Finance Committee

Report on the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill’s Financial Memorandum
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Finance Committee

1. The remit of the Finance Committee is to consider and report on-
   a. any report or other document laid before the Parliament by members of the Scottish Government containing proposals for, or budgets of, public expenditure or proposals for the making of a tax-varying resolution, taking into account any report or recommendations concerning such documents made to them by any other committee with power to consider such documents or any part of them;
   b. any report made by a committee setting out proposals concerning public expenditure;
   c. Budget Bills; and
   d. any other matter relating to or affecting the expenditure of the Scottish Administration or other expenditure payable out of the Scottish Consolidated Fund.

2. The Committee may also consider and, where it sees fit, report to the Parliament on the timetable for the Stages of Budget Bills and on the handling of financial business.

3. In these Rules, “public expenditure” means expenditure of the Scottish Administration, other expenditure payable out of the Scottish Consolidated Fund and any other expenditure met out of taxes, charges and other public revenue.

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Finance Committee
Report on the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill’s Financial Memorandum, 2015 (Session 4)
Introduction

1. The Finance Committee issued a call for evidence on the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill’s Financial Memorandum (FM) on 22 June giving a deadline of 14 August for responses. A total of fourteen responses were received and these are attached.

2. The majority of responses received related to Part 1 of the Bill whilst Healthcare Improvement Scotland (HIS), the Royal College of General Practitioners Scotland (RCGPS) and the Scottish Public Services Ombudsman (SPSO) commented on potential costs arising from Part 2.

3. To explore further the issues raised in the responses the Committee then took oral evidence on the FM from the Scottish Government Bill Team on 16 September. The official report of the evidence session is available via the Committee’s website.

The Bill

4. The FM states that the Bill is divided into three parts covering distinct policy areas—
   - Part 1: Tobacco, Nicotine Vapour Products (NVPs) and Smoking;
   - Part 2: Organisational Duty of Candour; and
   - Part 3: Offence of Ill Treatment and Wilful Neglect.

Part 1: Tobacco, Nicotine Vapour Products and Smoking

Regulation of NVP sales

5. The total cost of Part 1 on the Bill on local authorities in the first year after implementation is estimated at between £1,015,000 and £1,515,000 with similar ongoing costs expected thereafter.

6. The FM states that trading standards services would play a key role in advising businesses how to comply with the legislation. As the NVP market is “relatively new and still maturing”, the Government does not have robust data on the number of retailers of NVPs, but on the basis of a recent two week long survey, the FM suggests that the number of retailers needing advice could be expected to increase by 76%.

7. The FM states that COSLA has estimated the ongoing cost of enforcing the legislation to amount to an additional £2 million per annum. However, as a number of retailers sell both NVPs and tobacco products (for which Government funding is already provided), the FM anticipates the new additional ongoing cost to be in the region of £1 million to £1.5 million per year. The FM confirms that the Government
will “continue to monitor and review the number of retailers and continue dialogue with COSLA to assess and refine additional costs.”

8. Since the oral evidence session, Government officials have confirmed that initially and as stated in the FM, COSLA’s £2 million estimate appeared to relate solely to the costs of enforcement in relation to the sale of NVPs. However, following further correspondence between the Government and COSLA, it has since been confirmed that the estimate relates to enforcement costs for all provisions in Part 1 of the Bill (i.e. for enforcement in relation to the sale of NVPs and of the statutory ban on smoking in hospital grounds).

9. Whilst agreeing that broadly speaking, the FM’s estimates were “probably fairly accurate”, Angus Council noted that “proxy sales and the enforcement generally of age-restricted sales are resource-hungry in terms of money, recruitment, staff time and training” and had “the potential to generate significant on-costs.”

10. South Lanarkshire Council Environmental Services agreed that the FM’s costs relating to NVP enforcement and smoking on hospital grounds were “reasonably accurate.” However, it suggested that highly visible and rigorous enforcement would be required initially and that it had inadequate staffing resources to enhance enforcement regarding NVPs without impacting on other statutory functions. Therefore, it suggested, that local authorities should base enforcement activities “on a risk basis” and that it was a “suitable time to review the expected enforcement activity in relation to tobacco products.”

