currently the Common Services Agency, Health Boards and Special Health Boards can enter into arrangements with commissioners in England (Secretary of State, or Strategic Health Authorities acting on behalf of the Secretary of State) in order to secure services for patients in Scotland. To ensure this can continue within the new architecture in England, section 17A(2) of the National Health Service (Scotland) Act 1978 and section 9 of the National Health Service Act 2006 will be amended by the Bill to include the NHSCB. The GP commissioning consortia will also be added to section 17A(2) of the National Health Service (Scotland) Act 1978 and section 9 of the National Health Service Act 2006. This will allow Scottish NHS bodies to enter into arrangements with the NHSCB and GP commissioning consortia.

9. As amendment of the National Health Service (Scotland) Act 1978 is within the legislative competence of the Scottish Parliament, the proposed amendments will require the consent of the Parliament.

Financial implications

10. As now, the Scottish Government will be required to pay for services provided in England for Scottish patients. The provisions will allow for the Common Services Agency to enter into arrangements with the NHSCB to secure the provision of specialised services for Scottish patients from English providers, and will also allow for these services to be paid for. Establishment of the NHSCB should not in itself result in a change to the prices of these services.

Abolition of the Health Protection Agency

Background

11. The Secretary of State for Health wishes to take a more direct role in health protection in England and, to this end, the Health Protection Agency (HPA) is to be abolished in its current form and become part of the new Public Health Service (PHS) for England.

12. The HPA was established as a Non-Departmental Public Body (NDPB) under the Health Protection Agency Act 2004. This Act gives functions to the HPA, including health functions and radiation protection functions. In addition, the Act provides that the Scottish Ministers may, by order, confer devolved functions on the HPA to the extent that these relate to protection of the community against infectious disease and other dangers to health, prevention of the spread of infectious disease and provision of assistance to anyone in connection with these functions.

13. In 2003, an LCM was agreed to by the Parliament to allow the HPA to exercise certain health functions for Scotland, including functions connected to radiation in so far as they are devolved. In addition, two orders have been made by Scottish Ministers (The Health Protection Agency (Scottish Health Functions) Order 2006, and The Health Protection Agency (Scottish Health Functions) (Amendment) Order 2007), which conferred additional functions on the HPA. These included providing
advisory services to Scotland on chemicals, chemical incidents, clinical management of patients who have been poisoned and planning for public health emergencies, assessment of events in Scotland that may constitute a public health emergency of international concern and acting as the national International Health Regulations (IHR) focal point for Scotland as described in the IHR.

Legislative consent

14. The Bill proposes to abolish the HPA as a statutory organisation and the HPA Act will be repealed. Health protection functions that are not devolved to Scottish Ministers will be transferred to the Secretary of State for Health as part of the new Public Health Service for England.

15. Non-devolved functions currently undertaken by the HPA in relation to Scotland (such as the functions in relation to biological substances and most aspects of the radiation protection function) and UK wide functions such as the National Focal Point (under the International Health Regulations) will be provided for Scotland by Public Health England.

16. Scotland has made use of HPA advice for devolved functions as noted in paragraph 12 above, and to ensure Scotland can continue to access these services through the new PHS arrangement, it has been agreed to establish an agency agreement under section 93 of the Scotland Act 1998. This will allow Scottish Ministers to make arrangements for any of their specified functions to be undertaken by a Minister of the Crown. Under this agreement Scottish Ministers would retain the devolved functions but the Secretary of State would exercise them on our behalf.

17. A Memorandum of Understanding (MOU) will also be put in place with the new PHS for England to cover these issues. A separate MOU would also be required to cover reserved issues which may have an impact in Scotland, for example an incident at a nuclear power station taking place in Scotland. In addition, Scottish Ministers have agreed that the Secretary of State for Health should be designated as the national focal point under the International Health Regulations.

18. A duty of co-operation between bodies exercising functions in relation to health protection is also included in the Bill and this is intended to ensure co-operation between the four health administrations in the UK. This duty will therefore extend to Scottish Ministers and will allow them to recover any costs incurred in providing such co-operation, from the other bodies exercising functions in relation to health protection.

19. This approach will alter the executive competence of the Scottish Ministers and will therefore require the consent of the Scottish Parliament.

Financial implications

20. There are no new financial implications anticipated. Scottish Ministers currently pay the HPA for the services we access and would expect to pay the new Public Health Service for England in the same way.
Mental Health Act 1983

Background

21. The Bill proposes to amend section 122 of the Mental Health Act 1983 to remove the power of the Secretary of State to pay pocket money to persons who are receiving treatment as in-patients (whether liable to be detained or not) in hospitals wholly or mainly used for the treatment of persons suffering from mental disorder.

22. There is a similar provision under the Mental Health (Care and Treatment) (Scotland) Act 2003 for Scottish Ministers to make payments of pocket money to in-patients in hospital in Scotland.

23. However, section 122 of the Mental Health Act 1983 extends to Scotland. This appears to be an error that occurred when the 1983 Act was drafted, and is of no practical significance in any case since Scotland has no hospitals that would qualify for the purposes of this legislation. Scottish Ministers are therefore content that the UK Government should take the opportunity to correct this at the same time as section 122 is repealed for England.

Legislative consent

24. Since there would, technically, have been a transfer of competence to Scottish Ministers on devolution as regards section 122 of the 1983 Act, arguably, the repeal of that section in its extent to Scotland would amount to a “technical” alteration of competence of the Scottish Ministers. Therefore this will require the consent of the Scottish Parliament.

Financial implications

25. There are no financial implications associated with the mental health pocket money for in-hospital patients amendment.

Health and Social Care Information Centre

Background

26. The NHS Health and Social Care Information Centre is a national (for England) repository for data collection across health care, public health and adult social care. The Bill will establish the Information Centre (IC) in primary legislation, and place a clearer focus on data collections with a close working relationship with the NHS Commissioning Board.

27. The IC currently collects and publishes health and social care information, including annual earnings and expenses of general medical practitioners for the UK. The data is used to inform the Scottish evidence to the pay review bodies. The IC provides other services to the Scottish Government including services related to the NHS Central Register for Scotland and the Medical Research Information Service.
Legislative consent

28. In order that the services which the Scottish Government receives from the IC can continue, Section 9 of the National Health Service Act 2006 and Section 17A of the National Health Service (Scotland) Act 1978 will be amended by the Bill to include the new body. These sections detail the bodies which can enter into NHS Contracts. As amendment of the National Health Service (Scotland) Act 1978 is within the legislative competence of the Scottish Parliament, this provision requires the consent of the Parliament.

Financial implications

29. There are no financial implications associated with the change in statutory footing of the NHS Health and Social Care Information Centre.

Regulation of healthcare professions and health and social care workers

Background

30. For most of the currently regulated healthcare professions, regulation is reserved to Westminster. However, for those not regulated when the Scotland Act came into force in 1999, regulation is devolved to the Scottish Parliament. Currently, this includes only operating department practitioners and practitioner psychologists, regulated by the Health Professions Council (HPC); dental nurses, dental technicians, clinical dental technicians and orthodontic therapists, regulated by the General Dental Council (GDC); and pharmacy technicians, regulated by the General Pharmaceutical Council (GPhC). The future regulation of further professions is also devolved. The constitution of all the regulators is, however, reserved to Westminster, except for the devolved pharmacy body for Northern Ireland, and the GPhC, which was set up very recently by the Scottish Parliament as well as Westminster.

31. Historically, the Department of Health has taken the lead in taking forward the regulation of healthcare professions on a UK-wide basis, with input as appropriate from the other three countries, particularly in the devolved areas. UK-wide regulation by UK-wide regulators assists the cross-border flow of staff and ensures that the same standards are applied across the UK for particular groups of staff. The usual vehicle for regulating the healthcare professions is an order under section 60 of the Health Act 1999. Where a section 60 order makes provision in a devolved area it must be laid for approval by resolution of the Scottish Parliament as well as Westminster.

32. The Scottish Ministers and Ministers in Wales and Northern Ireland endorsed the contents of the previous UK Administration’s White Paper Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century, published in February 2007. This paper was part of the response to the Shipman Inquiry, and the primary aim of its policies was to improve patient safety and the quality of the care that patients receive from health professionals. Many of the policies in the White Paper have progressed significantly, including changes to the nine UK regulatory bodies, including the Council for Healthcare Regulatory Excellence (CHRE), which was set up by Westminster to scrutinise and quality assure the performance of those
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Annex A

regulators. Changes were made via the Health and Social Care Act 2008, for which an LCM was agreed, to enable the CHRE to take on a stronger and more independent role in providing expert advice on professional regulation. That Act also gave the Scottish Ministers the power to request advice from the CHRE on any matter connected with a profession appearing to be a health profession, and to require it to investigate and report on a particular matter. It also provided for one of the lay members of the CHRE to be appointed by the Scottish Ministers.

33. Work was also taken forward under the auspices of the 2007 White Paper in the Extending Professional Regulation Group (EPRG), whose report was endorsed by Ministers in all four countries. That report cited that the normal statutory regulation should not be the inevitable route for assuring the public that a healthcare professional was safe to practise. Instead, alternative methods, proportionate to the risks posed by the particular group, should be considered. Accredited voluntary registers were cited as one of those alternatives.

34. The report of the Department of Health’s review of Arms Length Bodies (ALB) in July 2010 confirmed that the CHRE would be removed from the ALB sector and made more independent. The current Health and Social Care Bill would give effect to this and also make some other related changes. It includes provisions to:

- Make the CHRE self-funding through levies paid by all the healthcare profession regulators, including the three which operate in devolved as well as reserved areas as explained above – the HPC, the GDC and the GPhC.
- Change the name of the CHRE to the Professional Standards Authority for Health and Social Care (PSAHSC).
- Extend the CHRE’s vires to social care in England.
- Allow the CHRE to charge fees, including for answering requests from Ministers for advice related to the regulation of healthcare professionals and (in England) social care workers.
- Give powers to the healthcare profession regulators to be able to hold voluntary registers for persons who are or have been members of an unregulated health profession, engaged in unregulated health care work, or participating in studies for the purpose of doing so.
- Extend the CHRE’S remit to enable it to set standards for, and quality assure, such voluntary registers.
- Abolish the Appointments Commission, which currently takes forward appointments to the healthcare professions regulatory bodies on behalf of the Privy Council.
- Give the CHRE the ability to provide advice or auditing services to the regulators or bodies which have functions corresponding to a regulator.

35. The report of the Department of Health ALB review also confirmed that the General Social Care Council (GSCC), which regulates social workers in England, would be abolished. The Bill will abolish the GSCC and transfer its regulatory function to the Health Professions Council (HPC), which it will rename as the Health and Social Care Professions Council. The HPC already regulates a wide range of healthcare professionals, including operating department practitioners and practitioner psychologists, whose regulation is devolved.
36. The Bill will amend section 60 of the Health Act 1999 to ensure that such orders can be made in future to regulate social workers in England and also social care workers in England. The regulation of these groups in Scotland is entirely devolved and a matter for the Scottish Social Services Council.

Legislative consent

37. There are a number of areas that require legislative consent, these are:

- The funding of the PSAHSC through a compulsory levy on the regulators and charging fees for advice provided, for investigations and reports, including for Ministerial requests for advice from the PSAHSC
- A new power for the PSAHSC to advise or provide auditing services to the regulatory bodies and bodies which have functions corresponding to those of a regulatory body, and to charge for this advice
- A new duty on the PSAHSC to lay its strategic reports before the four parliaments and assemblies
- New powers for the regulatory bodies and the PSAHSC to assist the Privy Council in the making of appointments to the regulators and to the PSAHSC
- New powers for the regulatory bodies to establish voluntary registers
- A new power for the PSAHSC to accredit such voluntary registers
- New additional functions imposed on the PSAHSC in relation to the accreditation of voluntary registers
- New powers for Privy Council Orders to effect transitional provisions, in so far as they relate to devolved matters
- New powers to allow the Scottish Ministers to make arrangements with the PSAHSC to assist them in the exercise of their power to appoint one member of the PSAHSC

38. The Bill provides for the new Health and Social Care Professions Council (previously the HPC) to provide administrative, technical or advisory services to any body or individual involved in maintaining registers of health or social care workers. As this impacts on the devolved functions of the HPC, and therefore the executive competence of Scottish Ministers, legislative consent is required.

Financial implications

39. The CHRE is currently entirely funded by Government, with all four UK countries contributing (Scotland contributed £223k for 2010-11). The Bill provides for Government to continue to fund the CHRE for the commissions it asks them to carry out; for the regulators themselves to pay levies to the CHRE for its performance management of them and any work around appointments to their Councils; and for the CHRE to charge organisations/ regulators for services they provide for them, including the accreditation of voluntary registers.

40. There will be a saving to the Scottish Government as its funding for the CHRE will reduce from its current share to paying its share of individual commissions. The cost of levies on the regulatory bodies, which are self-funded through the fees they charge, will inevitably be passed on to those on the statutory registers, but the
increases in fees should be low due to the number of registrants. Similarly, the payments that organisations and the regulators will have to pay to the CHRE for accrediting voluntary registers will be passed on to those registering on them.

National Institute for Health and Clinical Excellence

Background

41. The National Institute for Health and Clinical Excellence (NICE) provides national (for England) guidance on the promotion of good health and the prevention and treatment of ill-health. The Bill will establish NICE in primary legislation and expand its scope to include social care standards. The re-constituted NICE will provide advice and guidance to the Secretary of State and the NHS Commissioning Board on functions related to a comprehensive health service, including public health, other public health services and adult social care.

42. Scotland currently utilises a number of products and services from NICE, some of which are paid for. In addition, the NHS in Scotland (mainly through NHS QIS and Scottish clinicians; and to a lesser extent the Scottish Medicines Consortium) currently has commentator or observer status in a number of areas of NICE product development. Scotland also draws on the expertise of the NICE-led process whereby an independent advisory committee makes recommendations relating to the clinical indicators in the Quality and Outcomes Framework element of the GP contract, which are then used as a basis for UK negotiation with the BMA.

43. The Bill contains provisions allowing the Secretary of State to make regulations conferring powers on NICE regarding the supply of quality standards to Scottish Ministers on a commercial charging basis; the provision of advice to any persons regarding the provision of health care on a commercial charging basis; and the protection or improvement of public health or the provision of social care to be charged on the appropriate commercial basis. The Bill also provides that NICE may arrange with any person or body to provide or assist in providing any service which NICE is required or authorised to provide in the Bill and to charge for this.

