

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the Smoking, Health and Social Care (Scotland) Bill introduced in the Scottish Parliament on 16 December 2004. It has been prepared by the Scottish Executive to satisfy Rule 9.3.3(c) of the Parliament's Standing Orders. The contents are entirely the responsibility of the Scottish Executive and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 33-EN.

POLICY OBJECTIVES OF THE BILL - GENERAL

2. This Bill will enable the Executive to continue to take action to improve the health of Scotland, to continue its programme of NHS modernisation and to improve health and care services relevant to the needs of the people of Scotland.

3. A key policy objective for improving health is taking action on the impact of smoking. The Bill's policy is to introduce a comprehensive ban on smoking in certain wholly enclosed premises.

4. The Bill also makes provision for the introduction of free eye and dental checks for all, and modernises the frameworks for the delivery of dental and pharmaceutical services. The Bill introduces a range of measures to update legislation relating to the listing and disciplinary procedures for family health service practitioners.

5. The Bill contains provisions to allow Scottish Ministers to make a scheme authorising payments to be made to certain persons who became infected with the hepatitis C virus after having had NHS treatment involving the receipt of blood, tissue or blood products. There are provisions for amendments to the Regulation of Care (Scotland) Act 2001, provisions in relation to child care agencies and housing support services, and provisions to amend the Adults with Incapacity (Scotland) Act 2000. These will further improve the delivery of health and social care.

6. Included in the Bill are provisions to allow Scottish Ministers to set up or participate in joint venture companies. This will increase the range of options available to Health Boards for the delivery of facilities and services, and enable the Scottish Ministers and NHS bodies to make

the most of ideas and intellectual property generated by the NHS. Finally, the Bill makes provision to end the NDPB status of the Scottish Hospital Endowments Research Trust.

7. As the Bill covers a number of different policy areas, this document sets out the details of policy objectives, alternative approaches and consultation for each main policy area that appears in the Bill. The order of the subjects covered within this document is as follows:

- prohibition of smoking in certain wholly enclosed places (sections 1 - 8);
- free eye and dental examinations (sections 9 - 10);
- provision of General Dental Services (sections 11 - 14);
- listing of additional categories of general dental practitioners, optometrists and Ophthalmic Medical Practitioners (sections 15 - 17);
- pharmaceutical care services (sections 18 - 21);
- discipline (sections 22 - 23);
- payments to certain persons developing hepatitis C as a result of NHS treatment (section 24);
- amendment of Regulation of Care (Scotland) Act 2001, and child care agencies and housing support services (sections 25 - 29);
- authorisation of medical treatment (section 30);
- joint ventures (section 31); and
- Scottish Hospital Endowments Research Trust (section 32).

8. The effects of the Bill on equal opportunities, human rights, island communities, local government, sustainable development etc. is summarised at the end of the document. There is also an annex which contains a useful glossary of acronyms used in the document.

PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES

Policy objectives – background

9. Smoking has long been recognised as the most important preventable cause of ill-health and premature death in Scotland. In order to reduce the unacceptable toll smoking takes on Scotland's health, in January 2004, the Executive published the first ever action plan on tobacco control designed specifically for Scotland: *A Breath of Fresh Air for Scotland*¹. The plan offers a comprehensive programme of action to tackle smoking. This includes a clear commitment to take firm action to extend smoke-free provision within all enclosed public places, in order to protect non-smokers from the health risks posed by exposure to second-hand smoke.

10. The scientific evidence of the health risks of second-hand smoke is clear and irrefutable. Specifically, the Report of the UK Scientific Committee on Tobacco and Health (SCOTH)², published in 1998, highlighted these risks. The report concludes that exposure to

¹ Scottish Executive, *A Breath of Fresh Air for Scotland* (2004)

² Department of Health, *Report of the Scientific Committee on Tobacco and Health* (1998)

second-hand smoke is a cause of lung cancer and, in those with long-term exposure, the increased risk is 20-30%; is a cause of heart disease and represents a substantial public health hazard; and that it can cause asthma in children and may increase the severity of the condition in children already affected. SCOTH recently reviewed the evidence to emerge since 1998 into the health risks of exposure to second-hand smoke and this report³, which was published on 16 November 2004, reinforces the earlier findings. Additionally, research commissioned by the Scottish Executive and NHS Health Scotland in 2004 suggests that second-hand smoke is associated with some 865 deaths per year among life-long non-smokers in Scotland. Taking ex-smokers into account it is estimated that some 1,500 to 2,000 deaths per year in Scotland are related to environmental tobacco smoke exposure⁴. Further modelling by Aberdeen University⁵ has suggested that, of the 865 deaths, 120 are attributable to non-domestic exposure.

11. The benefits of reduced exposure to environmental tobacco smoke accrue over time and the analysis indicates that by 2034 the number of lives saved as a consequence of a ban on smoking in public places will be 186 per year. This is based on a minimum estimate of number of lives saved and only looks at the deaths attributable to lung disease and ischaemic heart disease, which have the greatest amount of evidence available.

12. The Executive acknowledges that much progress in smoke-free provision has been made through voluntary action but this has been much less pronounced in the leisure and hospitality sector (7 out of 10 pubs still allow smoking throughout). This has led to the conclusion that legislative action is now required if we are to make any real progress in this area. The Scottish Voluntary Charter Signatory Group (comprising the Scottish Licensed Trade Association, The Scottish Beer and Pub Association, the British Hospitality Association and the Scottish Tourism Forum) has presented a series of 5 targets to increase smoke-free provision and has indicated that these would require statutory backing to be effective.

13. Although there is much support for an approach that would create separate smoking or non smoking areas within leisure and hospitality premises, such an approach is difficult to justify on public health grounds given that there is no defined safe level of exposure to second hand smoke. A complete ban on smoking in all enclosed public places would provide the most comprehensive protection to public health and also has the advantage of being simpler to implement.