11. Glasgow City Council (GCC) also agreed that the FM’s estimates in respect of enforcement of NVP sales seemed reasonable although it considered the upper range to be more likely than the lower one. GCC went on to state its expectation that additional Government funding would be provided and recommended that the funding should be allocated “on the basis of the estimated proportion of e-cigarette businesses in each authority.”

12. When asked for its views in relation to GCC’s recommendation the Bill Team confirmed that this was something it could consider although it went on to state “Perhaps it would be a matter for the local authority funding distribution group to decide how that money is distributed to local authorities.”

13. Fife Health and Wellbeing Alliance (Fife HWA) noted that the Government had made resources available on introduction of the Enhanced Tobacco Sales Enforcement Programme and stated that the Bill could place a greater demand on Trading Standards resources, which had already “suffered both staff and budgetary reductions in recent years.”

14. When asked to comment on the difference between the Government’s estimates regarding ongoing enforcement costs and those of COSLA the Bill Team stated that it was working with COSLA but had yet to receive a breakdown of the figures underlying its estimate. However, the Bill Team did confirm the possibility that “there was a double-counting exercise rather than new money being required” as
there might be “overlap” in the case of existing tobacco retailers who also sell NVPs.

Smoking in hospital grounds

15. The FM states that ongoing costs associated with Part 1 are expected to fall primarily on local authorities as the enforcement agency. Short-term costs are expected for the NHS whilst the Government is expected to incur one-off costs associated with awareness-raising.

16. Estimated one-off costs of around £47,000 are expected to fall on the Government in relation to communications and awareness-raising for all proposals regarding the sale and advertising of tobacco and NVPs. This will include sending hard copy information packs to retailers and updating websites. The FM states that “this is subject to a fairly high degree of certainty” as it is based on costs for a similar recent exercise concerning the requirement to charge for carrier bags.

17. The Bill would make it an offence to smoke within a designated no-smoking area around buildings in NHS hospital grounds. The area will be immediately outside of buildings on hospital sites and bounded by a perimeter of a specified distance (to be determined in regulations). Outside of the designated zone, NHS boards would have the discretion to continue to operate a no-smoking policy, although it would not be an offence to smoke in these areas.

18. Health boards are expected to incur “modest costs” as a result of informing people about the smoke-free grounds legislation and the need for such activity is expected to reduce as the legislation becomes embedded. Should hospitals opt to introduce additional enforcement measures (such as employing wardens), the FM estimates the costs to range from £10,260 to £41,064 per annum at each site.

19. In oral evidence, the Bill Team confirmed that as there are 149 hospital sites in Scotland (excluding mental health and specialist hospitals), this translated to a total cost of between £1.5 million and £6 million across Scotland. However, the Bill Team went on to state that the £41,000 figure was based on a large site at NHS Glasgow and Clyde and “would be on the more expensive side.”

20. The Government is expected to incur costs in the region of £300,000 in relation to awareness-raising of smoke free areas in hospital grounds. The FM states that “this is subject to a fairly high degree of certainty” as it is based on recent campaigns publicising changes to the drink driving limit and the NHS smoke-free grounds policy.

21. However, NHS Ayrshire and Arran expressed doubts as to whether this sum was sufficient in comparison to previous high profile media campaigns such as the “green curtain” campaign.

22. When asked to comment on these doubts, the Bill Team confirmed that the £300,000 was based on the cost of the “green curtain” campaign as provided by
NHS Health Scotland and stated that it was “not sure where that confusion has come from.”

23. The FM confirms that the Government will be responsible for providing signage to health boards to ensure that staff, visitors and patients are aware that they may not smoke in designated areas of hospital grounds. Total national costs are estimated to be “in the range of £99,000 to £198,000.”

24. However, whilst stating that the financial implications “seem sensible” and that overall costs to the Government and the NHS “are modest and outweighed by the return on investment” in terms of the expected positive impact on overall public health, NHS Lothian stated that “in practice, if facilities funds are not available, funding for additional signage will need to be sourced from delivery of smoking cessation services to patients”

25. NHS Lothian also sought assurances that Government funding for tobacco cessation/reduction/prevention would be maintained. NHS Ayrshire and Arran noted that its tobacco control funding was fully allocated and stated that “any additional costs would require to be met from central funding.”