Legislative consent

44. In order that the Scottish Government and NHS bodies in Scotland can continue to receive services from the re-constituted NICE, and given that NICE does not as of right currently exercise any statutory functions in Scotland, but instead exercises functions through agreement with our health service bodies and the Scottish Ministers, the Bill will amend section 9 of the National Health Service Act 2006 (NHS Contracts) to include NICE, the Scottish Ministers and NHS Health Improvement Scotland (NHS HIS) to the list of bodies allowed to enter into agreements for the supply of goods and services.

45. The Bill will make similar amendments to section 17A of the National Health Service (Scotland) Act 1978 to enable NICE to enter into NHS contracts under Scots Law. As amendment of the National Health Service (Scotland) Act 1978 is within the legislative competence of the Scottish Parliament, this will require the consent of the Parliament.
Financial implications

46. Currently some of the products and services Scotland utilises from NICE are paid for, however, in future a wider range of NICE products will potentially be charged for. Where NICE products which are currently utilised without charge and which might in future be provided on a commercial charging basis, consideration needs to be given to the benefits of doing so, or whether alternative arrangements would need to be developed within the NHS in Scotland.

Non-consequential amendments

Background and legislative consent

47. It is proposed that the Bill makes several non-consequential amendments to the National Health Service (Scotland) Act 1978, National Health Service (Wales) Act 2006, The Health and Personal Social Services (Northern Ireland) Order 1991 and National Health Service Act 2006 in order to rectify devolution anomalies or uncertainties, and specify Scottish Ministers as able to enter into National Health Service (NHS) / Health and Social Services (HSS) contracts in the appropriate Scottish, Welsh, Northern Irish or English legislation.

48. In addition, these amendments will include provisions for joint dispute-determination of NHS/HSS contracts to which English, Welsh, Scottish or Northern Irish health bodies are parties, in a similar manner to those already provided for dispute determination of Scottish NHS contracts to which Northern Irish health bodies are parties in Section 17(10) of the National Health Service (Scotland) Act 1978.

49. These amendments alter the functions and executive competence of Scottish Ministers and therefore will require the consent of the Scottish Parliament.

Financial implications

50. There are no financial implications associated with the non-consequential amendments.

Consultation

51. The UK Government consulted on the proposals for the Health and Social Care Bill as set out in its White Paper, Equity and Excellence: Liberating the NHS, published in July 2010, in a number of consultation documents all published in July 2010 and closed on 11 October 2010:

- Consultation: Transparency in outcomes: a framework for the NHS
- Consultation: Increasing democratic legitimacy in health
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- Consultation: Liberating the NHS: commissioning for patients
- Consultation: Liberating the NHS: regulating healthcare providers

52. In December 2010 the UK Government published its analysis of the consultation responses, *Liberating the NHS: Legislative framework and next steps.*

53. The UK Government considered that the response to the consultation demonstrated support for the principles set out in the White Paper. However, following consultation, some changes were made, including, for example, that commissioning of maternity services will sit with GP consortia; and local authorities’ formal scrutiny powers will be extended to cover all NHS-funded services, and they will have greater freedom in how these are exercised.

54. A full consultation with Scottish stakeholders has not taken place. This is because the Bill predominantly affects England and the main areas that require legislative consent from the Scottish Parliament are to ensure current arrangements can continue within the new healthcare architecture in England.

**Conclusion**

55. The view of the Scottish Government is that it is in the interests of the people of Scotland that the provisions of the Health and Social Care Bill, so far as these matters fall within the legislative competence of the Parliament or the executive competence of the Scottish Ministers, should be considered by the UK Parliament.

SCOTTISH GOVERNMENT
January 2011
Legislative Consent Memorandum on the Health and Social Care Bill

Health Professions Council

The Health Professions Council (HPC) is pleased to make this submission to the Health and Sport Committee. In our submission to the Committee we have addressed the 'Regulation of healthcare professions and health and social care workers', these points are numbered 30 – 36 in the Legislative Consent Memorandum. Our submission examines the implications of the relevant sections and how it will alter the current system of regulation. One of the main aspects of the Bill is the change in the regulation of social workers in England, we will continue to develop and maintain a good working relationship with the Scottish Social Services Council (SSSC) to ensure consistency in regulation across the UK.

The HPC is an independent statutory regulator for 15 health professions. Our focus is on the protection of the public and we do this by maintaining a register of healthcare professionals who meet established standards for training, professional skills, behaviour and health. The HPC operates UK-wide and its founding legislation takes special account of Scottish law, as appropriate.

On the following pages we address Part 7 of the Bill comprising Clauses 193 to 215 by which the Health and Social Care Bill affects the HPC. We support the Bill and look forward to continuing to work closely with Stakeholders across the UK during the process of implementation. Should the Committee wish any for any further information we will be happy to provide it.

Summary of Part 7 of the Health and Social Care Bill

Part 7 of the Bill comprises Clauses 193 to 215 and deals with three areas of policy:

- Abolition of the General Social Care Council (GSCC) and the transfer of its regulatory functions (including approving the education and training of approved mental health professionals) to the Health Professions Council, which will be renamed the Health and Care Professions Council (HCPC). The HCPC’s governing legislation, the Health Professions Order 2001 (the Order), is renamed the Health and Social Work Professions Order 2001 by the Bill;
- Changes to the governance, functions and funding of the Council for Healthcare Regulatory Excellence (CHRE), which is renamed the Professional Standards Authority for Health and Social Care (PSAHSC). The Bill also gives PSAHSC the power to accredit voluntary registers; and
- Abolition of the Office of the Health Professions Adjudicator.
Clause 193 – Power to regulate social workers etc in England

This clause amends section 60 of the 1999 Act to enable Orders in Council to be made to regulate (and modify the regulation of) social workers and social care workers in England. ‘Section 60 Orders’ are currently used to regulate health professions. The clause also provides that the civil standard of proof is to apply in proceedings in relation to social workers in England (no change from the current HPC position).

Clause 194 - Training etc of AMHPs in England

This clause further amends the 1999 Act to enable section 60 Orders to modify the new functions of the HCPC in relation to the education and training of approved mental health professionals (transferred to the HCPC by the Bill).

Clause 195 – Orders regulating social care workers in England

This clause amends Schedule 3 to the 1999 Act to make clear that the Secretary of State’s duty to consult before laying a draft section 60 order before Parliament equally applies in relation to section 60 orders in respect of social care workers in England. It also provides that section 60 orders may be made in relation to those unregistered social care workers in England.

Clause 196 – Abolition of the General Social Care Council

This clause abolishes the General Social Care Council.

Clause 197 – Regulation of social workers in England

This clause renames the Order and amends to make the HCPC the regulator of social workers in England. It does so by amending the definition of a ‘relevant profession’ in Schedule 3 to the 2001 Order to include social workers in England. The clause also amends the definition of a lay member to exclude persons who are, or have been, registered as social workers with the General Social Care Council or the Care Councils of Wales, Scotland or Northern Ireland.

Clause 198 – The Health and Care Professions Council

This clause continues the Health Professions Council’s existence but renames it as the Health and Care Professions Council.

Clause 199 – HCPC Functions in relation to social work in England

This clause amends article 3(5)(b) of the Order to extend the HCPC’s duty to co-operate with certain bodies to public bodies or other persons concerned with the regulation of social work in England, the provision, supervision or management of social work in England and the Care Councils of Scotland, Wales and Northern Ireland.
It also amends article 3 of the Order to extend the HCPC’s existing power to make recommendations to the Secretary of State about professions which should be regulated to include social care workers in England.

The clause also makes a number of consequential amendments to the Order, including:

- Extending to social workers the current provisions relating to visiting health professionals from relevant European states;
- Amending article 12 to enable the HCPC to recognise social work training undertaken in Scotland, Wales and Northern Ireland as sufficient for admission to its register and to assess training or professional experience in social work gained outside England but within the UK, and to compare this with the standard of proficiency it requires for admission to its register as a social worker;
- Imposing a new duty on social workers to register with the HCPC if they practise England unless they are registered with one of the Care Councils of Scotland, Wales and Northern Ireland and are only practising in England on a temporary basis.

**Clause 200 – Appeals in cases involving social workers in England**

This clause provides that appeals from HCPC decisions relating to social workers in England are to be heard by either a county court or the High Court of Justice in England and Wales. It also amends the definition of ‘lay member’ for the purpose of HCPC appeal panels to exclude persons who are, or have been, registered as social workers with the General Social Care Council or one of the Care Councils of Wales, Scotland or Northern Ireland from the definition of lay member.

**Clause 201 - Approval of courses for AMHPs**

Approved mental health professionals (AMHPs) are professionals with particular expertise in mental health who are approved by local social services authorities to carry out certain important functions under the Mental Health Act 1983, including applying for people to be detained in hospital for assessment or treatment of their mental disorder. Most AMHPs are social workers, but The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 allows occupational therapists, practitioner psychologists and mental health nurses to be appointed as AMHPs. Appointment is by the local authority but having successfully completed approved training is a condition of appointment.

The clause gives the HCPC the power to approve such courses and to publish details of current and past approved courses. In practice, courses would be approved by the Education and Training Committee, which is already responsible for approving training and education for the existing HPC professions.
Clause 202 - Exercise of function of approving courses, etc

This clause amends the Order to reflect the HCPC’s role in approving AMHP courses, including enabling it to do so for professions which are not regulated by the HCPC. It also introduces the mechanism for approval which is based on the existing model in Part IV of the order.

The clause also amends the 2001 Order to make clear that the standards of conduct, performance and ethics may also cover the standards expected of registrants when acting as approved mental health professionals.

Clause 203 - Arrangements with other health or social care regulators

This clause amends the Order to enable the HCPC to provide administrative and other services to others who maintain registers of health or social work professionals, or health or social care workers. This would enable the HCPC to assist and support them in the goal of protecting service users and the public.

This clause is to be commenced on Royal Assent to enable the HCPC to provide assistance, if it is considered necessary and suitable arrangements are entered into, to the GSCC prior to its abolition.

Clause 204 - References in enactments to health professionals, etc

This clause amends various Acts to exclude social workers and social care workers in England from the definition of ‘registered health care professional’ and similar terms, to avoid the unintended consequence of social workers and social care workers in England, as a result of being regulated by the HCPC, being included within inappropriate definitions (e.g. in relation to prescription only medicines).

Clause 205 – Secretary of State’s functions: social care workers

This clause amends the Care Standards Act 2000 to withdraw from the Secretary of State functions in relation to social workers which will be exercised by the HCPC.

The clause also enables the Secretary of State to arrange for the HCPC to perform functions of the GSCC in the period between Royal Assent and the GSCC’s abolition.

Clause 206 - PSAHSC

This clause renames the Council for Healthcare Regulatory Excellence to the Professional Standards Authority for Health and Social Care, to reflect its new functions, particularly in relation to the accreditation of voluntary registers of unregulated health professionals, health care workers in and social care workers.
Clause 207 - Functions of the Authority

This clause makes amendments the functions of PSAHSC, including bringing social work and social care work within its remit (as a consequence to the widening of the HCPC’s remit). This includes referring unduly lenient decisions in respect of social workers in England to the High Court of Justice in England and Wales.

The clause enables PSAHSC to give advice to ministers etc. on both health (as now) and social care issues and, because of changes in its funding, requires the Secretary of State, the Welsh Ministers, the Scottish Ministers and the DHSSPS in Northern Ireland to pay for any advice received.

Clause 208 - Funding of the Authority

This clause changes the way in which PSAHSC is funded, requiring the Privy Council to make regulations providing for each regulatory body to fund specified PSAHSC functions.

Clause 209 - Power to advise regulatory bodies, etc

This clause enables PSAHSC to provide advice or auditing services on a fee-paying basis to the regulatory bodies and to similar bodies (whether or not their functions relate to health or social care).

The clause also transfers to the Privy Council the Secretary of State's power to make regulations about the investigation of complaints by PSAHSC.

Clause 210 - Accountability and governance

This clause amends PSAHSC’s constitution and governance provisions, reducing the number of executive members from two to one; and transferring responsibility for making certain appointment from the Secretary of State to the Privy Council.

The clause also requires PSAHSC to publish a strategic plan and lay its strategic reports before the four UK parliaments and assemblies after the end of the financial year.

Clause 211 - Appointments to regulatory bodies

This clause enables the Privy Council, in making appointments to the regulatory bodies, to be assisted by PSAHSC, the regulatory body in question or a third party (but still requires the Privy Council to make the appointment).

Similar power is given to the Scottish Ministers, the Welsh Ministers and the Department of Health, Social Services and Public Safety in Northern Ireland to make arrangements with PSAHSC in respect of the appointments to PSHSC made by the devolved administrations.
Clause 212 – Establishment of voluntary registers

This clause enables all of the regulatory bodies to establish and maintain voluntary registers of persons who are or have been unregulated health professionals and unregulated health care workers in the UK, and unregulated social care workers in England. The power is limited to establishing and maintaining voluntary registers of groups whose work supports or relates to the work of the profession which the body regulates, but that limitation does not apply to the HCPC. The fees payable for voluntary registration would be determined by the relevant regulatory body.

Registers will remain ‘voluntary’ even if an enactment makes it compulsory for a person to be on a particular register in order to carry out work or practice of a particular kind but only for a specific purpose.

The clause will enable regulatory bodies to set up voluntary registers of certain students. This power, for each regulatory body, is limited to establishing and maintaining voluntary registers of persons studying to become a member of a profession regulated by that body or in relation to which that body maintains a voluntary register, or studying to engage in work as an unregulated health care worker or unregulated social care worker in England in relation to which that body maintains a voluntary register.

The clause provides that, before setting up a voluntary register, the regulatory body must conduct an impact assessment, publish it and have regard to it in deciding whether to proceed. The regulatory body must also consult appropriate persons before establishing a voluntary register.

Clause 213 - Accreditation of voluntary registers

This clause enables PSAHSC to accredit voluntary registers. PSAHSC is required to publish its accreditation criteria and may publish a list of accredited registers. PSAHSC must carry out an impact assessment before accrediting a voluntary register and must also consult before doing so.

