NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL

EXPLANATORY NOTES
(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

1. As required under Rule 9.3 of the Parliament’s Standing Orders, the following documents are published to accompany the National Health Service Reform (Scotland) Bill introduced in the Scottish Parliament on 26 June 2003:
   
   • Explanatory Notes;
   • a Financial Memorandum;
   • an Executive Statement on legislative competence; and
   • the Presiding Officer’s Statement on legislative competence.

   A Policy Memorandum is printed separately as SP Bill 6–PM.
INTRODUCTION

2. These Explanatory Notes have been prepared by the Scottish Executive in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL – AN OVERVIEW

4. The Bill takes forward the proposals in the White Paper *Partnership for Care* and fulfils the commitments in the Partnership Agreement (*A Partnership for a Better Scotland: Partnership Agreement* published in May 2003) to bring forward legislation to reform the National Health Service (NHS) by introducing provisions in relation to:

   - the dissolution of NHS Trusts;
   - establishing community health partnerships;
   - placing a duty on Health Boards to co-operate with each other, with Special Health Boards and with the Common Services Agency, in the interests of developing more effective regional planning of health services;
   - extending Ministerial powers to intervene to secure the quality of healthcare services;
   - placing a duty on Health Boards and Special Health Boards to involve the public in the planning, development and operation of health services; and
   - placing a duty on the Scottish Ministers and Health Boards to take action to promote health improvement.

5. The Bill primarily impacts upon the National Health Service (Scotland) Act 1978 (“the 1978 Act”) by repealing, amending and inserting new sections into that Act.

6. The Bill is in three Parts:

   - Part 1: Organisation and operation of National Health Service;
   - Part 2: Promotion of health improvement;
   - Part 3: Supplementary.

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COMMENTARY ON SECTIONS

PART 1: ORGANISATION AND OPERATION OF NATIONAL HEALTH SERVICE

Section 1 – Dissolution of National Health Service trusts: modifications of enactments

7. This section repeals section 12A of, and Schedule 7A to, the 1978 Act, which are the main legislative provisions relating to NHS trusts. These provisions empower the Scottish Ministers to establish NHS trusts, dissolve trusts following consultation, and transfer their assets, rights and liabilities to Health Boards.

8. Schedules 1 and 2 include further amendments and repeals of enactments consequential on section 1.

Section 2 – Community health partnerships

9. Section 2 inserts a new section 4A into the 1978 Act which provides for the establishment of community health partnerships (CHPs). Subsection (1) requires every Health Board to produce a scheme for the establishment of CHPs within a period specified by the Scottish Ministers. A scheme for a Health Board may contain one or more CHPs to cover the area of the Health Board.

10. Subsection (2) provides that the general function of CHPs is to co-ordinate the planning, development and provision of services that Health Boards provide. The co-ordination is to take place with a view to improvement of those services.

11. Subsection (3) allows the Scottish Ministers to either approve the scheme, with or without modifications, or to reject the scheme. Subsection (4) allows Health Boards to submit to the Scottish Ministers a new scheme for CHPs in their Board area, and requires them to do so if directed by the Scottish Ministers.

12. Subsection (5) allows regulations to be made which may provide for: the number of CHPs to be established in the area of a Health Board; membership procedures, staffing and expenses; the procedures for submitting a scheme and their form and content; the functions which CHPs should have and how these functions should be exercised; and other matters relating to CHPs. Under section 105 of the 1978 Act, the regulations will be subject to negative resolution procedure before the Scottish Parliament.

13. Subsection (6) provides that regulations made under subsection (5)(d), in relation to a CHP’s functions, may in particular provide as follows: they may specify Health Board functions that are to be carried out by CHPs; explain the type of consideration CHPs should give to matters relating to the planning, development and provision of services in their area or district; the submission of advice and reports (on planning, development and provision of services as well as on their own activities); and ensure consultation between CHPs and Health Boards and other persons interested in the provision of services.
Section 3 – Health Boards: duty of co-operation

14. Section 3 inserts a new section 12I into the 1978 Act. That section places a new duty on Health Boards to co-operate with one another and with Special Health Boards and the Common Services Agency in exercising their functions in relation to the planning and provision of services. It enables Health Boards to make arrangements for the provision of services to persons from outwith their geographical area and in so doing, they may do anything which they could do in relation to provision of services to persons from within their own area.