26. In oral evidence, the Bill Team stated that the Government provided £10.5million per annum to NHS boards to deliver the tobacco control strategy which included cessation support. However, it went on to state that—

> “it is difficult to disaggregate the figures for the additional cost to NHS boards as they all operate entire grounds policies at the moment and have different levels of provision in place for promoting compliance with those policies.”

27. NHS Ayrshire and Arran pointed out that it had invested considerable sums in bespoke smoke free signage and expressed concerns that generic signage provided by the Government might also require it to revise its own branded signage at “considerable cost.”

28. Fife HWA expressed the view that “the change in message (from whole site to partial areas) will have considerable financial implications associated with amending policies, paperwork, communication materials (printed and digital). This will also impact on staff time and resource revisiting the work completed to date.”

29. Fife HWA therefore suggested that, as most health boards had already invested in smoke free signage covering hospital grounds in full, considerable savings could be made were the designated perimeter proposal to be removed from the Bill.

30. However, when asked whether the Government would expect NHS boards to replace existing smoke-free signage and whether it would cover the costs of doing so, the Bill Team explained that it saw the new statutory signage as complementing pre-existing smoke-free signage—
“There would need to be statutory signage to make people aware that smoking was an offence in that area rather than a policy...I think that it would be possible to work with health boards to ensure that the signage aligned. For example, the statutory signage might say that the grounds are smoke free but it is an offence to smoke within a certain perimeter. That would allow the two sets of signage to work together.”

31. In response to questioning from the Committee regarding why the statutory ban was not being brought in to force across the entire grounds of a hospital, the Bill Team explained that it had “had to take into account the different sizes of hospital grounds. For some people, there might be a very short distance to walk to get outside the grounds, but for others the distance could be a matter of miles.”

32. Expanding on this point, the Bill Team continued—

“We wanted to provide a proportionate and consistent approach across NHS boards, and we think that a perimeter approach captures the highest volume of traffic of people. The ultimate aim is that people do not have to walk through clouds of smoke to get into hospital. That approach captures where the main traffic of people is around hospitals.”

33. When asked whether it was confident that the FM’s estimated costs would cover both those hospitals contained in one building as well as those spread across several, The Bill Team confirmed that it was “happy” that the estimated costs would cover both situations.

34. Enforcement of smoke-free areas in NHS grounds will be undertaken by local authority environmental health officers for whom funding of £2.5 million per annum is currently provided by the Government. Whilst a short-term increase in demand for enforcement is expected after the introduction of the legislation, the Government does not envisage a need for additional resources. Instead, it suggests that “a reprioritisation of duties and resources” would be needed although it confirms that “dialogue will continue with local authorities and COSLA to assess the impact of this proposal.”

35. Dundee Council stated that additional officer time would be required to monitor/enforce the prohibition within hospital grounds and suggested that an additional staff member costing around £30k per annum may be needed to cover the additional duties. Dundee Council further suggested that it was not clear from the FM whether additional funding would be made available to cover such costs.

36. When asked whether the Government considered that the Bill was likely to result in a short-term increase in enforcement costs and whether it would meet any additional costs if this proved to be the case, the Bill Team stated that it remained “open-minded” on the issue and would consider the breakdown provided by COSLA once received.
37. The Committee welcomes the Government’s commitment to work with COSLA and to consider its breakdown of estimated enforcement costs once received. The lead committee may wish to seek further clarification of whether additional funding would be made available in the event that evidence indicates an increase in the cost of enforcement either in respect of the sale of NVPs or of smoking in hospital grounds.

Part 2: Duty of Candour

38. The Bill will introduce a duty on organisations providing health and social care to ensure that where death or harm has resulted from an unintended or unexpected event, people are notified, an apology is made and actions are taken to keep people informed of a review of the events and of further steps taken. Procedures in respect of the duty will be set out in regulations.

39. The FM states that, as the Bill’s duties in this regard will be “consistent with current policy and strategies reflected through work in support of improvements in complaint handling, reporting and learning from adverse events” no new costs are expected for the Scottish administration, the NHS or local authorities.