The Clause also confers new powers on PSAHSC in relation to voluntary registers:

- Promoting the interests of UK health care users, users of social care and social work in England, and other members of the public in relation to the maintenance or operation of accredited voluntary registers;
- Promoting best practice in the maintenance and operation of accredited voluntary registers; and
- Developing principles of good governance for voluntary registers and encourages keepers of voluntary registers to follow these.
Clause 214 – Consequential provisions and savings, etc

This clause authorises consequential amendments and enables the Privy Council, by Order, to make transitional, etc. provision in connection with this part of the Bill.

Clause 215 - Abolition of OHPE

This clause provides for the abolition of the Office of the Health Professions Adjudicator.

Clause 274 – 5: Transfer schemes

This clause provides for the transfer of staff and property. These are standard provisions for legislation winding up or creating new organisations.

Schedule 14 covers consequential amendments to legislation and regulations. On some minor matters: the HCPC will not be subject to the Parliamentary and Health Ombudsman. Nor will it be subject to the Public Bodies (Admission to Public Meetings) Act. It will be subject to the Freedom of Information Act.

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4 February 2011
LEGISLATIVE CONSENT MEMORANDUM

Health and Social Care Bill

Draft Legislative Consent Motion

1. The draft motion, which will be lodged by the Cabinet Secretary for Health and Wellbeing, is:

“That the Parliament agrees that the relevant provisions of the Health and Social Care Bill, introduced in the House of Commons on 19 January 2011, in respect of the establishment of the NHS Commissioning Board and GP commissioning consortia, abolition of the Health Protection Agency, duty of co-operation in relation to health protection functions, amendment of the Mental Health Act 1983, the Health and Social Care Information Centre, regulation of healthcare professions and health and social care workers, the National Institute for Health and Clinical Excellence and National Health Service /Health and Social Services contracts, so far as these matters fall within the legislative competence of the Parliament, or alter the executive competence of Scottish Ministers, should be considered by the UK Parliament.”

Background

2. This memorandum has been lodged by Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing, under Rule 9.B.3.1(a) of the Parliament’s standing orders. The Health and Social Care Bill was introduced in the House of Commons on 19 January 2011. The Bill can be found at:

http://www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.i-v.html

3. It is appropriate that the Health and Social Care Bill makes provision for the matters detailed below that fall within the legislative competence of the Scottish Parliament, or alter the executive competence of the Scottish Ministers. There is no suitable Scottish Parliament Bill or statutory instrument in process that could be used to make the necessary changes in a timely manner, and therefore the most practical method to achieve these provisions is by means of the Health and Social Care Bill.

Content of the Health and Social Care Bill

4. The overarching stated aim of the Health and Social Care Bill is to establish a sustainable national framework for the NHS in England, create a Health Service more responsive to patients, and deliver on the commitment to reduce bureaucracy. These proposals flow from a number of commitments made in the Department of Health’s (DH) White Paper ‘Liberating the NHS’ (July 2010), and the Bill will include measures to:

- Establish an independent NHS Board to allocate resources and provide commissioning guidance, and to allow GPs to commission services on behalf of their patients
- Improve efficiency and outcomes by strengthening the role of the Care Quality Commission and developing Monitor into an economic regulator to oversee aspects of access and competition in the NHS
• Take forward proposals to significantly cut the number of health quangos, helping cut the cost of NHS administration by a third.

5. There are seven areas where the Bill currently triggers the need for legislative consent, and these are discussed below:

• NHS Commissioning Board
• Abolition of the Health Protection Agency
• Mental Health Act 1983
• Health and Social Care Information Centre
• Regulation of healthcare professions and health and social care workers
• National Institute for Health and Clinical Excellence
• Non-consequential amendments

**NHS Commissioning Board**

**Background**

6. The Bill will establish the NHS Commissioning Board (NHSCB), which for England will:

• Provide national leadership on commissioning for quality improvement, for instance by developing commissioning guidelines based on quality standards and by designing tariffs and model NHS contracts
• Promote and extend public and patient involvement and choice
• Ensure the development of consortia and hold them to account for outcomes and financial performance
• Commission certain services that are not commissioned by GP consortia, such as the national and regional specialised services and primary care services
• Allocate and account for NHS resources

7. The NHSCB will be responsible for commissioning specialised and high secure services, which includes capacity for patients from the Devolved Administrations. The NHSCB will also be responsible for commissioning health care through GP consortia and for commissioning some primary care services.

**Legislative consent**

8. Currently the Common Services Agency, Health Boards and Special Health Boards can enter into arrangements with commissioners in England (Secretary of State, or Strategic Health Authorities acting on behalf of the Secretary of State) in order to secure services for patients in Scotland. To ensure this can continue within the new architecture in England, section 17A(2) of the National Health Service (Scotland) Act 1978 and section 9 of the National Health Service Act 2006 will be amended by the Bill to include the NHSCB. The GP commissioning consortia will also be added to section 17A(2) of the National Health Service (Scotland) Act 1978 and section 9 of the National Health Service Act 2006. This will allow Scottish NHS bodies to enter into arrangements with the NHSCB and GP commissioning consortia.
9. As amendment of the National Health Service (Scotland) Act 1978 is within the legislative competence of the Scottish Parliament, the proposed amendments will require the consent of the Parliament.

Financial implications

10. As now, the Scottish Government will be required to pay for services provided in England for Scottish patients. The provisions will allow for the Common Services Agency to enter into arrangements with the NHSCB to secure the provision of specialised services for Scottish patients from English providers, and will also allow for these services to be paid for. Establishment of the NHSCB should not in itself result in a change to the prices of these services.

Abolition of the Health Protection Agency

Background

11. The Secretary of State for Health wishes to take a more direct role in health protection in England and, to this end, the Health Protection Agency (HPA) is to be abolished in its current form and become part of the new Public Health Service (PHS) for England.

12. The HPA was established as a Non-Departmental Public Body (NDPB) under the Health Protection Agency Act 2004. This Act gives functions to the HPA, including health functions and radiation protection functions. In addition, the Act provides that the Scottish Ministers may, by order, confer devolved functions on the HPA to the extent that these relate to protection of the community against infectious disease and other dangers to health, prevention of the spread of infectious disease and provision of assistance to anyone in connection with these functions.

13. In 2003, an LCM was agreed to by the Parliament to allow the HPA to exercise certain health functions for Scotland, including functions connected to radiation in so far as they are devolved. In addition, two orders have been made by Scottish Ministers (The Health Protection Agency (Scottish Health Functions) Order 2006, and The Health Protection Agency (Scottish Health Functions) (Amendment) Order 2007), which conferred additional functions on the HPA. These included providing advisory services to Scotland on chemicals, chemical incidents, clinical management of patients who have been poisoned and planning for public health emergencies, assessment of events in Scotland that may constitute a public health emergency of international concern and acting as the national International Health Regulations (IHR) focal point for Scotland as described in the IHR.

Legislative consent

14. The Bill proposes to abolish the HPA as a statutory organisation and the HPA Act will be repealed. Health protection functions that are not devolved to Scottish Ministers will be transferred to the Secretary of State for Health as part of the new Public Health Service for England.

15. Non-devolved functions currently undertaken by the HPA in relation to Scotland (such as the functions in relation to biological substances and most aspects of the
radiation protection function) and UK wide functions such as the National Focal Point (under the International Health Regulations) will be provided for Scotland by Public Health England.

16. Scotland has made use of HPA advice for devolved functions as noted in paragraph 12 above, and to ensure Scotland can continue to access these services through the new PHS arrangement, it has been agreed to establish an agency agreement under section 93 of the Scotland Act 1998. This will allow Scottish Ministers to make arrangements for any of their specified functions to be undertaken by a Minister of the Crown. Under this agreement Scottish Ministers would retain the devolved functions but the Secretary of State would exercise them on our behalf.

17. A Memorandum of Understanding (MOU) will also be put in place with the new PHS for England to cover these issues. A separate MOU would also be required to cover reserved issues which may have an impact in Scotland, for example an incident at a nuclear power station taking place in Scotland. In addition, Scottish Ministers have agreed that the Secretary of State for Health should be designated as the national focal point under the International Health Regulations.

18. A duty of co-operation between bodies exercising functions in relation to health protection is also included in the Bill and this is intended to ensure co-operation between the four health administrations in the UK. This duty will therefore extend to Scottish Ministers and will allow them to recover any costs incurred in providing such co-operation, from the other bodies exercising functions in relation to health protection.

19. This approach will alter the executive competence of the Scottish Ministers and will therefore require the consent of the Scottish Parliament.

Financial implications

20. There are no new financial implications anticipated. Scottish Ministers currently pay the HPA for the services we access and would expect to pay the new Public Health Service for England in the same way.

Mental Health Act 1983

Background

21. The Bill proposes to amend section 122 of the Mental Health Act 1983 to remove the power of the Secretary of State to pay pocket money to persons who are receiving treatment as in-patients (whether liable to be detained or not) in hospitals wholly or mainly used for the treatment of persons suffering from mental disorder.

22. There is a similar provision under the Mental Health (Care and Treatment) (Scotland) Act 2003 for Scottish Ministers to make payments of pocket money to in-patients in hospital in Scotland.

23. However, section 122 of the Mental Health Act 1983 extends to Scotland. This appears to be an error that occurred when the 1983 Act was drafted, and is of no practical significance in any case since Scotland has no hospitals that would qualify for the purposes of this legislation. Scottish Ministers are therefore content that the UK
Government should take the opportunity to correct this at the same time as section 122 is repealed for England.

**Legislative consent**

24. Since there would, technically, have been a transfer of competence to Scottish Ministers on devolution as regards section 122 of the 1983 Act, arguably, the repeal of that section in its extent to Scotland would amount to a “technical” alteration of competence of the Scottish Ministers. Therefore this will require the consent of the Scottish Parliament.

**Financial implications**

25. There are no financial implications associated with the mental health pocket money for in-hospital patients amendment.

**Health and Social Care Information Centre**

**Background**

26. The NHS Health and Social Care Information Centre is a national (for England) repository for data collection across health care, public health and adult social care. The Bill will establish the Information Centre (IC) in primary legislation, and place a clearer focus on data collections with a close working relationship with the NHS Commissioning Board.

27. The IC currently collects and publishes health and social care information, including annual earnings and expenses of general medical practitioners for the UK. The data is used to inform the Scottish evidence to the pay review bodies. The IC provides other services to the Scottish Government including services related to the NHS Central Register for Scotland and the Medical Research Information Service.

**Legislative consent**

28. In order that the services which the Scottish Government receives from the IC can continue, Section 9 of the National Health Service Act 2006 and Section 17A of the National Health Service (Scotland) Act 1978 will be amended by the Bill to include the new body. These sections detail the bodies which can enter into NHS Contracts. As amendment of the National Health Service (Scotland) Act 1978 is within the legislative competence of the Scottish Parliament, this provision requires the consent of the Parliament.

**Financial implications**

29. There are no financial implications associated with the change in statutory footing of the NHS Health and Social Care Information Centre.
Regulation of healthcare professions and health and social care workers

Background

30. For most of the currently regulated healthcare professions, regulation is reserved to Westminster. However, for those not regulated when the Scotland Act came into force in 1999, regulation is devolved to the Scottish Parliament. Currently, this includes only operating department practitioners and practitioner psychologists, regulated by the Health Professions Council (HPC); dental nurses, dental technicians, clinical dental technicians and orthodontic therapists, regulated by the General Dental Council (GDC); and pharmacy technicians, regulated by the General Pharmaceutical Council (GPhC). The future regulation of further professions is also devolved. The constitution of all the regulators is, however, reserved to Westminster, except for the devolved pharmacy body for Northern Ireland, and the GPhC, which was set up very recently by the Scottish Parliament as well as Westminster.

31. Historically, the Department of Health has taken the lead in taking forward the regulation of healthcare professions on a UK-wide basis, with input as appropriate from the other three countries, particularly in the devolved areas. UK-wide regulation by UK-wide regulators assists the cross-border flow of staff and ensures that the same standards are applied across the UK for particular groups of staff. The usual vehicle for regulating the healthcare professions is an order under section 60 of the Health Act 1999. Where a section 60 order makes provision in a devolved area it must be laid for approval by resolution of the Scottish Parliament as well as Westminster.

32. The Scottish Ministers and Ministers in Wales and Northern Ireland endorsed the contents of the previous UK Administration’s White Paper Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century, published in February 2007. This paper was part of the response to the Shipman Inquiry, and the primary aim of its policies was to improve patient safety and the quality of the care that patients receive from health professionals. Many of the policies in the White Paper have progressed significantly, including changes to the nine UK regulatory bodies, including the Council for Healthcare Regulatory Excellence (CHRE), which was set up by Westminster to scrutinise and quality assure the performance of those regulators. Changes were made via the Health and Social Care Act 2008, for which an LCM was agreed, to enable the CHRE to take on a stronger and more independent role in providing expert advice on professional regulation. That Act also gave the Scottish Ministers the power to request advice from the CHRE on any matter connected with a profession appearing to be a health profession, and to require it to investigate and report on a particular matter. It also provided for one of the lay members of the CHRE to be appointed by the Scottish Ministers.

33. Work was also taken forward under the auspices of the 2007 White Paper in the Extending Professional Regulation Group (EPRG), whose report was endorsed by Ministers in all four countries. That report cited that the normal statutory regulation should not be the inevitable route for assuring the public that a healthcare professional was safe to practise. Instead, alternative methods, proportionate to the risks posed by the particular group, should be considered. Accredited voluntary registers were cited as one of those alternatives.

34. The report of the Department of Health’s review of Arms Length Bodies (ALB) in July 2010 confirmed that the CHRE would be removed from the ALB sector and made
more independent. The current Health and Social Care Bill would give effect to this and also make some other related changes. It includes provisions to:

- Make the CHRE self-funding through levies paid by all the healthcare profession regulators, including the three which operate in devolved as well as reserved areas as explained above – the HPC, the GDC and the GPhC.
- Change the name of the CHRE to the Professional Standards Authority for Health and Social Care (PSAHSC).
- Extend the CHRE’s vires to social care in England.
- Allow the CHRE to charge fees, including for answering requests from Ministers for advice related to the regulation of healthcare professionals and (in England) social care workers.
- Give powers to the healthcare profession regulators to be able to hold voluntary registers for persons who are or have been members of an unregulated health profession, engaged in unregulated health care work, or participating in studies for the purpose of doing so.
- Extend the CHRE’s remit to enable it to set standards for, and quality assure, such voluntary registers.
- Abolish the Appointments Commission, which currently takes forward appointments to the healthcare professions regulatory bodies on behalf of the Privy Council.
- Give the CHRE the ability to provide advice or auditing services to the regulators or bodies which have functions corresponding to a regulator.

