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:


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
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