Policy objectives – specifics

14. Given the unacceptable health impact of second-hand smoke and the need to take firm action to accelerate progress, specifically in the leisure and hospitality sector, it is clear to the Executive that statutory action is now required to increase smoke-free places in order to protect public health. The provisions of the Bill take into account that 70% of Scots do not smoke and surveys suggest that a majority of those who do smoke wish to give up. They also take into

³ Department of Health, Scientific Committee on Tobacco and Health (SCOTH), *Second-hand Smoke: Review of Evidence Since 1998* (2004)

⁴ David Hole, Professor of Epidemiology and Biostatistics, University of Glasgow, *Passive smoking and associated causes of death in adults in Scotland* (2004)

⁵ Ludbrook, Bird, van Teijlingen, *International Review of Health and Economic Impact of Regulation of Smoking in Public Places* (2004)

account that there is no safe level of exposure to second-hand smoke and that restrictions help to encourage existing smokers to give up or reduce consumption and children and young people not to start in the first place.

15. As evidence of the latter point, the number of regular smokers in New York dropped from 21.6% of adults to 19.3% and cigarette consumption by 13% from 2002 to 2003 following the introduction of the smoking prohibition. Further evidence is provided by the Irish ban, where cigarette sales are reported to have dropped by some 16% since the ban came into force in March 2004. Other evidence is also available from other parts of the world where smoking is regulated.

16. The policy intention is to prohibit smoking in premises which are fully enclosed to which the public or a section of the public has access in order to protect public health. Detailed provisions, including exemptions, will be prescribed through regulations which will be subject to affirmative procedures. However, the scope of the ban is intended to be comprehensive and to cover, for example, public transport, cafes, restaurants, bars, function suites, shops, private clubs and larger buildings such as shopping centres, hotels, railway stations, airports, offices, factories, conference centres, museums, galleries, hospitals, day centres etc. The policy will not extend to aircraft as there is already provision in UK statute (Article 66 of the Air Navigation Order 2000 (SI 1562/2000)) which prohibits smoking on UK registered aircraft. In addition to fulfilling the commitment made in the action plan, the provisions also fulfil and go beyond the Partnership Agreement⁶ commitment to consult on measures to achieve considerably more smoke-free restaurants and pubs and take measures to enforce restrictions on public transport.

17. The Executive's intention is also for restrictions on smoking to be extended to prisons. The policy is to carry out these restrictions through altering the prison rules, which are governed by statutory instrument. It is intended that prison rules will be amended contemporaneously with the introduction of the prohibition of smoking provisions in the Bill.

18. The provisions of the Bill create offences, set out the penalties to be imposed, define the kind of premises which are capable of being described as no-smoking under regulations, and give police and local government officers powers of entry in order to enforce the prohibition. It will be an offence to smoke in no-smoking premises, and it will be an offence for a person who, having management or control of no-smoking premises, knowingly allows someone to smoke, or fails to display warning notices. These offences will attract penalties as set out in the Bill's schedule. The principal enforcement authority will be local authority environmental health officers. Detailed provisions will be prescribed by regulations. These will include exemptions, detailed definitions of regulated areas, fixed penalties and content of fixed penalty notices which offer a person the opportunity of discharging any liability to conviction for an offence under 1, 2 or 3 of the Bill. These regulations will be subject to pre-legislative consultation with interested parties in the normal way.

⁶ Scottish Executive, *A Partnership for a Better Scotland: Partnership Agreement* (2003)

Alternative approaches

Voluntary approach

19. Voluntary approaches are likely to impact differentially across different types of public place. As noted above, the Scottish Voluntary Charter Signatory Group has presented a series of five voluntary targets on smoking, which they acknowledge would require statutory backing to be effective. Whilst 56% of Scottish small to medium sized businesses offering access to the general public do not allow smoking in such areas, little progress has been made within the leisure and hospitality sector, although there is an element of support for split smoking and non-smoking areas. This does not, however, offer protection from the health impact of environmental tobacco smoke which permeates from smoking to non-smoking areas.

Legislation with dispensation for hospitality sector

20. Public health legislation could be used to introduce a ban on smoking in public places except in those areas, typically pubs, clubs and possibly restaurants, where there is less support for restrictions. However, excluding pubs from legislation would again be difficult to justify on public health grounds, given the level of exposure to second-hand smoke that is likely to occur there compared to other public places. A similar argument would also apply to approaches that saw smoking banned in pubs with a children's certificate, or where food is served, or to an approach which delegates responsibility to local decision makers.

21. Licensed trade bodies and a number of businesses, particularly in the leisure sector have expressed fears about a loss of profitability and jobs as a result of a smoking ban. This, however, is not backed up by research including that commissioned by the Scottish Executive and NHS Health Scotland from Aberdeen University referred to above. The modelling they have done suggests that the most likely economic impact of a ban will be a net gain for Scottish society, with conservative estimates of savings in Scottish workplaces through reduced absenteeism, a reduction in smoking breaks, reduced fire damage and reduced redecoration costs, exceeding the worst case scenario for losses in the hospitality sector. Additional financial gains would flow from health benefits resulting from the ban. This is expanded upon in the Financial Memorandum.

22. Despite trade fears about a loss of profitability and jobs as a result of a smoking ban, international experience suggests that whilst such losses are almost invariably predicted prior to the introduction of a ban, there is little robust, published evidence to suggest that this happens in practice. In Ireland, at least one trade association continues to report a significant drop in trade, but this is based on anecdotal reports rather than verifiable sales data and official statistics suggest that bar sales (volume) were down 1.3% in the 3 months following the ban. It should be noted that bar sales were falling in Ireland before the introduction of the ban and the picture is clouded by the impact of recent alcohol price rises. Evidence from New York also suggests that there has not been the predicted impact on the licensed sectors, with bar and restaurant tax receipts up 8.7% in the 9 months following the ban compared to the same period in the previous year.