35. The report of the Department of Health ALB review also confirmed that the General Social Care Council (GSCC), which regulates social workers in England, would be abolished. The Bill will abolish the GSCC and transfer its regulatory function to the Health Professions Council (HPC), which it will rename as the Health and Social Care Professions Council. The HPC already regulates a wide range of healthcare professionals, including operating department practitioners and practitioner psychologists, whose regulation is devolved.

36. The Bill will amend section 60 of the Health Act 1999 to ensure that such orders can be made in future to regulate social workers in England and also social care workers in England. The regulation of these groups in Scotland is entirely devolved and a matter for the Scottish Social Services Council.

Legislative consent

37. There are a number of areas that require legislative consent, these are:

- The funding of the PSAHSC through a compulsory levy on the regulators and charging fees for advice provided, for investigations and reports, including for Ministerial requests for advice from the PSAHSC
- A new power for the PSAHSC to advise or provide auditing services to the regulatory bodies and bodies which have functions corresponding to those of a regulatory body, and to charge for this advice
- A new duty on the PSAHSC to lay its strategic reports before the four parliaments and assemblies
- New powers for the regulatory bodies and the PSAHSC to assist the Privy Council in the making of appointments to the regulators and to the PSAHSC
• New powers for the regulatory bodies to establish voluntary registers
• A new power for the PSAHSC to accredit such voluntary registers
• New additional functions imposed on the PSAHSC in relation to the accreditation of voluntary registers
• New powers for Privy Council Orders to effect transitional provisions, in so far as they relate to devolved matters
• New powers to allow the Scottish Ministers to make arrangements with the PSAHSC to assist them in the exercise of their power to appoint one member of the PSAHSC

38. The Bill provides for the new Health and Social Care Professions Council (previously the HPC) to provide administrative, technical or advisory services to any body or individual involved in maintaining registers of health or social care workers. As this impacts on the devolved functions of the HPC, and therefore the executive competence of Scottish Ministers, legislative consent is required.

Financial implications

39. The CHRE is currently entirely funded by Government, with all four UK countries contributing (Scotland contributed £223k for 2010-11). The Bill provides for Government to continue to fund the CHRE for the commissions it asks them to carry out; for the regulators themselves to pay levies to the CHRE for its performance management of them and any work around appointments to their Councils; and for the CHRE to charge organisations/regulators for services they provide for them, including the accreditation of voluntary registers.

40. There will be a saving to the Scottish Government as its funding for the CHRE will reduce from its current share to paying its share of individual commissions. The cost of levies on the regulatory bodies, which are self-funded through the fees they charge, will inevitably be passed on to those on the statutory registers, but the increases in fees should be low due to the number of registrants. Similarly, the payments that organisations and the regulators will have to pay to the CHRE for accrediting voluntary registers will be passed on to those registering on them.

National Institute for Health and Clinical Excellence

Background

41. The National Institute for Health and Clinical Excellence (NICE) provides national (for England) guidance on the promotion of good health and the prevention and treatment of ill-health. The Bill will establish NICE in primary legislation and expand its scope to include social care standards. The re-constituted NICE will provide advice and guidance to the Secretary of State and the NHS Commissioning Board on functions related to a comprehensive health service, including public health, other public health services and adult social care.

42. Scotland currently utilises a number of products and services from NICE, some of which are paid for. In addition, the NHS in Scotland (mainly through NHS QIS and Scottish clinicians; and to a lesser extent the Scottish Medicines Consortium) currently has commentator or observer status in a number of areas of NICE product development. Scotland also draws on the expertise of the NICE-led process whereby an independent advisory committee makes recommendations relating to the clinical
indicators in the Quality and Outcomes Framework element of the GP contract, which are then used as a basis for UK negotiation with the BMA.

43. The Bill contains provisions allowing the Secretary of State to make regulations conferring powers on NICE regarding the supply of quality standards to Scottish Ministers on a commercial charging basis; the provision of advice to any persons regarding the provision of health care on a commercial charging basis; and the protection or improvement of public health or the provision of social care to be charged on the appropriate commercial basis. The Bill also provides that NICE may arrange with any person or body to provide or assist in providing any service which NICE is required or authorised to provide in the Bill and to charge for this.

Legislative consent

44. In order that the Scottish Government and NHS bodies in Scotland can continue to receive services from the re-constituted NICE, and given that NICE does not as of right currently exercise any statutory functions in Scotland, but instead exercises functions through agreement with our health service bodies and the Scottish Ministers, the Bill will amend section 9 of the National Health Service Act 2006 (NHS Contracts) to include NICE, the Scottish Ministers and NHS Health Improvement Scotland (NHS HIS) to the list of bodies allowed to enter into agreements for the supply of goods and services.

45. The Bill will make similar amendments to section 17A of the National Health Service (Scotland) Act 1978 to enable NICE to enter into NHS contracts under Scots Law. As amendment of the National Health Service (Scotland) Act 1978 is within the legislative competence of the Scottish Parliament, this will require the consent of the Parliament.

Financial implications

46. Currently some of the products and services Scotland utilises from NICE are paid for, however, in future a wider range of NICE products will potentially be charged for. Where NICE products which are currently utilised without charge and which might in future be provided on a commercial charging basis, consideration needs to be given to the benefits of doing so, or whether alternative arrangements would need to be developed within the NHS in Scotland.

Non-consequential amendments

Background and legislative consent

47. It is proposed that the Bill makes several non-consequential amendments to the National Health Service (Scotland) Act 1978, National Health Service (Wales) Act 2006, The Health and Personal Social Services (Northern Ireland) Order 1991 and National Health Service Act 2006 in order to rectify devolution anomalies or uncertainties, and specify Scottish Ministers as able to enter into National Health Service (NHS) / Health and Social Services (HSS) contracts in the appropriate Scottish, Welsh, Northern Irish or English legislation.

48. In addition, these amendments will include provisions for joint dispute-determination of NHS/HSS contracts to which English, Welsh, Scottish or Northern Irish health bodies are parties, in a similar manner to those already provided for dispute
determination of Scottish NHS contracts to which Northern Irish health bodies are parties in Section 17(10) of the National Health Service (Scotland) Act 1978.

49. These amendments alter the functions and executive competence of Scottish Ministers and therefore will require the consent of the Scottish Parliament.

Financial implications

50. There are no financial implications associated with the non-consequential amendments.

Consultation

51. The UK Government consulted on the proposals for the Health and Social Care Bill as set out in its White Paper, *Equity and Excellence: Liberating the NHS*, published in July 2010, in a number of consultation documents all published in July 2010 and closed on 11 October 2010:

- Consultation: Transparency in outcomes: a framework for the NHS  
- Consultation: Increasing democratic legitimacy in health  
- Consultation: Liberating the NHS: commissioning for patients  
- Consultation: Liberating the NHS: regulating healthcare providers  

52. In December 2010 the UK Government published its analysis of the consultation responses, *Liberating the NHS: Legislative framework and next steps*.  

53. The UK Government considered that the response to the consultation demonstrated support for the principles set out in the White Paper. However, following consultation, some changes were made, including, for example, that commissioning of maternity services will sit with GP consortia; and local authorities’ formal scrutiny powers will be extended to cover all NHS-funded services, and they will have greater freedom in how these are exercised.

54. A full consultation with Scottish stakeholders has not taken place. This is because the Bill predominantly affects England and the main areas that require legislative consent from the Scottish Parliament are to ensure current arrangements can continue within the new healthcare architecture in England.

Conclusion

55. The view of the Scottish Government is that it is in the interests of the people of Scotland that the provisions of the Health and Social Care Bill, so far as these matters
fall within the legislative competence of the Parliament or the executive competence of the Scottish Ministers, should be considered by the UK Parliament.

SCOTTISH GOVERNMENT
January 2011
Agenda Item 1
23 February 2011

Legislative Consent Memorandum on the Health and Social Care Bill

NHS National Services Scotland

NHS COMMISSIONING BOARD

In respect of our role in commissioning specialist health services from hospitals in England, directly, and via the current National Specialist Commissioning Team (which will be subsumed into the NHS Commissioning Board), we were given the opportunity to advise Scottish Government Health Directorate (SGHD) on requirements for specialised services while the SGHD was working with the Department of Health colleagues on the drafting of the part of the Bill about the NHS Commissioning Board. As a result we had an opportunity to inform SGHD about the need for provisions to ensure that residents of Scotland could continue to access specialised services in England.

Paragraphs 7 and 8 of the Legislative Consent Memorandum (LCM) confirm that the information which we provided has been taken into account in the proposals for the powers of the NHS Commissioning Board. This is welcome.

We would, however, like to see a modification to paragraph 8 of the LCM to clarify that the Common Services Agency (CSA) (understood to be the legally correct title for NHS National Services Scotland) could, in addition to being able to enter into arrangements with English commissioners, continue to be able to enter into agreements and contracts directly with English Trusts. The paragraph only refers to enabling agreements with commissioners. The powers for CSA and Health Boards to enter into contracts with English Trusts may be contained in other legislation but this provision will continue to be required to ensure that Scottish residents can access required specialist care and treatment in England.

Current cost liabilities of NSS, for services delivered by NHS

There is a general trend of increasing costs of specialist treatment in England which is likely to increase further as regulation of the market is removed in England, and as a result of the disbanding of regional Specialised Commissioning Groups. There are no direct cost liabilities to NSS from the establishment of the NHS Commissioning Board.

Bodies and agencies whose status is altered by the provisions of the Bill

The disbanding of the English regional Specialised Commissioning Groups (SGC), and the subsuming of the National Specialised Commissioning Team (NSCT) into the NHS Commissioning Board, will remove the current level of quality monitoring and specialist services planning, inspection and cost control on which NHS National Services Scotland (NSS) depends for quality assurance of the specialist services to which residents of Scotland are referred. The NHS Commissioning Board is likely to have such a wide range
of responsibilities that it will not be able to provide the same level of clinical quality assurance of services than the current arrangements.

Any discussions undertaken with such bodies or agencies on the implications of the Bill for services delivered by them

NSS meets every two months with SCG Directors and the NSCT and is seeking to work through with English colleagues arrangements for transition to the new NHS Commissioning Board that minimise the impact on specialist health services for residents of Scotland.

The extent to which we expect those costs, if any, to increase or decrease, following implementation of the changes proposed in the Bill.

As described above - As controls are removed, in the area of highly specialist health services there are no market forces to suppress prices (most providers are unique or part of closely linked networks – not in competition with each other). In a monopoly situation the cost of procuring specialist services needed by the population of Scotland will increase.

Implications for NSS as a result of the Bill, which we wish to bring to the attention of the Committee.

When all NHS Trusts in England become Foundation Trusts – outwith the legal framework of the NHS – there will be increased expensive bureaucracy for NHS Scotland in having to develop full legally binding contracts for the provision of specialist health services rather than the simple, cost effective Service Agreements between NHS bodies that we currently use.

ABOLITION OF THE HEALTH PROTECTION AGENCY

Health protection is the branch of public health which seeks to protect the public from hazards which damage their health. A division of NHS National Services Scotland (NSS), Health Protection Scotland (HPS) is the national health protection organisation established by the Scottish Government in 2005 to strengthen and co-ordinate health protection in Scotland. HPS works at the heart of the health service across Scotland, delivering services critical to preventing ill health in the community, enhancing frontline patient care and supporting the efficient and effective operation of NHSScotland, local authorities and national agencies such as Scottish Environmental Protection Agency and the Food Standards Agency.

Protecting Scotland’s health from communicable diseases and environmental hazards depends on co-operation across territorial boundaries. HPS therefore works closely with other UK and European agencies. The abolition of the Health Protection Agency (HPA) is therefore of particular concern to NSS. We have current close relationships with three key HPA bodies, namely National Institute for Biological Standards and Control (NIBSC), NHS Blood and Transplant Epidemiology Unit and the CJD Incidents Panel. It is
imperative that we receive continued access to these important services through the auspices of the newly formed Public Health England. It is to be hoped that we can have input into the memorandum of understanding described in para.17.

Other parts of the Bill which affect health protection in Scotland are:

- The shift in the role of the Secretary of State to focus on protecting and improving public health;
- The establishment of the Health and Social Care Information Centre;
- The continuation of the Joint Committee on Vaccination and Immunisation as a statutory body.

Current Situation

With regard to Scotland, the Health Protection Agency (HPA) operates at different levels.

- It provides services directly in Scotland as part of its statutory, UK-wide responsibilities. These cover radiation protection and poisons. With regard to Scottish Services, the first is funded by the Scottish Government, the second by the NHS (see below).
- It provides services purchased from it by the NHS so that the latter can discharge its health protection responsibilities in Scotland. These cover certain laboratory tests and expert advice on chemicals. These are funded by the NHS (see below).
- It provides impartial expert advice to Scottish health protection agencies (including at times, Scottish Government) either through ongoing professional liaison or standing scientific advisory groups. These latter consider new and emerging infections and certain specialist topics such as CJD and hepatitis B. There is no specific Scottish funding associated with this.
- It acts as the competent body for the UK with regard to the European Commission’s (EC) Centre for Disease Prevention and Control. This latter co-ordinates the EC’s health protection activity especially scientific policy and the monitoring of communicable disease and other threats to the member states. As such, HPA enables Scotland to discharge its responsibilities under EC Directives relating to the surveillance of infectious disease.
- It collaborates with HPS (and its Welsh and Northern Ireland counterparts) in producing UK reports on topics of public health importance such as AIDS, tuberculosis and influenza. There is no specific Scottish funding associated with this.
- It maintains an overview of the public health incidents in the UK, Europe and internationally, disseminates alerts and facilitates information sharing about these. There is no specific Scottish funding associated with this.
- Lastly it usually co-ordinates the UK health protection response to cross-border or major outbreaks (e.g. pandemic influenza). In particular, it leads on health protection as it relates to reserved issues such as bioterrorism or
other types of national security incidents (e.g. polonium). There is no specific funding associated with this.

Given the importance of these services to protecting Scotland’s health, a tripartite memorandum of understanding is in place between HPS, Scottish Government and HPA to support effective collaboration between all parties. The UK Health Protection Oversight Group (involving all four UK nations’ health protection services and government department representatives) acts as a forum for liaison. Scotland’s member on the Board of the HPA and an HPA official sit on Scotland’s Health Protection Advisory Group that advises the Scottish Chief Medical Officer on health protection in the country.