Section 4 – Powers of intervention in case of service failure

15. Section 4 inserts two new sections into the 1978 Act: sections 78A and 78B. Section 78A gives the Scottish Ministers power, in the case of a failure by a body or person to provide a service under the 1978 Act to an acceptable standard, to direct that the relevant functions to which that service relates should be performed by another body or person.

16. Subsection (1) of section 78A describes when the section applies. The section will apply where a body or person has failed, is failing, or is likely to fail either to provide a service which it is their function under the 1978 Act to deliver or to provide that service to a standard that the Scottish Ministers regard as acceptable.

17. Subsections (2) and (3) provide that when section 78A applies, the Scottish Ministers may direct that another body, person or persons may perform specified functions of the body or person to ensure the provision of the service in question to a standard that the Scottish Ministers consider to be acceptable. The direction may specify the extent to which those functions are to be performed by the alternative body or person and the duration of the intervention.

18. Subsection (4) lists the bodies which may be identified in a direction made under subsection (2) (specifically a Health Board, a Special Health Board or the Common Services Agency).

19. Subsection (5) lists the persons who may be identified in a direction made under subsection (2): employees of the bodies listed in subsection (4) or of the Scottish Administration.

20. Section 78B makes it clear that the power in section 78A is additional to those in sections 77 and 78 of the 1978 Act, and that the powers in those sections are to be read separately.

Section 5 – Public involvement

21. Section 5 inserts a new section 2B into the 1978 Act covering public involvement. It will place a duty on Health Boards and Special Health Boards to ensure that patients and the public are involved in the development of services for which Boards are responsible, and consulted about decisions that will affect the operation of those services.
Section 6 – Dissolution of local health councils

22. Subsection (1) of section 6 provides for local health councils to be dissolved on a date specified in an order made by the Scottish Ministers. Under subsection (2), such an order will be subject to negative resolution procedure before the Scottish Parliament.

23. Schedules 1 and 2 include amendments and repeals of enactments consequential on the dissolution of local health councils.

PART 2: PROMOTION OF HEALTH IMPROVEMENT

Section 7 – Duty to promote health improvement

24. Section 7 inserts two new sections into the 1978 Act. It inserts section 1A, which places a duty upon the Scottish Ministers to promote health improvement, and section 2A, which places a duty upon Health Boards to promote health improvement. Section 1A will provide the Scottish Ministers with an express basis to act in their own right to implement a wide range of measures designed to improve health. It also provides that the duty shall not restrict any other functions of the Scottish Ministers, in particular those contained in section 1 of the 1978 Act. Section 2A of the 1978 Act confers upon Health Boards the same duty of health improvement and powers that the Scottish Ministers are given under section 1A.

25. Subsection (1) of section 1A makes it a duty of the Scottish Ministers to promote the improvement of the physical and mental health of the people of Scotland. Subsection (2) allows the Scottish Ministers to do anything that they think is likely to assist in promoting health improvement including:

• giving direct financial assistance to any person;
• entering into arrangements or agreements with any person;
• co-operating with, or facilitating or co-ordinating the activities, of any person.

26. Subsections (1) and (2) of section 2A make corresponding provision in relation to Health Boards. Subsection (4) of section 2A provides that anything done by a Health Board under section 2A is to be treated as done in exercise of a function of Ministers delegated to the Health Board by way of an order made under section 2(1)(a) of the 1978 Act.