Consultation

23. The measures proposed within the Bill have been informed by widespread public consultation conducted between June and September 2004 and wider evidence-gathering on possible approaches to minimise the impact of second-hand smoke. Account has been taken of information gathered through all elements of the consultation process. This includes peer reviewed research conducted through NHS Health Scotland, including a review of international evidence on health and economic impact of controls.

24. A written public consultation⁷ received 52,441 personal responses to the consultation and 1,033 responses from groups, organisations and businesses. Analysis of these responses indicated that 82% of all respondents thought that further action was needed to reduce people's exposure to second-hand smoke, 80% of all respondents would support legislation to make enclosed public spaces smoke-free, and 56% of all respondents did not think that there should be any exemptions if such legislation was introduced, although 35% indicated that there should be. Only 24% of those who indicated that they would support a law were in favour of exemptions. Whilst the general public and hospitality sector tended to focus on pubs, clubs and restaurants in terms of exemptions, organisations also referred to long-stay care facilities, prisons and workplaces that are also homes of looked after individuals.

25. A total of 15 public seminars were held throughout Scotland in order to listen directly to the views of people in their own communities. The events stimulated a broad range of views and the majority of participants supported the need to increase smoke-free provisions, although there were differing opinions about how that might be achieved. Licensed trade representatives were totally opposed to a complete smoking ban in pubs at this time, mostly on economic grounds, although some were relaxed about such restrictions in restaurants. There was strong support amongst trade representatives for better ventilation and a staged approach to greater restrictions. Health professionals in particular spoke in favour of a total ban on the basis of the health evidence, personal experiences of treating smoking-related conditions and the perceived need to de-normalise smoking within society.

26. An opinion poll conducted for the Executive by MRUK in September 2004, consisting of a total of 1026 in-home interviews, suggested that just over half of respondents would support a law to ban smoking in public places, with around a third opposing such a measure. Overall, two thirds of those that would support a law thought that exemptions should be considered, with 57% citing pubs and 21% citing restaurants as places where such exemptions should apply.

27. Additional elements of the consultation included a national conference with international speakers, a youth consultation run by Young Scot, and focus group work. There was a general consensus that the time has come for increased smoke-free provision in public places.

⁷ Scottish Executive, *Smoking in Public Places: A Consultation on Reducing Exposure to Second-hand Smoke* (2004)

FREE EYE AND DENTAL EXAMINATIONS

Policy objectives

28. One of the Partnership Agreement commitments states that “we will invest in health promotion and, as a priority, we will systematically introduce free eye and dental checks for all before 2007”. The Executive’s policy is to make the necessary legislative changes for implementation of this commitment. These provisions will improve health where dental and eye examinations may detect early signs of disease, illness or injury.

29. The current legislative position regarding charges for dental and optical examinations is contained in the National Health Service (Scotland) Act 1978 (the 1978 Act). The policy intention is that it should be clear on the face of the 1978 Act that no charge shall be made for:

- oral examinations, whether provided as part of General Dental Services (GDS) under Part II of the 1978 Act or as part of dental treatment provided in accordance with section 17C arrangements; or
- eye examinations provided as part of general ophthalmic services (GOS).

30. The Bill provides for free examinations to be provided after 1 April 2006.

Alternative approaches

31. As this is a Partnership Agreement commitment, no alternative approaches were considered.

Consultation

32. The Partnership Agreement included a pledge to systematically introduce free eye and dental check ups for all by 2007 and as such has not been consulted on. However, the dental checks pledge was highlighted in the wide-ranging consultation *Modernising NHS Dental Services in Scotland*⁸ which ended in April 2004. Discussions are on-going with the dental and optical professions on whether the free checks should be more extensive than the current dental check and sight test. An eye care review is also currently underway to review arrangements for the provision of eye care services in the community in Scotland and to provide recommendations on good practice for effective models of care. Provision of General Dental Services

PROVISION OF GENERAL DENTAL SERVICES

Policy objectives – background

Introduction

33. General Dental Services are provided by General Dental Practitioners (GDP) under the 1978 Act. A significant amount of primary dental care is also undertaken by the Community Dental Service (CDS) and by salaried dentists employed by Health Boards and the policy also addresses these services.

⁸ Scottish Executive, *Modernising NHS Dental Services in Scotland* (2004)

34. The Bill amends the provisions of the 1978 Act relating to the arrangements currently made between Health Boards and dental practitioners for the provision of GDS and personal dental services (PDS). At its heart, this will enable the development of new arrangements between Health Boards and their constituent dentists. The policy intention is to develop a system that satisfies both national requirements and meets local needs.

General Dental Services

35. Every Health Board has a duty to make arrangements with dental practitioners under which any person for whom a dental practitioner undertakes, in accordance with the arrangements, to provide dental treatment and appliances shall receive such treatment and appliances. Under GDS, the Health Board enters into separate statutory arrangements with individual practitioners (“GDP principals”) for the provision of those services. GDPs may be independent professionals, or may be salaried dentists (either those who provide GDS as emergency dental services or as non-emergency GDS). These groups provide GDS in accordance with the National Health Services (General Dental Services) (Scotland) Regulations 1996 (the GDS Regulations).

36. The legal and financial framework has remained broadly the same since the late 1970s. There has been a shift to some capitation payments, including enhanced capitation payments for preventive measures for children, in addition to gross fees introduced in 1990 (the new contract). Since 2002, some additional allowances have been introduced in Scotland aimed at recruiting and retaining GDPs within GDS and improving services.