**Current cost liabilities for HPS, for services delivered by NHS bodies or agencies whose status is altered by the provisions of the Bill.**

We commission reference laboratory services and the national poisons service on behalf of Scottish Government from HPA. Service Level Agreements are in place with the HPA to cover these services and associated funding from NSS (via NSD). Funds paid to HPA in 2009/10 by NHS NSS for these services totalled £792,627, as follows:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Clinical Test Expenditure</td>
<td>£261,988.33</td>
</tr>
<tr>
<td>Distribution of MMR Saliva Kits</td>
<td>£5,691.84</td>
</tr>
<tr>
<td>Contribution to UK Poisons Service</td>
<td>£396,750.00</td>
</tr>
<tr>
<td>Contribution to Chemical Services</td>
<td>£34,670.00</td>
</tr>
<tr>
<td>Velindre Cryptosporidium Contract</td>
<td>£93,528.00</td>
</tr>
</tbody>
</table>

NSS also paid the amounts below to the HPA in 2009/10 for the services indicated. These are expected to be ongoing:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK Data Warehouse/TESSy</td>
<td>£6,552.00</td>
</tr>
<tr>
<td>Publications of UK annual reports</td>
<td>£1,194.00</td>
</tr>
<tr>
<td>Flu – AIMS (Colindale)</td>
<td>£3,000.00</td>
</tr>
<tr>
<td>Flu – NHS24 Syndromic Surveillance (HPA Birmingham)</td>
<td>£16,110.00</td>
</tr>
<tr>
<td>Delegate fees for various training events</td>
<td>£2,000.00/annum</td>
</tr>
</tbody>
</table>

In addition, HPA receives ad-hoc time-limited funding for its services in relation to outbreaks and incidents, e.g. anthrax and joint research e.g. FF100 study into H1N1 Flu.

**Discussions HPS has undertaken with such bodies or agencies on the implications of the Bill for services delivered by them.**

We have had some discussion with the HPA and its equivalents in Wales and Northern Ireland about the proposed changes in England. In addition we have considered with the SGHD public health team the possible impact of the Bill for Scotland. However these discussions are at a relatively early stage.
The extent to which HPS expects those costs, if any, to increase or decrease, following implementation of the changes proposed in the Bill

So far no direct financial consequences resulting from the Bill have been defined. At this moment, there is no reason to believe that the cost liability of NHS NSS will be affected directly by the LCM on the Health and Social Care Bill. However, there are other factors associated with the Bill's intentions that may impact on the cost liability. The Bill aims to increase efficiency and we are aware that the intention is to reduce costs (of the HPA). We understand that the HPA currently has the ability to generate income from some of its activities and there is a risk that the new arrangements and finance picture could result in increase costs for Scotland, as the HPA seeks to sustain its income levels.

The level of collaboration between the HPA and HPS in many of the areas detailed above in ‘Current Situation’ at 1.2.2 has not been financially quantified. There is a risk that this may be attempted in the future, as budgets and finance become increasingly constrained. There is also a risk that, given the HPA's functions will be absorbed into the Department of Health, the sharing of information and the publication of joint UK public health reports could become more difficult. This may have cost implications for HPS.

Other implications for HPS as a result of the Bill

Part 1 – The Health Service in England

7. The Secretary of State’s duty as to protection of public health

Of particular interest to NSS is the definition of a duty on the Secretary of State to protect public health with specific responsibilities distinct from his/her health improvement, inequalities in health and healthcare responsibilities. The Secretary of State’s health protection responsibilities include screening services that are not currently defined as part of health protection in Scotland.

With regard as to how the Secretary of State will discharge his/her responsibilities, the White Paper “Healthy Lives, Healthy People: Our strategy for public health in England” sets out how a new, dedicated, professional public health service – Public Health England – will be set up as part of the Department of Health. There will be ring-fenced public health funding from within the overall NHS budget; stronger incentives for GPs to play an active role in public health; new functions for local government; a public health outcomes framework and specific funding and commissioning arrangements for public health

Co-operation across territorial boundaries is essential to protecting Scotland’s health. Cross boundary relationships on health protection were reviewed by the Calman Commission and found to be satisfactory. The scale, shape and impact of the reforms in England on health protection may have considerable implications as to how NSS discharges its own responsibilities not least whether the close working relationship it currently has with HPA, (a non-
Departmental public body) will continue with the forthcoming Public Health England, (likely to be part of the Department of Health). These matters will be discussed further in Scottish Government’s current Health Protection Stocktake which is due to report in November 2011.

Part 2 - Further Provision about Public Health

46 Abolition of the Health Protection Agency

The section “Current Situation” summarises the current role of the HPA in Scotland. Its abolition and absorption into Public Health England (part of the Department of Health) will have the following implications:

- **Direct provision of services in Scotland: radiation protection is dealt with in clause 48 of the Bill. A decision will have to be made as to whether the current commissioning arrangements for poisons (specifically the Scottish Poisons information Bureau based at the Royal Infirmary of Edinburgh) continue.**

- **Services purchased by the NHS so that it can discharge its health protection responsibilities:** Commissioning arrangements will need reviewing.

- **Impartial expert advice to Scottish health protection agencies (including at times, Scottish Government):** Given that this advice will in the future come from a Government Department, there could be a conflict between scientific impartiality and political interest. The current relatively free sharing of information on risks to public health and their management across UK health protection bodies could be impeded. Scotland’s interests should be protected in this regard.

- **Competent body for UK with regard to the European Commission’s Centre for Disease Prevention and Control (ECDC):** Competent Bodies are institutions or scientific bodies providing independent scientific and technical advice or capacity for action in the field of the prevention and control of human disease. They have been designated by the Member States governments. There are two for the UK: Department of Health (policy issues) and HPA (all other aspects of health protection). Further discussion will need to take place on the implications of the abolition of the HPA.

- **UK reports on topics of public health importance:** There may be some implications especially if such reports comment on Government policy.

- **Overview of public health incidents in the UK, Europe and internationally:** Further discussion will need to take place on the implications of the abolition of the HPA with regard to sharing information.

- **Coordination of the UK health protection response to cross-border or major outbreaks:** Further discussion will need to take place on the implications of the abolition of the HPA with regard to sharing information, accountability for managing incidents and reporting on them.
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47 Functions in relation to biological substances

This clause relates to the future of the National Institute for Biological Standards currently part of the HPA. There are no specific implications for NSS.

48 Radiation Protection Functions

Currently Scottish Government leads on the commissioning of this service from HPA. Future arrangements will have a bearing on the public health management of incidents related to radiation hazards and impartial advice on ionising and non-ionising radiation matters. NSS has an interest in all these issues.

Part 9 - Health and Social Care Services: Information

The Powers in this part of the Bill relating to Information standards and the role of the Health and Social care Information Centre have implications for NSS given the need to share communicable disease surveillance and other types of public health information with our counterparts in England. We would welcome further discussion on the consequences of this part of the Bill.

Part 10 – Abolition of Certain Public Bodies etc.

263 Standing Advisory Committees

Representatives from NSS currently act as ex-officio members of the Joint Committee on Vaccination and Immunisation and its sub-groups. We submit evidence to it. We welcome the retention of the Committee and await further discussion on our future role.

Conclusion

The Health and Social Care Bill has widespread implications for the work of HPS and health protection in general in Scotland. We hope that this evidence is clear and supports the work of the Committee in its review of the Legislative Consent Memorandum.

MENTAL HEALTH ACT 1983

No comment

HEALTH AND SOCIAL CARE INFORMATION CENTRE

We do not expect that the changes proposed will affect the capacity for the Information Centre to continue providing the services described.
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Current cost liabilities of NSS, for services delivered by NHS

The proposal has no cost liability to NSS or for services delivered by NSS.

Bodies and agencies whose status is altered by the provisions of the Bill

The NHS Health and Social Care Information Centre will continue to provide the services currently provided. Its status will be changed in that the Information Centre is established in primary legislation.

Any discussions undertaken with such bodies or agencies on the implications of the Bill for services delivered by them

There have not been discussions between NSS and the Information Centre.

Implications for NSS as a result of the Bill, which we wish to bring to the attention of the Committee

Amending Section 9 of the National Health Service Act 2006 and Section 17A of the National Health Service Scotland Act 1978 will include NHS Health and Social Care Information Centre as a body which can enter NHS contracts. This would enable NHS Scotland organisations to enter contractual relationship with the Information Centre. In a competitive environment this may have implications for services which are provided currently, although this is not certain.

REGULATION OF HEALTHCARE PROFESSIONS AND HEALTH AND SOCIAL CARE WORKERS

No comment

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

No comment

NON-CONSEQUENTIAL AMENDMENTS

No comment

Ian Crichton
Chief Executive
NHS National Services Scotland
9 February 2011
NHS Commissioning Boards (NHSCB)

Regarding access to some specialist or highly secure services procured by NHSCB, what safeguards will be in place to ensure Scottish patients are not increasingly disadvantaged over time by having to travel longer distances for national subspecialist treatment? And how can we ensure patients in the devolved nations such as Scotland are not disadvantaged by having slower access, or less choice of access, as compared to patients in England? Perhaps the control over this won’t be changed by the new arrangements.

Could some sub-specialist services currently located in Scotland - such as paediatric neurosurgery or childrens cancer services - gradually all be moved to England if, as NHSCB capacity issues suggest, collocating these services in Scotland and England is not cost effective or providing adequate numbers to maintain ‘quality’ in both regions? Building all the expensive cutting edge equipment on English soil may not be in Scotland’s long term interest.

When NHSCB commission some services from primary care providers in Scotland, will they do this by approaching CHPs directly or through NHS Scotland centrally? And will the CHPs offer these service contracts to GMS providers first?

The principle that GMS providers in Scotland should be regarded as preferred bidders is something that can be incorporated in legislative amendments?

National Institute for Health and Clinical Excellence (NICE)

1(a) If there is not capacity for SIGN to develop a mirrored devolved guideline network, and concerns have been raised that there is not the capacity, procurement requests for NICE data and financial transactions are undertaken through one NHS body in Scotland such as NES so that here is not duplications of cost for NHS bodies in Scotland increasing the overall cost for NHS Scotland; and

(b) Scottish involvement, including GPs, in NICE guidance development should offset costs to the Scottish NHS of procuring services from NICE.

Or

2. Phase out the SIGN and health services research and effectiveness unit quangos and constitute ‘NICE Scotland’ which would provide 10% of collaborative and co-ordinated work (reflecting population) towards UK guideline development and remove cost transactions between NICE and devolved nation NHS bodies - overall cost saving to NHS. NICE Scotland would feed into to the new body Healthcare improvement Scotland
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Whichever, Scottish GPs need to continue to be involved in guidance development and NICE guidance strengthened.

RCGP Scotland
16 February 2011
I am responding to your letter of 28th January regarding the Legislative Consent Memorandum that results from the introduction of the Health and Social Care Bill into the UK Parliament but which is concerned to the reform the NHS in England only.

There are 8 provisions within the Health and Social Care Bill which had been identified as falling within the legislative competence of the Scottish Parliament or altering the executive competence of Scottish Ministers. I will respond to each of these in turn.

1. **NHS Commissioning Board / GP Commissioning**

It is the case that NHS Tayside like other Boards does procure a number of services in England for Tayside residents. Many of these are managed under National Contracts agreed by the Common Services Agency in Scotland on behalf of Scottish Boards. However, some services are procured directly by us. This is usually done through the appropriate local commissioning body. Some are done however directly with the relevant service provider. The picture is a mixed one, but it is important to stress that it applies to a very small number of Tayside patients. The change to commissioning arrangements proposed in England will obviously have a consequence for Scottish Boards, but so long as there is provision for NHS Boards to enter into arrangements with the new commissioning structures in England we do not envisage any specific difficulties. There maybe some practical implications of dealing with GP consortia, although there is insufficient detail at the moment to be equivocal about this matter. Any implications however would relate to the management and operation of the Commissioning Board and GP consortia, not to the legislative provisions under consideration. Similarly, at this stage, so far as we can deduce, the new arrangements should not have any implications for costs.

2. **Abolition of the Health Protection Agency**

This is obviously a matter predominantly for Scottish Ministers, but the proposed arrangements in response to the abolition of the Health Protection Agency and the transfer of its functions to the new Public Health Service are to us sound.

3. **Mental Health Act 1983**

We note the amendment to Section 122 of the Mental Health Act 1993. This will have no practical implications for the Health Service in Scotland although it will require the consent of the Scottish Parliament.
4. Health and Social Care Information Centre

We note the legislative changes that will be required to allow the Scottish Government to receive pay information and other services, but that it has no wider implications than that.

5. Regulation of Healthcare Professionals and Health and Social Care Workers

We note that the Council for Healthcare Regulatory Excellence, which scrutinises and quality assures the performance of various professional regulatory bodies, is transferring to a self funding basis. In future, it will fall to the regulatory bodies who will ‘reclaim’ through increases in fees to members of the respective professions. It would certainly appear that the financial implications of this are going to be minimal.

6. National Institute for Health and Clinical Excellence

We note that the functioning of the National Institute for Health and Clinical Excellence is to change, and that one of the consequences of this is that the range of services which the Institute provides to Scotland for which charges are made will potentially increase. We would agree that the consequences of now being charged for a service would have to be a factor taken into account about whether the service should be procured or alternative arrangements to procure it put in place.

Finally, I would thank the Health and Sport Committee for the opportunity to comment upon the Legislative Consent Memorandum. However, the consequences of the Health and Social Care Bill in England at this stage would appear very much to be legislative ones that require the consent of the Scottish Parliament, but will have a very limited impact on Health Boards.

Gerry Marr
Chief Executive
NHS Tayside Board
17 February 2011
Legislative Consent Memorandum on the Health and Social Care Bill

NHS Greater Glasgow and Clyde

Having reviewed the provision of the Legislative Consent Memorandum and the questions posed to boards, we wish to make the following comments:

- The majority of the changes appear to involve the transfer of existing functions or services to a different body. Provided that the functions do continue as expected, these are unlikely to have major implications for Boards.

- The changes to NICE are the ones we have identified as most likely to have an impact on the NHS in Scotland, although not necessarily a direct financial impact on individual Boards. For example, NHSGGC generally considers NICE drug MTAs to be helpful and to complement SMC advice. It would be a disadvantage if this service ceased to be available.