40. The FM confirms that the Government will produce training resources “for use by all organisations which have to implement the duty.” This is estimated to cost £182,000 in the first year reducing to £45,000 in the following year and £25,000 in recurring costs thereafter. The FM states that “these are the maximum costs likely” and have a low margin of uncertainty as they are based on the costs of similar Government programmes.

41. No additional training-related costs are expected for the NHS or local authorities as they are expected to incorporate the training within their existing training and induction programmes.

42. However, HIS stated “if we are to truly support staff and build capacity and capability to be open and honest with people about their care then additional investment is likely to be required.”

43. HIS highlighted its recent experience of supporting the “Being Open” pilot in the maternity department of the Edinburgh Royal Infirmary which provided training for 46 staff at a total cost of £60,000 or £1,300 per staff member. Whilst acknowledging that costs could be expected to reduce once the model was further developed, HIS stated “it is clear [that] to train and support staff to implement the duty of candour will require investment.”

44. HIS also suggested that NHS boards may have to make changes to their existing systems and processes to accommodate the candour procedure (which will be set out by regulation) and that this was “likely to have a resource implication specifically around capacity and capability.”
45. In response to questioning from the Committee regarding whether NHS staff working in an Accident and Emergency department for example, were not already sufficiently well-trained and experienced to deal with "unintended and unexpected events", the Bill Team explained that even for front-line staff, “having to deal with an episode of unintended or unexpected death or significant physical injury is not that common.”

46. The Bill Team further explained that it was “talking about the sorts of harm that result from systems and process failures, which staff do not always feel confident to deal with” and as such, “some of the challenges that that presents to individual staff requires specialist training and support.”

47. Finally HIS stated that it had asked that the Bill be amended to clarify that it is the monitoring body for those independent healthcare services which it currently regulates “and where the legislative powers for regulation have been commenced.” This, it stated, would have “significant resource implications” for HIS.

48. HIS expanded on this point in correspondence with the clerks. This clarification is attached as an annexe.

49. The lead Committee may wish to seek clarification regarding HIS’ expected role in respect of the monitoring of independent healthcare providers.

Potential Savings

50. The FM also suggests that some savings may result in the event that fewer people embark on formal complaints or claims or require more intensive specialist interventions and support.

51. However, the SPSO pointed out that it was currently impossible to assess the impact that the Bill might have on the number of complaints and suggested that an increase in public confidence along with publicity around the duty of candour could result in a rise in complaints. Were such a rise to occur, the SPSO sought assurances that increased resources would be made available to it to accommodate its increased workload.

52. Responding to this suggestion in oral evidence, the Bill Team stated that feedback it had received had consistently suggested that where “there is early disclosure, support, engagement and involvement of the people affected, and there is a commitment by the organisation to review and learn from what has happened in a way that actively involves the people affected, the result is often that a complaint is not made.”

53. When asked by the Committee about how the duty of candour provisions would interact with laws relating to medical negligence the Bill Team explained that
negligence would be determined by a legal process whereas the duty of candour would not—

“In some cases, it may be an incident that is subject to future legal scrutiny and to a claim being made for negligence, but the duty of candour procedure itself is silent in relation to determining the negligence.”

54. The Committee then asked whether any analysis had been undertaken of the potential impact of the Bill on the number of negligence claims (along with their related costs). The Bill Team confirmed that it had received similar feedback to that on the duty of candour and pointed towards international evidence which indicated that the introduction of disclosure and apology procedures could result in a reduction in the number of claims. On that basis, it could be expected that the Bill would have a positive impact on the volume of claims, although the Bill Team confirmed that the number of claims and complaints would be “monitored closely in the initial months and years after implementation.”

55. The Bill Team further confirmed that the NHS central legal office will have factored the flexibility to respond to changes in the number of claims into its ongoing planning and that this would include the possibility that numbers might increase. However, the Bill Team also noted that smaller organisations would also need to be considered and that “some of the training and support resources that have been identified will be focused on helping those organisations to plan and think about the impact of the two issues that have been raised.”

56. The Committee welcomes the commitment to monitor closely the number of claims and complaints made following commencement of the Bill’s provisions.

Conclusion

57. The Health and Sport Committee is invited to consider the above as part of its scrutiny of the Bill.