37. The current statutory arrangements are commonly known as the “GDS contract”. They are neither an NHS contract nor a private law contract. Fees and allowances are determined by Scottish Ministers, taking into account recommendations of the Independent Review Body. This follows consultation with the British Dental Association (BDA) and is published in the Statement of Dental Remuneration (SDR).

Payments system

38. The GDS Regulations determine the terms of service of GDPs and remuneration. The “Statement of Dental Remuneration” (SDR) sets out the scale of fees and comprises over 400 individual items of service. The SDR also includes items such as seniority payments, various allowances, long term sickness payments and re-imbursment of non-domestic rates. National Services Scotland (Practitioner Services Division) makes payments to GDPs on behalf of Health Boards.

Charging system

39. The present charging system derives from the Health and Medicines Act 1988 (the 1988 Act). This introduced a simplified charging regime where patients pay 80% of the cost of their treatment. Where a patient is subject to an extensive course of treatment the maximum patient charge is presently set at £378. Certain categories of patient are exempt from dental charges, for example people up to the age of 18 and people who fall into certain benefit categories.

40. The proposed changes to GDS will address the shortcomings of the current system. These include:

- restricted ability of Health Boards to plan, fund and deliver dental services as part of the overall provision of health services in an area;
- reduced commitment from some dentists to participate in providing NHS services;
- the complexity of the current system, including a SDR covering over 400 fee types;
- the perceived “treadmill” for dentists of maximising items of treatment provided to maintain income and incentives;
- lack of focus on preventive service because of the fee structure; and
- complexity of patient charging system.

Community Dental Service

41. A significant amount of primary dental care is provided not by GDPs, but by the Community Dental Service (CDS). The CDS is not mentioned directly in the 1978 Act as the dentists concerned are employees of Health Boards. It is the CDS who provide dental inspections of pupils attending public schools and all young persons attending other public educational establishments. They also provide education in dental health of these pupils and young people. In some areas of Scotland (usually rural and remote areas), the CDS, rather than independent GDPs, also provide for the full range of care and treatment required by pupils and other young people. They have 4 further roles set out in guidance:

- epidemiological field work for use in planning local and national dental services;
- provision of facilities for a full range of treatment to patients for whom there is evidence that they would not otherwise seek treatment from the GDS (usually patients with special needs);
- provision of facilities for a full range of treatment to patients who have experienced difficulty in obtaining treatment in the GDS (known as the safety net function); and
- provision of treatment on referral which is not generally available in the GDS, for example sedation.

42. In effect, the role of the CDS is similar now to that of the salaried GDS and the policy intention is to merge them administratively.

Personal dental services

43. The NHS (Primary Care) Act 1997 provided for the introduction of personal dental services (PDS) under which Health Boards could make local arrangements for the provision of dental services, similar to GDS but delivered more flexibly. There were enabling powers to allow delivery of PDS under both pilot and permanent arrangements. No PDS arrangements have been introduced in Scotland to date.

Listing

44. Section 25 of the 1978 Act provides for regulations to make provision for lists to be kept by Health Boards of dental practitioners who undertake to provide GDS. The GDS Regulations set out certain restrictions as to who is eligible to be on such a list. Removal from the dental list is provided for in the 1978 Act. Once included in the list, a dentist stays on it until he decides to leave or retires, unless he is removed.

45. Under the 1988 Act GDPs are automatically removed from the dental list, and consequently required to retire, at the age of 70. It is the intention to remove this age limit.

Policy objectives – specifics

46. It is the policy intention to allow Health Boards to take a more active role in securing and providing general dental services. This will enable Health Boards, as part of their overall planning and delivery responsibilities, to take a more holistic view of local needs and the most appropriate provision of the range of dental services required. It will help integration between types of care where it can be shown that this is in the best interests of patients and the NHS.

General Dental Services

47. The policy intention is to introduce legislative changes to allow:

- Health Boards to be able to make arrangements with individual dentists, or dental corporations to undertake to provide GDS, or provide general dental services themselves through salaried NHS staff; and
- Health Boards to be able to give financial help to support GDS providers (for example support to staff, premises, infrastructure and quality).

48. Health Boards will be able to secure or provide dental services to meet reasonable need. Such services will fall within the current GDS definition which is “all proper and necessary care and treatment which a dentist usually undertakes for a patient and which the patient is willing to undergo, including advice, planning of treatment and preventive care”.

49. Currently the patient charge is linked to a dentist’s item of service fee and unless exempt, patients pay 80% of this fee. It is the policy intention (section 11(4) of the Bill) to break the current link between the GDS item of service fees paid to dentists and the patient charges levied. It is also our policy intention that, in the future, patients who do not fall within the categories for free treatment, or who are not exempt from NHS charges, will continue to make a contribution towards the costs of their dental treatment. The proposed changes are consistent with the outcome of the consultation on making the charging system more flexible.

Summary

50. The policy intention for future delivery of NHS dental services in Scotland is that responsibility for meeting local needs for dental services will rest with Health Boards and these Boards would make arrangements with:

- individual dentists (as at present);
- dental corporations as defined in the Dentists Act; or
- provide the services themselves through directly employed staff.

51. The arrangements would be nationally agreed and would be supplemented by local arrangements for services outwith the national framework.

52. It is also the policy intention to simplify the patient charging system and to provide more flexibility for patient charges, the Bill (section 11(4) of the Bill) provides for de-linking the patient charge from the dentist's item of service.

Alternative approaches

53. The consultation was a comprehensive process and the approaches taken were consistent with the analysis from the consultation. The consultation paper put forward a range of options for changing the current system, including simplification of the fee scale, the method of delivering NHS dental services in the future and changing the patient charging system. These ranged from a fundamental reform of dental services along the lines of England's *Option for Change*⁹ framework to a more simplified approach to the current system. It was clear from the consultation responses that a different approach from that in England and Wales was favoured in Scotland and there was widespread support for proposals, including simplification of the feescale.