- There are other broader implications of the Health and Social Care Bill beyond the direct consequences of the LCM, most notably the increasing divergence in health policy between England and other parts of the UK. This is likely to have implications in relation to issues which are currently dealt with on a UK wide basis. For example, it is increasingly likely that elements of the GMS contract may begin to be negotiated separately for Scotland. The infrastructure to support such developments (which includes input from NICE on the Quality and Outcomes Framework) would have to be developed at a Scotland level which may have cost implications.

NHS Greater Glasgow and Clyde
17 February 2011
14 February 2011

Dear Christine

Adam Ingram and I thought it would be helpful for your Committee in considering the regulations being made under the Public Services Reform (Scotland) Act 2010 (the "2010 Act") in relation to the creation of Social Care and Social Work Improvement Scotland (SCSWIS) and Healthcare Improvement Scotland (HIS) if we were to provide some additional background information on the proposed operation of these new bodies.

We intend that SCSWIS and HIS will provide more streamlined and better co-ordinated scrutiny of social care, social work, child protection and healthcare services. They will provide public assurance on service quality, hold up a mirror to councils, health boards and service providers and target their support for service improvement. They will do this by regulating; inspecting; assessing risk; providing evidence; providing guidance and advice; influencing standards; supporting improvement, and reporting publicly. The 2010 Act now places a duty on all local authorities and health boards when providing care and healthcare services (or contracting to do so) to consider reports and other information published by SCSWIS and HIS.

In your Committee’s report at Stage 1 of the Bill you recommended that we should consider moving to a single scrutiny body. I indicated at that time that we felt that was too great a change in one step but it has not been ruled out for the longer term either. However, the new bodies will integrate their activities as far as possible and under the duty of co-operation will co-ordinate their activities with each other, avoiding any duplication of processes.

Under the duty of co-operation SCSWIS and HIS will also collaborate with other bodies to understand and report how services could be improved to achieve better outcomes for individuals. They will collaborate to look across services, such as social work, social care, acute, primary and community healthcare, housing, education, mental welfare, justice and child protection, wherever services are delivered together to meet individuals’ needs. Both HM Chief Inspector of Prosecution and the Scottish Housing Regulator have now been added to the list of scrutiny bodies subject to the duty of co-operation under the 2010 Act.
SCSWIS and HIS will analyse evidence and other information from inspections, registration, complaints, investigations and other professional intelligence. From this analysis they will report on the quality of services, how risks can be minimised and problems addressed.

On the basis of performance evidence the new bodies and the other scrutiny bodies will move away from cyclical scrutiny programmes towards shared and risk-based programmes. In time, all scrutiny bodies will collaborate on strategic and thematic scrutiny using common reporting practices, standards and language. The integrated and collaborative approach will support self-evaluation by service providers and will minimise duplication and overlap and enable less effort to be spent on scrutiny and more on improving services by directing resources and efforts where most needed.

The new bodies will be required to focus on service users to provide a comprehensive picture of how the needs of people using services are met - from service strategy and design, the assessment of need through to the provision of services to individuals. This will be supported by a greater involvement of users in the planning and assessment of scrutiny activities. The creation of SCSWIS and HIS will, over time, allow people who use services, their carers and the wider public to see and experience further significant improvement in the quality of their services.

We intend the new bodies will commence operation on 1 April 2011. To that end we have now appointed a Chair and interim Chief Executive for each body and will shortly announce the Board members. I will also be announcing the chair for the Scottish Health Council who will be a member of the board of HIS. In addition, the 2010 Act provides that the Chair of each body will be a member of the Board of the other body.

The regulations which your Committee will consider on 23 February and 2 March 2011 complete the legislative framework for establishing SCSWIS and HIS. These regulations along with the Code of Practice for joint inspections have been the subject of a public consultation targeted at service providers and more directly with the current scrutiny bodies - the Care Commission, SWIA, HMIE and NHS QIS.

SCSWIS

Applications, registration and requirements regulations
The Social Work and Social Care Improvement (Requirements for Reports) Regulations 2011 (SSI 2011/26)
The Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 (SSI 2011/28)
The Social Care and Social Work Improvement Scotland (Applications) Order 2011 (SSI 2011/29)
The draft Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/draft)

These regulations are broadly similar to those in force at present for services regulated by the Care Commission. They set out obligations on those applying to register a care service with SCSWIS and the criteria that must be met whilst they are registered. We have taken this opportunity to simplify the requirements placed on providers and afford SCSWIS greater flexibility in designing its registration procedures. This will enable SCSWIS to streamline its operational systems and develop efficient and effective procedures while still ensuring that the necessary information is obtained on services. In particular, the regulations will allow SCSWIS the flexibility to gather additional self-assessment information from providers.

St Andrew’s House, Regent Road, Edinburgh  EH1 3DG
www.scotland.gov.uk
This information along with other intelligence will inform SCSWIS risk-assessment of providers and subsequently the further development of its inspection plan.

**Fees**
The Social Care and Social Work Improvement (Fees) Order 2011 (SSI 2011/27)

This Order prescribes the maximum fees which may be imposed by SCSWIS from 1 April 2011. These fees are the same as those that may be charged currently by the Care Commission which have remained frozen at 2005/2006 levels. However, the 2010 Act allows SCSWIS to charge a nominal fee or remit the fee altogether where it considers that to be appropriate.

**Inspections**
The Social Work and Social Care Improvement (Requirements for Reports) Regulations 2011 (SSI 2011/26)
The draft Public Services Reform (Social Services Inspections) (Scotland) Regulations 2011 (SSI 2011/draft)

As required by the 2010 Act, SCSWIS is drawing up a plan for inspecting services from April 2011 which is in accordance with best regulatory practice. The plan, which Ministers have to approve, will ensure that SCSWIS takes a proportionate approach to inspections and is being developed on the basis of a detailed analysis of the quality of and risks posed by groups of services. The plan anticipates a step-down approach to the frequency of inspections. While the Act makes provision for regulations in relation to the timing and frequency of inspections we do not intend to make any such regulations at this time. This will provide SCSWIS with the flexibility to develop a more proportionate inspection regime and to focus its efforts on services which perform less well or present the greatest risk.

In assessing services, SCSWIS will consider information gathered from services as part of the application, from annual returns, from self-assessments by the services and from complaints. SCSWIS will be able to inspect single services, all services provided by a provider and a local authority’s provision of social services. The SCSWIS inspection regulations provide the powers which the body will require when conducting these inspections.

SCSWIS will also use these inspection powers when conducting multi-disciplinary inspections of services in co-operation with other scrutiny bodies, such as the inspections of services for people with learning disabilities conducted by SWIA with support from the Care Commission and HMIE and NHS QIS. With due respect for confidentiality, SCSWIS inspectors will be able to share information on services gathered during inspections with other scrutiny bodies thereby helping to avoid duplication of scrutiny.

All SCSWIS inspection reports will be publicly available and when an inspection requested by Scottish Ministers is completed a copy of the inspection report will be sent to Ministers as soon as reasonably practicable.
Applications, Registrations and Requirement Regulations
The Healthcare Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI 2011/34)
The Healthcare Improvement Scotland (Applications and Registration) Regulations 2011 (SSI 2011/35)
The draft Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 (SSI 2011/draft)

These regulations are broadly similar to those in force at present for independent healthcare services as regulated by the Care Commission. They set out obligations on those applying to register an independent healthcare service with HIS and the criteria that must be met whilst they are registered. We have taken a similar approach as the regulations for SCSWIS and simplified the requirements placed on providers to afford HIS greater flexibility in designing its registration procedures. This will enable HIS to streamline its operational systems and develop efficient and effective procedures while still ensuring that the necessary information is obtained on services which wish to be or are registered. In particular the regulations will allow HIS the flexibility to gather additional self-assessment information from providers. This information along with other intelligence will be used when drawing up its inspection programme.

Fees
The Healthcare Improvement Scotland (Fees) Regulations 2011 (SSI 2011/33)

These regulations prescribe the maximum fees which may be imposed by HIS from 1 April 2011. These fees are the same as those that may be charged currently by the Care Commission for independent healthcare providers which have remained frozen at 2005/2006 levels. However the 2010 Act allows HIS to charge a nominal fee or remit the fee altogether where it considers that to be appropriate.

Inspections
The Healthcare Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI 2011/34)
The draft Healthcare Improvement Scotland (Inspections) Regulations 2011 (SSI 2011/draft)

As required by the 2010 Act, a HIS inspection plan for independent healthcare services and NHS services from 1 April 2011 is being prepared which is in accordance with best regulatory practice. The plan must be approved by Scottish Ministers following consultation with such persons as HIS consider appropriate. The plan will set out how HIS will take a proportionate and risk based approach to inspections. While the Act makes provision for regulations in relation to the timing and frequency of inspection we do not intend to make any such regulations at this time. As with SCSWIS this will provide HIS with greater flexibility in developing its inspection regime for independent healthcare services.

In assessing these services, HIS will consider information gathered from services as part of the application process, from annual returns, from self-assessments by the services and from complaints and additional intelligence gained throughout the course of the year. This intelligence will inform a risk matrix which will see services scrutinised on the basis of the level of risk. The HIS inspection regulations provide the powers which the body will require when conducting inspections. HIS will also use these powers when conducting multi-disciplinary inspections of services.
All HIS inspection reports for registered independent healthcare services will be publicly available and when an inspection requested by Scottish Ministers is completed a copy of the inspection report will be sent to Ministers as soon as reasonably practicable.

**The future regulation of independent health services**

From 1 April 2011 we intend to commence the independent healthcare services which are currently regulated by the Care Commission; these are independent hospitals, voluntary hospices and private psychiatric hospitals. I also promised during the passage of the 2010 Act to consult on the future arrangements for the regulation of the independent healthcare sector including seeking views on the definition and scope of independent healthcare services that should be regulated. This consultation took place from July to October last year and we appreciate the input from those who responded. We are currently considering the way forward and will issue a consultation report shortly.

**Joint Inspections**

The draft Public Services Reform (Joint Inspections) (Scotland) Regulations 2011 (SSI 2011/draft)

Scottish Ministers have the power to require a scrutiny body to lead a joint inspection of children and other services and to ask any or all of the other scrutiny bodies listed in section 115 of the Act to participate in these inspections. Both HM Chief Inspector of Prosecution and the Scottish Housing Regulator have now been added to this list.

These regulations make provision for the conduct of such joint inspections. They will replace the existing legislation providing for the joint inspection of children’s services. Scottish Ministers will request SCSWIS to lead the third year of joint inspection of child protection services and we expect these to be conducted in a similar manner to those in year 1 and 2 led by HMIE. The existing Code of Practice has been updated to reflect the change in the legislation.

At present we have no specific plans for joint inspections of other services. We intend to use these powers for inspections of services to the most vulnerable service users and where the existing multi-agency arrangements would be insufficient to enable thorough inspection of the services and their co-ordination. We will be considering areas where such inspections might be helpful in consultation with SCSWIS and HIS and the other scrutiny bodies.

**Consequential Changes**

The draft Public Services Reform (Scotland) Act 2010 (Consequential Modifications) Order 2011 (SSI 2011/draft)

This order makes a number of changes to other Scottish primary and secondary legislation as a consequence of the creation of SCSWIS and HIS and the dissolution of the Care Commission and NHS QIS.
I hope this letter provides helpful background for your Committee. I will be attending your Committee on Wednesday 23 February 2011 when it considers these regulations and will be happy to answer any questions your members may have on them.

SHONA ROBISON
Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

Purpose

The purpose of the instrument is to set out requirements on independent health care services that will be regulated by HIS.

Drawn to attention by Subordinate Legislation Committee (SLC)?

The SLC reported on a number of drafting errors in this instrument. The report of the Committee is set out in Annex A
<table>
<thead>
<tr>
<th>Agenda Item 2</th>
<th>23 February 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Services Reform (Social Services Inspections) (Scotland) Regulations 2011</strong></td>
<td>7 March</td>
</tr>
<tr>
<td><strong>Public Services Reform (Joint Inspections) (Scotland) Regulations 2011</strong></td>
<td>7 March</td>
</tr>
<tr>
<td><strong>Public Services Reform (Scotland) Act 2010 (Consequential Modifications) Order 2011</strong></td>
<td>14 March</td>
</tr>
<tr>
<td><strong>Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011</strong></td>
<td>14 March</td>
</tr>
</tbody>
</table>
REPORT FROM THE SUBORDINATE LEGISLATION COMMITTEE

The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 (SSI 2011/draft)

1. The Regulations set out the requirements as to providers of independent health care services, under the National Health Service (Scotland) Act 1978, as amended (“the 1978 Act”). “Independent health care services” are defined in section 10F of the 1978 Act.

2. The Committee sought information from the Government on a number of drafting errors. Correspondence between the Scottish Government and the Committee is reproduced at paragraphs 10 and 11.

3. The response acknowledges the two drafting errors which the Committee identified in the preamble to the instrument. The Committee agreed with the Government’s assertion that the errors do not affect the operation or validity of the instrument, and that it is clear from the context which provisions are intended to be referred to, so there is no issue of ambiguity between different meanings.

4. The same drafting error in the citation of the Nursing and Midwifery Order 2001 which appears in several of the instruments being brought forward to implement changes in health care inspections and social care services made under the Public Services Reform (Scotland) Act 2010 (see below).

5. In this instance, in the context used, the instrument which was intended to be referred to is quite clear, and the affected provision in regulation 1(2)(e) is limited in scope. It relates to the definition of a registered nurse, midwife or health visitor as types of “health care professional”, and that only in confirming that those persons must be registered under article 5 of the 2001 Order.

6. The Committee considers however that this drafting error ought to be corrected to ensure clarity from the beginning of the new HIS regime.

7. The Scottish Government also confirmed that it will bring forward an amendment to correct this error in a further order to be laid shortly, and that the correction will come into force at the same time as the present instrument. The Committee reports that this instrument contains a drafting error in the incorrect citation of the Nursing and Midwifery Order 2001, in the definition of a “registered nurse, midwife or health visitor”.

8. The Committee welcomes the undertaking from the Government to correct that drafting error in regulation 1(2)(e), immediately by a further order.