PART 3: SUPPLEMENTARY

Section 8 – Ancillary provision

27. Section 8 contains power to make any incidental, supplemental, consequential, transitional, transitory or saving provision in consequence of any provisions in the Bill. Such an order will be subject to negative resolution procedure before the Scottish Parliament (subsection (3)) unless the order contains amendments to primary legislation in which case the order will be subject to affirmative resolution procedure (subsection (4)).
Section 9 – Modification of enactments

28. Section 9 introduces schedule 1 (which makes consequential amendments) and schedule 2 (which contains consequential repeals).

Section 10 – Commencement and short title

29. Section 10 allows the Scottish Ministers to set different dates to commence different provisions of the Act.

FINANCIAL MEMORANDUM

INTRODUCTION

30. The Executive plans to increase investment in health over the lifetime of this Parliament and to match this investment with continued reform so that public services are designed and delivered around the needs of individuals and the communities within which they live.

31. As many of these proposals involve formalising or reforming existing obligations, there is no net additional expenditure arising from the Bill. Nevertheless, whilst there will be no additional expenditure associated with the Bill, the following paragraphs discuss the financial implications of the changes arising from the Bill. The assessment that there will be no net additional expenditure for the Bill is considered to be an accurate one.

COSTS ON THE SCOTTISH ADMINISTRATION

Dissolution of NHS Trusts

32. Section 1 of the Bill and the related amendments and repeals in schedules 1 and 2 remove from the statute book references to NHS Trusts in Scotland. It is expected that, by the time these provisions are brought into effect, all NHS Trusts in Scotland will have been wound up using existing powers. Consequently, no costs will fall on the NHS as a result of enacting those provisions of the Bill.

Community health partnerships

33. The proposals for the submission by Health Boards to Scottish Ministers of schemes for the establishment of community health partnerships (CHPs) will not result in additional expenditure by the Executive or Health Boards. Arrangements are already in place in each area to support financially local health care co-operatives (LHCCs), which will be subsumed by CHPs once they are introduced. The funding for the enhanced role and responsibilities of CHPs will be met by a reallocation of existing resources within each Board, including monies currently set aside for LHCCs. CHPs will receive the funding provided for functions previously carried out by Health Boards or LHCCs. There will be fewer CHPs than LHCCs, which may reduce administrative costs.
Health Boards: duty of co-operation (regional planning)

34. It is not anticipated that Health Boards will need any additional funds to engage more substantively in regional consortia, whether to promote service redesign through managed clinical networks or in planning services in a more vertically integrated way or horizontally, for example on issues like workforce planning. Any additional costs on Health Boards as a result of the new duty to co-operate with each other will relate to management and administration, will be modest, and will be met within existing financial allocations. Boards are already co-operating in aspects of regionally- and nationally-planned services, and are meeting any associated costs within existing budgets. In addition, the Executive has allocated £1 million over 2002-03 and 2003-04 to support the development of managed clinical networks. Effective co-operation should result in reduced capital and running costs through more efficient use of resources in jointly planned and delivered services.

Powers of intervention

35. Costs will be incurred as a result of the new powers that the Bill proposes to confer on the Scottish Ministers only if these powers are used. If so, costs will depend on how the powers are used; the Executive would expect any such costs to be contained within existing NHS financial allocations. It is estimated that a task force which comprised 6 people and lasted for 10 months would incur costs in the order of £85,000. Potential costs would be commensurate with that amount.

Public involvement in the NHS and the dissolution of local health councils

36. The proposed statutory duty upon Health Boards to involve the public in the design and delivery of healthcare underpins existing practice in many respects. This new duty is not expected to lead to any significant additional expenditure although some adjustment of Boards’ priorities within their existing allocations may be necessary as public involvement becomes a higher priority.

37. Section 6 of the Bill provides for the dissolution of local health councils in Scotland. Local health councils are currently funded by the Executive. It is not envisaged that the costs of dissolving local health councils will exceed existing financial allocations. Future allocations to local health councils will transfer to NHS Quality Improvement Scotland on 1 April 2004 when the Scottish Health Council becomes operational as a committee of that Special Health Board. The Scottish Health Council will be responsible for monitoring the effectiveness of Boards in involving the public in the planning development and operation of health services. The £2,108,000 currently allocated to local health councils for 2003-04 will be sufficient to fund the new Scottish Health Council.