Consultation

54. The proposed new arrangements follow a comprehensive consultation on the future of NHS dental services in Scotland¹⁰. As well as a number of consultation events across Scotland, over 200 written responses were received¹¹. The consultation responses indicated a broad consensus for the provisions addressed by these sections of the Bill. The outcome of the consultation and the Executive's policy direction in response to this will be outlined in the formal Executive response which is expected to be announced in the New Year.

LISTING OF ADDITIONAL CATEGORIES OF GENERAL DENTAL PRACTITIONERS, OPTOMETRISTS AND OPHTHALMIC MEDICAL PRACTITIONERS

Policy objectives

55. Health Boards are currently required to maintain lists of all:

- general dental practitioners who undertake to provide general dental services (GDS) in their area under the National Health Service (General Dental Services) (Scotland) Regulations 1996; and

⁹ Department of Health, *NHS Dentistry: Options for Change* (2002)

¹⁰ Scottish Executive, *Modernising NHS Dental Services in Scotland* (2004)

¹¹ Scottish Executive, *Modernising NHS Dental Services in Scotland – Analysis of Responses* (2004)

- ophthalmic contractors who undertake to provide general ophthalmic services (GOS) in their area under the National Health Service (General Ophthalmic Services) (Scotland) Regulations 1986.

56. GDS are the range of NHS dental care provided by family dentists to patients. GOS comprise the testing of sight of eligible patients, informing general practitioners (GPs) of the results of certain tests, the completion of prescriptions (a written order giving details of lenses intended to be made up into glasses or contact lenses) and the issuing of NHS optical vouchers to eligible patients.

57. The relevant lists in a given area are known as the dental list and the ophthalmic list. Dentists, optometrists and ophthalmic medical practitioners (OMP) on these lists are commonly known as “principals” or “contractors”. A dentist has to be on the dental list before he or she can provide GDS in an area. An optometrist or OMP has to be on the ophthalmic list before he or she can provide GOS in an area.

58. To join a dental or ophthalmic list, a principal/contractor has to satisfy rules on suitability, including registration with the professional regulatory body and appropriate experience. Once on a list, a principal is subject to discipline procedures relating to statutory Discipline Committees and the NHS Tribunal.

59. The list system does not currently extend to non-principal optometrists/ophthalmic medical practitioners assisting with the provision of GOS, to non principal dentists assisting with the provision of GDS, to dentists who perform personal dental services (a sub-set of GDS) nor to dental bodies corporate. Non-principal dentists may include dentists undertaking vocational training, assistant dentists and locum dentists working in GDS who do not act as principals. Non-principal optometrists and OMPs may comprise employed assistants, deputy and locum optometrists and OMPs working in general ophthalmic services but not on a regular basis for a principal.

Policy objectives – specifics

60. The Executive’s policy is that those non-principal dentists who assist with the provision of GDS, those dentists who perform personal dental services (PDS) and those non-principal optometrists and OMPs who assist with the provision of GOS and whose names do not currently appear on the dental or ophthalmic lists held by Health Boards should now be listed for the first time. Dental bodies corporate are to be permitted to make arrangements with Health Boards for the provision of GDS and will also be listed. This will assist Health Boards to be aware of and monitor all those who are providing or assisting with the provision of GDS or GOS in their areas. This will also enable non-principals to be referred to an NHS Discipline Committee or to the NHS Tribunal where their acts or failures to act merit such a referral.

61. The policy intention is that, in order to make arrangements with a Health Board to provide GDS in its area, a principal dentist or dental body corporate will require to be on the part of the dental list for that area of those who have undertaken to provide GDS, i.e. the first part. A dentist will be unable to assist with the provision of GDS in an area unless he or she is on the second part of the dental list for that area (that is, apart from where a principal also assists

another principal with GDS provision in the same area where he is already on the first part of the list). A dentist will be unable to perform PDS in an area unless on the “PDS” list for the area. Similarly, the GOS list held by each Health Board will be divided into 2 parts – principals and non-principals who assist with GOS provision.

Entry to, control of and operation of the lists

62. The Executive’s policy is that the following principles will apply:

- the entry and control arrangements for principals and non-principals working in family health services should be uniform, that is, for non-principals they should mirror as far as practicable those for principals, including any requirements as to suitability;
- principals should be required to ensure that any organisation providing non-principals provide only listed non-principals;
- bureaucracy will be kept to a minimum by developing a “fast track” application procedure. The practitioner will indicate on the application the area or areas where he or she wishes to work, a “host” Health Board will check the information supplied on the application and, where this is found to be satisfactory, the practitioner will then be granted entry to the list held by the host Health Board and the other relevant Health Boards may also choose to grant him/her entry without undertaking further checks;
- statutory requirements as to NHS Discipline Committees should cover non-principals as well as principals. Reference of a principal to a Discipline Committee arises from a potential breach of the National Health Service (General Dental Services) (Scotland) Regulations 1996, or the National Health Service (General Ophthalmic Services) (Scotland) Regulations 1986, including a potential breach of the terms of service set out in Schedule 1 of these. Those terms of service and those other parts of the Regulations which concern performance should apply to non-principals, while those which relate to the performance of a principal as a contractor to the Health Board (for example registering and de-registering dental patients) should not apply to non-principals; and
- the NHS Tribunal should have the same jurisdiction in relation to listed non-principals as it has to listed principals.