9. The Committee reports that this instrument contains further drafting errors in the form of the instrument, which could be corrected when the instrument is made.
10. On 28 January the Scottish Government was asked:

(1) What is the effect of the apparent error in the second line of the preamble, which cites the enabling power to make the Regulations, but refers to “the National Health (Scotland) Act 1978” (omitting “Service”)?

(2) What is the effect of the apparent error, that the 3rd paragraph of the preamble cites “section 104 (2) of that Act” as the provision which requires the instrument to be laid in draft for approval by resolution, but it appears that this should refer to section 105(3) of the 1978 Act?

(3) What is the effect of the apparent error in regulation 1(2)(e), in the citation of the “Nurses and Midwives Order 2001” rather than “Nursing and Midwifery Order 2001”?

11. The Scottish Government responds as follows:

(1) The Scottish Government considers the error in the second line of the preamble, which cites the enabling power to make the Regulations but refers to the National Health (Scotland) Act 1978 (“omitting Service”) to be unfortunate but does not consider that it has any material effect on this instrument. The enabling power has a correct footnote so it is considered unlikely that there will be ambiguity as to which piece of legislation is being referred to. Furthermore, it is well established precedent that the preamble is not part of the text of an instrument therefore failure to cite a relevant enabling provision does not result in the invalidity of an instrument. (Craies on Legislation 3.3.6).

(2) The Scottish Government does not consider that the error in the 3rd paragraph of the preamble, which cites section 104(2) of that Act as the provision which requires the instrument to be laid in draft for approval by resolution, rather than section 105(3) of the 1978 Act, has any material effect on the validity of the instrument. It is a matter of fact that the instrument has been laid in draft for approval by resolution of the Scottish Parliament, the headnote refers to the correct section in the 1978 Act under which the instrument must be laid in draft and as this paragraph forms part of the preamble, it is not part of the text of the instrument and therefore failure to cite a relevant enabling provision does not result in the invalidity of an instrument, as we have mentioned above.

(3) The Scottish Government considers the error in the citation of the Nursing and Midwifery Order 2001 to be unfortunate but does not consider that it has any significant effect on these Regulations. The Order in question is correctly footnoted and it is submitted that the Order can easily be recognised by the title given, together with the description in the definition of registered nurse. The description refers to the register maintained under Article 5 of the Order. There is only one register that can fall within this definition therefore we do not consider that the error in the citation would mislead the reader. The Regulations are therefore fit for purpose. However we have noted the concern of legal advisors to the Subordinate Legislation Committee on this point and, in the forthcoming Consequential Modifications (Public Services
Reform (Scotland) Act Order 2011, (which will be laid in Parliament this week) we have taken the opportunity to correct the erroneous citation. This Order will come into force on the same day as the Healthcare Improvements Scotland (Requirements as to Independent Healthcare) Regulations 2011 so there will be no delay in the correction being effective.

The Healthcare Improvement Scotland (Inspections) Regulations 2011 (SSI 2011/draft)

The Public Services Reform (Social Services Inspections) (Scotland) Regulations 2011 (SSI 2011/draft)

The Public Services Reform (Joint Inspections) (Scotland) Regulations 2011 (SSI 2011/draft)

12. The Committee asked the same question concerning a drafting error in each of the above instruments, as was identified in question 3 to the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 (SSI 2011/draft) (above).

13. The drafting error appears in several of the instruments being brought forward to implement changes in health care inspections and social care services made under the Public Services Reform (Scotland) Act 2010.

14. The Government have not correctly cited the Nursing and Midwifery Order 2001 – referring in each case to the Nurses and Midwifes Order 2001. Instruments invariably provide themselves for how they are to be cited in other legislation or documents. In addition, the 1999 Transitional SI order provides that instruments may be cited by using only the year of their publication and their SSI number. While the Government have footnoted the instrument correctly, it does not amount to a form of citation which gets the benefit of the citation provision contained either in the 2001 order itself or under the 1999 Order rule.

15. This is clearly a drafting error. The Committee wished to investigate the effect of this error in terms of the risk of the instrument failing to operate correctly and whether the Government proposed to take corrective action. Correspondence with the Scottish Government is reproduced at paragraphs 19 and 20.

16. The Government does not consider that the error renders the instrument defective. While accepting that it is reasonably clear what instrument it is intended to refer to, the Committee considers that it is significant that the reference to the 2001 order is used to define entitlement to conduct examinations and to investigate medical records. The Committee considers that the identification of the persons entitled to perform these functions should be absolutely clear.

17. The Scottish Government has confirmed that it will bring forward an amendment to correct this error in a further order to be laid shortly and that the correction will come into force at the same time as the present instrument.

18. The Committee reports that these instruments contained a drafting error in the incorrect citation of the Nursing and Midwifery Order 2001 in the definition of “registered nurse”. However, the Committee welcomes the
Scottish Government’s commitment to correct this error immediately since this definition is important, being used to determine a class of persons entitled to conduct examinations and to inspect medical records.

19. On 28 January the Scottish Government was asked:

The Scottish Government is asked to explain what is considered to be the effect of the error in the citation of the Nursing and Midwifery Order 2001 in the definition of “registered nurse” and following through to the definition of “health professional” for the purposes of restricting access to information under regulation 5 and the conduct of interviews and examination under regulation 7(4)? Does the Scottish Government intend to correct this error?

20. The Scottish Government responds as follows:

The Scottish Government considers this error in the citation of the Nursing and Midwifery Order 2001 to be unfortunate but does not consider that it has any significant effect on these Regulations. The Order in question is correctly footnoted and it is submitted that the Order can easily be recognised by the title given, together with the description in the definition of registered nurse. The description refers to the register maintained under Article 5 of the Order. There is only one register that can fall within this definition therefore we do not consider that the error in the citation would mislead the reader. The Regulations are therefore considered to be fit for purpose.

However we have noted the concern of legal advisors to the Subordinate Legislation Committee on this point and, in the forthcoming Consequential Modifications (Public Services Reform (Scotland) Act Order 2011, (which will be laid in Parliament this week) we have taken the opportunity to correct the erroneous citation. This Order will come into force on the same day as the Healthcare Improvements Scotland (Inspections) Regulations 2011 so there will be no delay in the correction being effective.
Overview

There are seven negative instruments for consideration. All of these instruments relate to the forthcoming establishment of Healthcare Improvement Scotland ("HIS") and Social Care and Social Work Improvement Scotland ("SCSWIS") on 1 April 2011. These bodies are established under the Public Services Reform (Scotland) Act 2010 ("PSR Act").

A brief explanation of the 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 Annul</th>
<th>Purpose</th>
<th>Drawn to attention by Subordinate Legislation Committee (SLC)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Work and Social Care Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI/2011/26)</td>
<td>7 March</td>
<td>No</td>
<td>The purpose of the instrument is to prescribe the circumstances when copies of reports prepared by SCSWIS under section 57 of the PSR Act should be made available to Scottish Ministers.</td>
<td>SLC has no comments to make on this instrument</td>
</tr>
<tr>
<td>Social Care and Social Work Improvement Scotland (Fees) Order 2011 (SSI/2011/27)</td>
<td>7 March</td>
<td>No</td>
<td>The purpose of the instrument is to prescribe the maximum fees that may be imposed by SCSWIS in relation to: applications for registration of care services, annual continuation of such registration, variation or removal of a condition of registration, applications for cancellation of registration and new certificates of registration.</td>
<td>SLC has no comments to make on this instrument</td>
</tr>
<tr>
<td>Instrument Description</td>
<td>Date</td>
<td>Comments</td>
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<tr>
<td>Social Care and Social Work Improvement Scotland (Registration) Regulations 2011(SSI/2011/28)</td>
<td>7 March</td>
<td>No</td>
<td></td>
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<tr>
<td>The purpose of the instrument is to set out provisions relating to the registration of care services with SCSWIS. “Care services” are defined in section 47(1) of the PSR Act and will be regulated by SCSWIS from 1 April 2011. Care services which are currently registered with the Care Commission will be deemed registered with SCSWIS.</td>
<td>SLC has no comments to make on this instrument</td>
<td></td>
<td></td>
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<tr>
<td>Social Care and Social Work Improvement Scotland (Applications) Order 2011(SSI/2011/29)</td>
<td>7 March</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>The purpose of the instrument is to set out provisions relating to the applications made to SCSWIS to register a care service, and to the information which an applicant will be required to provide. Care services which are currently registered with the Care Commission will be deemed registered with SCSWIS and will not need to go through the application process.</td>
<td>SLC has no comments to make on this instrument</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Healthcare Improvement Scotland (Fees) Regulations 2011 (SSI/2011/33)</td>
<td>7 March</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The purpose of the instrument is to prescribe the maximum fees that may be imposed by HIS in relation to: applications for registration of independent health care services, annual continuation of such registration, variation or removal of a condition of registration, applications for cancellation of registration and to issue new certificates of registration.</td>
<td>SLC has no comments to make on this instrument</td>
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<td></td>
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<tr>
<td><strong>Healthcare Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI/2011/34)</strong></td>
<td>7 March</td>
<td>No</td>
<td>The purpose of the instrument is to prescribe the circumstances when copies of reports prepared by HIS under section 10N of the PSR Act should be made available to Scottish Ministers.</td>
<td>SLC has no comments to make on this instrument</td>
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<tr>
<td><strong>Healthcare Improvement Scotland (Applications and Registration) Regulations 2011 (SSI/2011/35)</strong></td>
<td>7 March</td>
<td>No</td>
<td>The purpose of the instrument is to set out provisions relating to the applications made to HIS to register an independent health care service, and to the information which an applicant will be required to provide. &quot;Independent health care services&quot; are defined in section 10(F) of the PSR Act and will be regulated by HIS from 1 April 2011. Independent health care services which are currently registered with the Care Commission will be deemed registered with HIS and will not need to go through the application process again.</td>
<td>SLC has no comments to make on this instrument</td>
</tr>
</tbody>
</table>
Health & Social Care Bill (UK) Legislative Consent Memorandum

Response to the Call for Written Evidence from the Scottish Parliament Health and Sport Committee

Feb 2011
Introduction

UNISON Scotland recognises and welcomes the fundamentally distinct approach to NHS policy in Scotland, NHS Scotland services in part will be directly affected by these proposals. Over and above the specific changes which are the subject of the Legislative Consent Memorandum we have a concern that the proposals in the Bill may begin to impact on the operation of the NHS in Scotland. This paper therefore represents a consideration of not only the LCM but the Bill as a whole.

NHS Scotland for example utilises England for certain specialist services. In order for such services not to be subject to the marker forces being promoted here, the Scottish Parliament should take this opportunity to seek to encourage repatriation to Scotland of these services (SEE Appendix 1 of Submission).

Some could and should be provided in Scotland. There would appear to be a preponderance of referrals to England from the East Coast.

Also in 2008 Organ Donation was organised on a UK basis following a Four Nations Ministerial Taskforce. Again the consequences for this life saving service in Scotland of the structural and market driven changes in England requires careful consideration.
1. UNISON is the major union in the health service and social care sector. Across the UK we represent more than 450,000 healthcare staff and 300,000 social care staff employed in the NHS and local government, and by private contractors, the voluntary sector and GPs. Our members include nurses, student nurses, midwives, health visitors, healthcare assistants, paramedics and ambulance staff, occupational therapists, operating department practitioners, cleaners, porters, catering staff, medical secretaries, clerical and admin staff, pharmacy technicians and scientific staff, and primary care staff.

**Summary**

2. UNISON opposes the Bill’s plans to introduce wholesale competition to the NHS, including price competition. The Bill will give hospitals the option of prioritising those who can afford to pay for their care over NHS patients. It will lead to instability and potentially to services being lost to patients. Proposals for Health and Wellbeing Boards need considerable strengthening to sustain the claim that greater democratic accountability is being brought to the NHS. The plans will also have a massive impact on staff – most obviously with the 20,000 job losses predicted by the government, but also related to terms and conditions, and the regulation of social workers.

3. With huge structural upheaval and full-blown competition introduced at a time of unprecedented financial pressure, UNISON’s overriding concern is that the Bill endangers the whole future of our National Health Service, with its genuine public service ethos and improving levels of healthcare for patients. It is therefore deeply disingenuous of the government to suggest that the Bill represents a logical, evolutionary step from what has gone before. It is also extremely disappointing that, in attempting to build support for its plans, the government has felt the need to deride the achievements and improvements of the NHS and its staff over the past decade – all the more so when the government’s use of evidence has been proven to be highly selective at best.

**Wholesale competition**

4. UNISON opposes the Bill’s plans to introduce wholesale competition to the NHS for its own sake, subjecting healthcare services to economic regulation and opening the NHS up to European competition law. Contrary to the government’s claims, the Bill also permits the regulator Monitor to pay private providers at a preferential rate.

5. UNISON will therefore be seeking amendment to Clause 52 in which the first duty of Monitor, the foundation trust regulator, will in future be to "promote competition" as an economic regulator.

6. Crucially, UNISON will be seeking to amend Clause 104 which permits Monitor to vary prices "in relation to different descriptions of provider", meaning that Monitor could decide to provide extra incentives to bring new private operators into a market by insisting that commissioners pay them a preferential price (despite the government claim that "we will not rig the market in favour of the private sector").
7. UNISON will be seeking to amend Clauses 60-68 on Competition, which contain virtually no reference to boosting choice or to attempting to enhance the quality of service. The repeated references to the Competition Commission and the Office of Fair Trading are completely at odds with a public health service that must be treated as distinct from the likes of the privatised utilities.

8. UNISON will be seeking to amend Clauses 15 and 60, which refer directly to compliance with EU legislation and would give the Secretary of State legislative backing to enforce EU competition law. Once services are commercialised and put out to tender it is virtually impossible under these rules for them to be taken back into a public sector health service.

9. In terms of transparency, UNISON will also seek to amend Clause 67, which states that the private companies entering the new system can "exclude from publication… commercial information" which will damage the proper scrutiny of new providers. As currently worded, this sets up a two-tier system of scrutiny, in which NHS organisations would be obliged to open their papers and accounts to the public, but private companies would not.

**Price over quality**

10. UNISON is particularly worried about plans to bring price competition into the NHS with repeated references to the use of "maximum prices". A strong consensus exists among commentators and academics – including those that are avowedly pro-market, such as Zack Cooper from the LSE and Carol Propper from Bristol University – that price competition will have a detrimental impact on the quality of care received.