Duty to promote health improvement

38. The proposals relating to health improvement aim to address deficiencies in the interpretation of the 1978 Act, which is seen as laying a greater emphasis on treatment of illness by health services rather than on health services which have a role to play in health improvement.
39. These proposals are expected to be implemented in a cost neutral way. The proposed statutory duty for the Scottish Ministers will enable Ministers to pay grants or secure expenditure for the purposes of health improvement. At present Ministers may only fund Health Boards for such purposes or pay grants to voluntary bodies under section 16B of the 1978 Act. If Ministers wish to direct funding for health improvement to areas outwith the NHS or the voluntary sector, for example to local authorities as part of the community planning process, the expectation is that any such funding would come from a re-allocation of existing resources.

40. The proposed statutory duty of Health Boards to promote health improvement is expected to lead to some adjustment of emphasis within Boards’ activities as health improvement becomes a higher priority. It is not possible to estimate what additional expenditure Boards may incur on health improvement as a result of the proposed new duty but it is expected that Health Boards will be able to manage the readjustment of existing resources to reflect the adjustment of emphasis. Any additional funding for health improvement will be notified to Parliament through the normal Budget process.

COSTS ON LOCAL AUTHORITIES AND OTHER BODIES, INDIVIDUALS AND BUSINESSES

41. The Executive is of the view that there will be no impact on other aspects of public expenditure, including local authorities, or on the costs of the voluntary or private sectors or individuals, as a result of the provisions in the Bill.

SUMMARY

42. There will be no additional expenditure associated with this Bill. The following table summarises the financial implications:
<table>
<thead>
<tr>
<th>PROVISION</th>
<th>FINANCIAL IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissolution of NHS Trusts</td>
<td>No direct cost implications. Winding up of Trusts likely to produce modest reductions in administrative costs to be used by Health Boards to improve patient care.</td>
</tr>
<tr>
<td>Community health partnerships</td>
<td>No overall additional expenditure. Resources previously used to support local health care co-operatives will be used to fund community health partnerships.</td>
</tr>
<tr>
<td>Health Boards: duty of co-operation (regional planning)</td>
<td>No overall additional expenditure. Existing resources to be used more effectively.</td>
</tr>
<tr>
<td>Powers of intervention</td>
<td>No direct cost implication until used. If the power is used, any expenditure is expected to be modest and will be contained within existing NHS financial allocations.</td>
</tr>
<tr>
<td>Public involvement in the NHS and the dissolution of local health councils</td>
<td>No overall additional expenditure but change expected in pattern of expenditure as a result of new priority. The cost of the new Scottish Health Council will be met from the £2.108 million currently allocated to Local Health Councils, which are being dissolved</td>
</tr>
<tr>
<td>Duty to promote health</td>
<td>No overall additional expenditure but change expected in pattern of expenditure as a result of new priority.</td>
</tr>
<tr>
<td><strong>SUMMARY</strong></td>
<td>Overall additional expenditure as a result of the above provisions will be zero, for the Scottish Administration; local authorities and other bodies, individuals and businesses.</td>
</tr>
</tbody>
</table>
EXECUTIVE STATEMENT ON LEGISLATIVE COMPETENCE

43. On 24 June 2003, the Minister for Health and Community Care (Malcolm Chisholm) made the following statement:

“In my view, the provisions of the National Health Service Reform (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

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PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

44. On 24 June 2003, the Presiding Officer (Mr George Reid) made the following statement:

“In my view, the provisions of the National Health Service Reform (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”
These documents relate to the National Health Service Reform (Scotland) Bill (SP Bill 6) as introduced in the Scottish Parliament on 26 June 2003

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

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