63. The Executive’s policy is also to harmonise the ways in which practitioners apply to Health Boards for admission to lists. At present the information varies according to the profession and is limited in scope. Health Boards are therefore restricted in their ability to check the fitness to practice of the practitioner to join or remain on a list. The policy intention is that Scottish Ministers may make regulations to require those who apply to join a list to provide certain information, for example an enhanced criminal record certificate which is obtainable from Disclosure Scotland. Such a certificate would show if the practitioner has any criminal convictions as well as any non-conviction information provided by a Chief Constable. The Scottish Ministers may also make regulations to require such certificates from practitioners already on a list. Other requirements which may be placed on those on lists will be to declare gifts above a certain limit and financial interests which might be seen to influence the delivery of services.

Alternative approaches

64. No alternative approaches were considered. The listing of non-principal practitioners for the purposes of undergoing the same checks as principals, to enable Boards to monitor who is working in their area and to bring non-principals within the family health service disciplinary arrangements is a post-Shipman measure. Non-principal GPs are already listed.

Consultation

65. A consultation paper¹² was sent to Health Boards, Primary Care Trusts and other interested parties in February 2004. Copies were also sent to all practices in Scotland providing general dental and ophthalmic services. Dental and ophthalmic contractors were asked to draw it to the attention of all non-principals who work in the practice.

66. 15 responses to the consultation paper were received and these demonstrated agreement to the principle that those who assist in the provision of GDS and GOS should be listed. The representative body for optometrists, Optometry Scotland, requested that listing should be done in the least bureaucratic way possible. They have been assured that the list entry procedure will be established with minimal bureaucracy in mind.

67. The proposal that Health Boards should be able to make arrangements with dental corporations for the provision of GDS formed part of the consultation on Dental Services. This was generally supported.

PHARMACEUTICAL CARE SERVICES

Policy objectives – background

68. The over-arching policy objective of this section of the Bill is to make the necessary legislative changes to implement new arrangements for modernising NHS community pharmacy in Scotland and, in particular, allow implementation of a new contract for providers of pharmaceutical care services. It amends the provisions of the National Health Service (Scotland) Act 1978 (the 1978 Act) relating to the arrangements currently made by Health Boards with community pharmacists for the provision of pharmaceutical services, and with appliance suppliers for the supply of listed appliances.

69. In February 2002 the Scottish Executive published its strategy for pharmaceutical care in Scotland, *The Right Medicine*¹³. This followed the 2001 publication of the Scottish Health Plan *Our National Health: a plan for action, a plan for change*¹⁴. Collectively these documents set an agenda for modernising and redesigning pharmacy services. The over-arching aim is to improve patient care and to better use the skills of community pharmacists and their support staff to meet local population needs.

¹² Scottish Executive, *Listing of Non Principal General Dental Practitioners, Optometrists and Ophthalmic Medical Practitioners* (2004)

¹³ Scottish Executive, *The Right Medicine* (2002)

¹⁴ Scottish Executive, *Our National Health: A plan for action, a plan for change* (2000)

70. In January 2003 the Office of Fair Trading (OFT) issued a report *The control of entry regulations and retail pharmacy services in the UK*¹⁵. Its one recommendation was to abolish the controls under which NHS community pharmacy contracts are granted and so leave the delivery of NHS pharmaceutical services open to market forces.

71. Whilst competition and price regulation issues are reserved, health matters are devolved and in March 2003 Scottish Ministers decided that the OFT recommendation was not the way forward for Scotland. They did so having weighed the interests of consumers against the Executive's public health policy and the potential impact on patients – particularly in Scotland's remote and rural communities and deprived urban areas. In announcing their decision, Ministers advised that in implementing the pharmaceutical services strategy and negotiating the new community pharmacy contract the opportunity would be taken to consider how pharmacy services in the future could best respond to the interests and needs of both patients and consumers in Scotland. Additionally, a Partnership Agreement commitment stated that the Executive would continue to protect the status of community pharmacies.

72. The negotiation of a new community pharmacy contract is a key factor in delivering the policy aims of *The Right Medicine*. Whilst elements of those negotiations remain to be finalised, the framework for the new contract has been agreed and, in March 2004, the legislative proposals to underpin its delivery were put out to consultation in the document *Modernising NHS Community Pharmacy in Scotland*¹⁶.

73. Separately, in June 2003, but still in the context of modernising community pharmacy, the Executive consulted on alternative options for providing listed appliance services, which can currently be provided by either community pharmacists or contracted appliances suppliers.

74. Currently, pharmaceutical services comprise the provision of dispensing services, professional services and locally negotiated additional pharmaceutical services. The policy intention is that the new contract will comprise four clinically based components, referred to as *essential* pharmaceutical care services; a fifth component covering infrastructure requirements (premises and information management and technology); and, similar to now, *additional* pharmaceutical care and support services.

Policy objectives – specifics

Duties on Health Boards

75. Current legislation places Health Boards under a duty to secure the provision of pharmaceutical services for people in their respective areas. There is no formal contract as such between Boards and the persons or businesses that provide pharmaceutical services. Instead Boards are required to make arrangements for service provision in accordance with regulations made under the 1978 Act - the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995 (the 1995 Regulations).

¹⁵ Office of Fair Trading, *The Control of Entry Regulations and Retail Pharmacy Services in the UK* (2003)

¹⁶ Scottish Executive, *Modernising NHS Community Pharmacy in Scotland* (2004)

76. To reflect the increased emphasis on patient care that underpins the new community pharmacy contract, the Bill creates a new terminology referred to as “pharmaceutical care services” (PCS). It is the Executive’s intention that the public should have access to the full range of PCS irrespective of where they stay or are located in Scotland. To that end, the Bill places a duty on Health Boards to secure or provide PCS that they consider necessary to meet all reasonable needs of persons in their respective areas. Such provision will enable Boards to provide PCS directly or by means of arrangements with others according to which is most appropriate to meet local circumstances.