11. The government has attempted to portray their policy as merely a continuation of the previous government’s plans for the NHS, prompting the controversy at the Bill’s Second Reading which focused on misleading comparisons between a paragraph each from the final operating framework of the Labour government and the first of the Conservative-Liberal Democrat government.

12. The most obvious difference to point out is that the previous government neither legislated for price competition nor suggested that it planned to. Secondly, there is a major difference between the approach of the previous government which was to drive down the prices paid to existing providers by commissioners, and introducing maximum pricing into a system of unconstrained market forces, as envisaged by the current government’s plans to subject the NHS to Competition Commission, Office of Fair Trading and EU rules and regulations. The pursuit of "best practice" tariffs is something which both governments have in common, but this is not about price competition – rather about bringing fixed prices down to the level of the most efficient for particular services.

13. UNISON will therefore be seeking a number of amendments to Clauses 103-105 and 110-111, in which price competition is unequivocally introduced with references to the use of "maximum prices" which would potentially allow healthcare providers, including private companies, to undercut prices in order to enter a market or to bolster their position within a market.
Private patients prioritised

14. The Bill will abolish the private patient income cap. There is currently a limit on the amount of private patient income a hospital can make – set for foundation trusts at the percentage they made when foundation trust legislation was first introduced, and more recently set at 1.5% for mental health foundation trusts.

15. The purpose of the cap is to stop hospitals from prioritising private patients that bring in extra income and thereby pushing NHS patients to the back of the queue. In the new ultra-competitive system, hospitals are likely to be tempted to prioritise those that bring extra income over free NHS patients, as they struggle to keep afloat with tariff reductions and a more cut-throat failure regime.

16. Plans for foundation trusts to keep separate accounts listing their private income and their NHS income are so far only referred to in the Bill’s impact assessment, rather than being formally legislated for.

17. UNISON will therefore be seeking to amend Clause 150 that would abolish the private patient income cap.

18. In the interests of furthering transparency and scrutiny, UNISON will also seek to add into the Bill a legal requirement for foundation trusts to produce separate accounts for private and NHS income, which the government has already agreed to in principle.

Instability and threat to services

19. The Bill opens up the possibility of instability and services being lost to patients. UNISON will be seeking to amend Clause 148 that confirms borrowing limits on foundation trusts will be removed, raising the likelihood of hospitals getting into financial difficulty.

20. There will no longer be a fall-back option of failing hospitals being brought back into the NHS; instead hospitals can be sold off and only those services "designated" as essential will have to be provided elsewhere – setting the stage for a two tier NHS. UNISON will therefore be seeking to amend Clause 158 that repeals this aspect of existing legislation.

Democratic engagement

21. The plans for Health and Wellbeing Boards need to be strengthened to ensure greater democratic involvement and to provide a role for education and the voice of staff.

22. UNISON will therefore be seeking amendments to Clause 178 which establishes Health and Wellbeing Boards. For them to express real democratic accountability, a majority of the Board should be elected councillors (rather than "at least one" as currently stated). Boosting the democratic legitimacy of the Boards is particularly important as Clause 180 allows a local authority to arrange for a Board "to exercise any other functions of the authority".
23. In addition, also in Clause 178, UNISON will be seeking to add a representative of the local Schools Forum to the list of those sitting on a Health and Wellbeing Board. As currently worded there is a role for directors of children’s services but not for representatives from education, which is an oversight given the idea of the Board is to join-up services across areas.

24. The Boards also lack the input of trade union representatives, which would be a way of ensuring that the staff voice is heard – UNISON will seek further amendment to Clause 178 in this regard.

**NHS staffing issues**

25. There is a risk for staff transferred to commissioning consortia that their new employer could move to change their pay, terms and conditions unilaterally, with the Bill stating explicitly that transfers taking place under Transfer of Undertakings (Protection of Employment) regulations could be unravelled after the fact.

26. UNISON will therefore be seeking to amend Schedule 2.

**Regulation of social workers**

27. The Bill heralds a significant change for social workers who are currently registered with the General Social Care Council but in future will have to register with the new Health & Care Professions Council. This means that the right of appeal will be to the High Court rather than the current Care Standards Tribunal. This is causing great disquiet among social workers because permissible grounds for appeal are much narrower and less responsive to the complexities of social work cases. Pursuing an appeal will become more expensive and risky. UNISON is very concerned that the new system will reduce access to justice as parties have to instruct barristers or solicitors with higher rights and social workers pursuing appeals run the risk of having costs awarded against them. The current Care Standards Tribunal system has proved itself to be accessible, efficient and cost effective in ensuring fair outcomes for social workers.

28. UNISON will therefore be seeking to amend Clause 200 and calling for the current appeal arrangements to be retained.

**For further information please contact:**

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Tel 0870 7777 006
Fax 0141-331 1203
e-mail mike.kirby@unison.co.uk
APPENDIX I:

UK and English designated specialist services

The National Commissioning Group is responsible for commissioning nationally designated clinical services which are either very low volume or require rare skills. In some circumstances, the portfolio of NCG services overlaps with Scottish nationally-designated services, e.g. adult liver transplantation or ophthalmic oncology and pathology. Some services for very rare conditions are only available at one or two sites in the UK.

NSD makes a contribution towards the cost of Scottish residents accessing these services, although some are funded entirely by NCG on a UK basis. For more information on the NCG, please follow this link to the external National Commissioning Group website.

<table>
<thead>
<tr>
<th>Specialist Services (outwith Scotland)</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alstrom syndrome service for adults and children</td>
<td>Birmingham Children's Hospital</td>
</tr>
<tr>
<td></td>
<td>Torbay Hospital</td>
</tr>
<tr>
<td>Amyloidosis (diagnosis and advice on management - not drug costs)</td>
<td>Royal Free Hospital, London</td>
</tr>
<tr>
<td>Ataxia telangiectasia service for children</td>
<td>Papworth Hospital NHS Foundation Trust, London</td>
</tr>
<tr>
<td>Autoimmune paediatric gut syndromes</td>
<td>Great Ormond Street Hospital for Children NHS Trust</td>
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<tr>
<td></td>
<td>Newcastle Upon Tyne NHS Foundation Trust</td>
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<tr>
<td>Child and Adolescent Gender Identity Development Service</td>
<td>The Tavistock and Portman NHS Foundation Trust (outreach clinic to RHSC Yorkhill, Glasgow)</td>
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<tr>
<td>Chronic pulmonary aspergillosis</td>
<td>University Hospital of South Manchester NHS Foundation Trust</td>
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<tr>
<td>Complex Neurofibromatosis type 1</td>
<td>Central Manchester and Manchester Children’s University Hospitals NHS Trust</td>
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<td>Guy’s &amp; St Thomas’ NHS Foundation Trust</td>
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<tr>
<td>Complex Tracheal Disease</td>
<td>Great Ormond Street, London</td>
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<tr>
<td>Craniofacial surgery</td>
<td>Great Ormond Street Hospital, London</td>
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<td></td>
<td>Radcliffe Infirmary, Oxford</td>
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<td></td>
<td>Birmingham Children’s Hospital</td>
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<td>Royal Liverpool Children’s Hospital, Alder Hey</td>
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<td>Agenda Item 1</td>
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| Ehlers Danlos Syndrome | North West London Hospitals NHS Trust  
| | Sheffield Children’s NHS Foundation Trust  |
| Encapsulating Sclerosing Peritonitis surgical service | Cambridge University Hospitals NHS Foundation Trust  
| | Central Manchester and Manchester Children’s Hospitals NHS Trust  |
| Epidermolysis Bullosa services | Great Ormond Street Hospital  
| | Birmingham Children’s Hospital  
| | Solihull Hospital  
| | St Thomas’ Hospital, London  |
| Extra Corporeal Life Support (for Adults) | Glenfield Hospital, Leicester  |
| Heart, heart /lung and lung transplantation (including ventricular assist devices) | Freeman Hospital, Newcastle (Adult and child)  
| | Papworth Hospital, Cambridge (Adult)  
| | Harefield Hospital, London (Adult)  
| | Wythenshaw Hospital, Manchester (Adult)  
| | Queen Elizabeth Hospital, Birmingham (Adult)  
| | Great Ormond Street Hospital, London (Child)  |
| Hydatidiform Mole (Choriocarcinoma) Treatment | Charing Cross Hospital  
| | Weston Park Hospital, Sheffield  |
| Intestinal Failure | St Mark’s Hospital, London  
| | Hope Hospital, Salford  |
| Liver transplantation | St James’ University Hospital, Leeds  
| | Queen Elizabeth Hospital, Birmingham  
| | Birmingham Children’s Hospital  
| | King’s College Hospital, London  
| | Royal Free Hospital, London  
| | Addenbrookes’ Hospital, Cambridge  
| | Freeman Hospital, Newcastle  |
| Lysosomal storage disorders (LSDs) diagnosis and management funded by NSCAG, drug costs by NSD through risk-sharing arrangements) | Addenbrooke’s Hospital, Cambridge  
| | Royal Free Hospital, London  
| | Great Ormond Street Hospital, London  
| | Manchester Children’s Hospital  |
| Mental health services for deaf children and adolescents (outreach) | Dudley PCT  
| | North Yorkshire and York PCT  
| | South West London and St George’s Mental Health NHS Trust  
<p>| | Taunton Partnership Foundation NHS Trust  |
| Mental health services for deaf children and adolescents (inpatient only) | Springfield Hospital, London  |
| Mental health services for deaf adults (inpatient only) | John Denmark Unit, Manchester  |
| Osteo odonto keratoprosthesis for corneal | Sussex Eye Hospital, Brighton  |</p>
<table>
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<tr>
<th>Condition / Service Description</th>
<th>Healthcare Provider(s)</th>
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| Blindness                      | Great Ormond Street Hospital, London  
|                                | Royal Manchester Children's Hospital / Royal Liverpool Children's Hospital, Alder Hey (joint centre) |
| Persistent hyperinsulinaemic hypoglycaemia of infancy | Royal Brompton Hospital, London  
|                                | Glenfield Hospital, Leicester  
|                                | Southampton General Hospital |
| Primary Ciliary Dyskinesia (diagnostic service) | Royal National Orthopaedic Hospital, Stanmore  
|                                | Royal Orthopaedic Hospital, Birmingham  
|                                | Freeman Hospital, Newcastle  
|                                | Robert Jones & Agnes Hunt Orthopaedic & District Hospital, Oswestry  
|                                | Nuffield Orthopaedic Centre, Oxford |
| Primary Malignant Bone Tumour | Great Ormond Street Hospital for Children NHS Trust, London |
| Pulmonary hypertension service for children | Currently obtained abroad, NCG developing UK centre(s)  
|                                | Access via St James University Hospital, Leeds |
| Pseudomyxoma peritonei of the appendix | The Christie Hospital, Manchester  
|                                | North Hampshire Hospital, Basingstoke |
| Pulmonary thromboendarterectomy | Papworth Hospital, Cambridge |
| Rare Mitochondrial diseases service for adults and children | Newcastle (Newcastle upon Tyne Hospitals NHS Foundation Trust)  
|                                | Oxford (Oxford Radcliffe Hospitals NHS Trust)  
|                                | London (University College London) |
| Rare neuromuscular disease | Great Ormond Street, Hospital  
|                                | Institute of Human Genetics, Newcastle  
|                                | John Radcliffe Hospital, Oxford  
|                                | National Hospital for Neurology and Neurosurgery, London |
| Reconstructive surgery for congenital malformations of the female genital tract | Queen Charlotte's Hospital, London |
| Retinoblastoma | Barts and The London NHS Trust, London  
|                                | Birmingham Children's Hospital  
|                                | Royal London Hospital, London |
| Secure forensic learning disability service for young people | Malcolm Arnold House, Northampton (St Andrew’s Hospital)  
<p>|                                | Newcastle (Northumberland, Tyne &amp; Wear NHS Trust) |</p>
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| Secure forensic mental health services for adolescents | Roycroft Unit, Newcastle  
Gardener Unit, Salford  
Ardenleigh, Birmingham  
Bill Yule Adolescent Unit,  
London Wells Unit, London |
| Severe combined immunodeficiency and related disorders (SCIDs) | Newcastle General Hospital  
Great Ormond Street Hospital, London |
| Severe obsessive compulsive disorder and body dysmorphic disorder service for adolescents and adults | South West London & St George’s Mental Health  
NHS Trust  
East and North Hertfordshire NHS Trust  
South London and Maudsley NHS Foundation Trust  
The Priory Hospital North London |
| Small bowel transplantation | Oxford (Oxford Radcliffe Hospitals NHS Trust)(Adult)  
King’s College Hospital, London(Adult)  
Addenbrookes Hospital, Cambridge (Adult)  
Great Ormond Street Hospital, London(Child)  
Birmingham Children’s Hospital (Child) |
| Specialist paediatric liver disease service (including Kasai procedure) | King’s College Hospital, London  
Birmingham Children’s Hospital  
St James' University Hospital, Leeds |
| Stem cell transplantation for juvenile idiopathic arthritis and related connective tissue disorders | Great Ormond Street Hospital, London  
Freeman Hospital, Newcastle |
| Vein of Galen malformation in Children | Royal Hospital for Sick Children, Glasgow  
Great Ormond Street Hospital, London |

Specialised regional services in England

Since 1 April 2002, NSD has also commissioned specialised services provided to residents of Scotland by NHS Trusts in England. NSD funds 35 sets of services at around 80 different NHS Trusts in England. The range of services is diverse, and includes:

- highly individual packages of care for adults and children with complex mental health needs
- gender dysphoria services

The clinical performance of these services is not monitored by NSD in the same way as designated national specialist services, instead the service is primarily a financial arrangement through which NSD meets the costs on behalf of NHS Boards from pooled funds. All decisions on appropriate treatment for any individual referred to England remain the responsibility of the Director of Public Health of the NHS Board of the patient's
residence.

Costs in 2007/08 were approximately £7m.

The specialised services definitions are broad headings and do not cover all care within these specialities. Non-specialised elements of care continue to be funded by NHS Boards. NSD is only responsible for commissioning these services within England. These definitions do not extend to funding of services in Scotland, Wales or Northern Ireland. For more information on specialised regional services in England, please visit the external Department of Health Specialised Services Definition set website.

National Services Division works with the National Specialised Commissioning Group to foster collaborative working at a pan-Specialised Commissioning Group level. For more information, please visit the external National Specialised Commissioning Group website.

For further information on the commissioning of specialised services, please visit the external introduction to commissioning and specialised services commissioning website.