77. Currently, the means by which a Health Board secures the provision of pharmaceutical services is through the maintenance of a “pharmaceutical list”. Persons or businesses wishing to open or relocate a NHS community pharmacy must, in accordance with the 1995 Regulations, apply to the local Health Board for approval to be entered on its pharmaceutical list. The process is referred to as the “control of entry” arrangements. Those arrangements include a criterion that before a Health Board grants an application it must be satisfied that it is “necessary and desirable” to do so in order to secure the adequate provision of pharmaceutical services in the neighbourhood in which the premises are to be located.

78. Overall, the Health Board’s role in the current control of entry arrangements is reactive rather than proactive. As a consequence there are instances where, particularly in rural, remote or deprived areas, the public may not have full or ready access to a full range of pharmaceutical services. Therefore, as well as placing a duty on Health Boards to secure or where necessary provide PCS themselves, the policy intention is that individual Health Boards should do so in accordance with a PCS Plan that they will be required to prepare and maintain. This will allow Health Boards to take a more holistic view of local needs and the most appropriate provision and distribution of services required.

79. Placing the provision of PCS into a formal planning framework means that whilst control of entry arrangements will be retained – in line with the Executive’s decision on the OFT report – applications for entry to pharmaceutical lists will no longer be made on a speculative basis but, instead, in response to clearly identified and stated service needs.

80. To ensure that the planning and service securing process is conducted on a uniform basis across Scotland, the Bill creates powers to introduce regulations to detail what PCS Plans should provide and how they will be prepared, implemented and maintained.

Categories of Pharmaceutical Care Service

81. Under current arrangements, community pharmacists are, through the 1995 Regulations, required to provide medicine and/or appliance dispensing services and may also undertake to provide certain additional professional services.

82. The Bill will bring in powers to create a new set of Pharmaceutical Services regulations that will, amongst other things, define “essential” and “additional” services. The intention is that:

- all PCS contractors will provide “essential services”; and

- PCS contractors will be able to opt into “additional services”, which will be commissioned by Health Boards to meet locally identified needs.

83. Businesses or persons eligible and able to provide all prescribed essential PCS will be able to seek PCS contracts (see below). Providers of individual essential services and/or additional PCS will, as at present for the latter category of service, be able to enter into locally negotiated contract arrangements with NHS Boards.

Pharmaceutical Care Service contracts

84. The policy intention is to introduce the legislative changes required to allow the implementation of the new community pharmacy contract, negotiated between the Executive and the Scottish Pharmaceutical General Council (SPGC).

85. The contract will be between a community pharmacy business and a Health Board. This is a change from the present arrangements under which the “contract” is essentially a set of arrangements governed by regulations. Giving the responsibility for holding contracts to Health Boards accords with the Executive’s policy intention to devolve responsibility from the central to the local level. The White Paper *Partnership for Care*¹⁷ explicitly rejects a command and control approach and emphasises the importance of giving local systems the tools and freedom to redesign services and lead change.

86. Placing the responsibility for setting contracts on Boards will put PCS on the same footing as that for general medical services (GMS) provision. This will also allow for contracts to take an integrated approach to care and deliver a full range of services for patients. It will also allow community pharmacies to expand into other health care provision including, for example, nurse-led or other specialised services.

87. Although PCS contracts will be negotiated or set at a local level, it is the Executive’s intention to have a degree of uniformity to reflect the fact that the new contract has been agreed at a national level. The Bill creates powers to introduce secondary legislation make directions on a range of issues including who can hold a contract, mandatory contractual terms, the types of services to be provided, the manner in which they are to be provided, and the arrangements by which Health Boards will calculate and make payments under PCS contracts.

88. The intention behind the regulation making powers is to ensure that service providers and Health Boards maintain a base level of quality and organisation wherever they happen to be in Scotland. Scottish Ministers will retain the overall responsibility for ensuring that a comprehensive health service exists in Scotland. The Bill will ensure that they can discharge this over-arching duty through setting the parameters within which Health Boards must work.

Who can hold a PCS contract?

89. The Bill has the effect of creating a power to prescribe those who can enter into a PCS contract. The situation will remain largely as at present but with only registered pharmacists, or persons lawfully conducting a retail pharmacy business in accordance with section 69 of the

¹⁷ Scottish Executive, *Partnership for Care* (2003)

Medicines Act 1968, being able to enter into a PCS contract. By definition Health Boards will not be able to enter into PCS contracts with businesses providing only appliance supply services. This is because they are not providing the full range of services that constitute PCS, for which there will be pharmacy specific and mandatory contract conditions. However, Health Boards will continue to be able to secure appliance supply and fitting services from the providers of such services through the Health Boards' normal healthcare commissioning and contract arrangements.

Disputes

90. The negotiation and implementation of any contract has the potential to give rise to disagreements between the parties to the contract. The Executive intends to bring forward regulations that will set out a process for dispute resolution. The policy intention is that the vast majority of disagreements will be resolved by discussion and good working relationships at a local level. However, it is essential that all parties have access to a fair and independent dispute resolution system. In keeping with the concept of a national contract, the Executive believes the process should be common across Scotland. This will ensure that any dispute follows a single, easily understood procedure and adheres to the principles of the European Convention on Human Rights.

Listing arrangements

91. It is the policy intention to ensure that the persons providing PCS services, that is "essential" and "additional", under a NHS contract are fit and competent to do so. This is in the public interest and is essential to retaining public confidence in the provision of family health services.

92. Under current arrangements, Health Boards are required to maintain lists of the names and addresses of the "persons, firms or bodies corporate" that provide pharmaceutical services in their area. The list, known as the "pharmaceutical list" must also detail the pharmaceutical services being provided and opening hours. The purpose of the list is in part to control where community pharmacies are located but also to tie the contractors into stated terms and conditions of service and to ensure that disciplinary action can be taken against them, that is the "principal" pharmacist, if they are found to be in breach of these conditions. There is currently no requirement to list the pharmacy contractors' employees, that is the "non-principals", so principals are responsible for both their own acts or omissions and also for those of the non-principals that they employ.

93. The policy intention is that the "pharmaceutical list" will be retained, but as a control mechanism for those who perform PCS and not for control of entry purposes, which will in future be addressed by the proposed service planning and provision arrangements.

94. The Executive therefore intends that there should be a single list maintained by each Health Board for all registered pharmacists providing PCS in their area, whether they are principals or non-principals. The Bill will empower Scottish Ministers to provide by regulations that a health care professional of a prescribed description may not perform any pharmaceutical care services for which a Health Board is responsible unless the pharmacist is included in a list maintained under the regulations by that Board.

Financial arrangements

95. Currently, whilst Health Boards pay their pharmaceutical services providers, the funds for all nationally negotiated services are drawn from centrally held (Executive) resources. The costs of locally negotiated services are met from the Health Boards' own allocated resources.

96. Given the policy intention to make Health Boards responsible for planning and, thereafter, securing or providing all required PCS in their respective areas, Scottish Ministers consider that Health Boards should also assume full accountability for the financial consequences of their decisions and actions with regard to PCS. Accordingly the Bill contains amendments that will make Boards responsible for meeting all future PCS expenditure from their unified budgets/allocations. The intention is to disburse the central budget to Health Boards on a weighted capitation basis but over a period of time that enables Health Boards to adjust to any changes from historic funding levels under the current arrangements.

97. Recognising that delivery of a PCS plan that meets local needs will in some cases require Health Boards to provide new or additional services, or facilitate changes in service configuration, the Bill contains a provision that will enable Health Boards to provide assistance and support (including financial support) to those providing, or proposing to provide PCS, under a PCS contract.

Alternative approaches

98. The proposals contained within the Bill reflect the legislative requirements for implementing elements of the Executive's pharmaceutical strategy *The Right Medicine* but notably for introducing new contract arrangements for community pharmacies. Negotiations on the latter are still ongoing but the structure and content of the contract have been agreed.

99. There are two alternative options. The first would be to leave the current contract and service provision arrangements as they are. Given the widely supported aims of *The Right Medicine*, by the public and pharmacists alike, the Executive considers that option untenable. The second would be to model the contract and service provision arrangements on the existing legislation. Whilst it would be possible to implement some changes within the current legislative framework they would be limited in scope and would not deliver the full package of patient benefits sought by *The Right Medicine*.

Consultation

100. This section of the Bill is different from many others in that it provides a legislative framework for NHS contracts to provide pharmaceutical care services. The structure and content of the new contract has been agreed by the pharmacy contractors' representative body, the Scottish Pharmaceutical General Council, and discussions on the clinical and financial detail of the contract are ongoing.

101. The legislative proposals to underpin its delivery were put out to consultation in March 2004 in the document *Modernising NHS Community Pharmacy in Scotland*. Around 6,000 copies were distributed to key stakeholders, including all registered pharmacists in

Scotland. Some 100 responses were received and in general the principles of what was proposed were widely supported.

102. Options for changing the arrangements under which the provision of listed (in the Drug Tariff) appliance supplies and services are provided and remunerated were put out to consultation in June 2003¹⁸. A total of 29 responses were received, the majority from NHS bodies and appliance manufacturers or contractors. There was general support for the objective to protect and improve the standards of service for patients, and their access to the services, but no one supply and remuneration model option emerged as the preferred one for delivering the objectives.

DISCIPLINE

Policy objectives

103. The NHS Tribunal is the principal disciplinary body for family health service practitioners (general practitioners, dentists, community pharmacists, optometrists and ophthalmic medical practitioners). It is an independent body comprising a Chair, appointed by the Lord President of the Court of Session, a member of the relevant profession and a lay member both appointed by the Scottish Ministers. At present the Tribunal may inquire into cases where the continued inclusion of a practitioner on a list held by a Health Board would prejudice the efficiency of the NHS or where a practitioner on a list, or an applicant, has committed or attempted to commit fraud against any publicly funded health service.

104. The Bill's policy is to introduce an additional ground under which the Tribunal may deal with a practitioner who has been referred to it. This is one of unsuitability by reason of professional or personal conduct. This will apply, for example, when information comes to the attention of a Health Board that a practitioner has been convicted of an offence, the nature of which suggests he or she no longer deserves the trust which is necessary between practitioner and patient.

105. At present the Tribunal may direct, after an inquiry carried out under statutory guidelines, that a practitioner's name should be removed from the list of the Health Board (local disqualification) or that the practitioner should be excluded from all Health Boards' lists (national disqualification). Disqualification may be substantive or conditional. The latter provides that the practitioner's name may remain on the list subject to conditions. In addition to a national substantive disqualification the Tribunal may direct that a practitioner is not fit to be engaged in the NHS in any capacity. This has the effect of ensuring that a practitioner may not assist another in the delivery of services.

106. The policy intention is to remove the sanction of local disqualification. Thus, if a practitioner is not fit to deliver services in one Health Board's area he or she should not be able to do so in another. There is a right of appeal to the Court of Session on points of law against decisions of the Tribunal and disqualified practitioners may apply to the Tribunal for their disqualification to be removed. If successful with such an application a practitioner would be free to apply to any Health Board to provide services once more.

¹⁸ Scottish Executive, *Appliance Contractors* (2003)

107. Where it is necessary to protect patients, the Tribunal has the power to suspend a practitioner, on application by the relevant Health Board, while the full case is considered. This has proved unwieldy and the Bill introduces changes. The policy is for regulations to make provision to allow suspension of a listed person directly by a Health Board from its own list (local suspension), unless or until representations are made to the Tribunal. This could be on the existing ground of patient protection, or on a new ground of protection of the public interest. The latter would apply, for example, where there was suspicion of fraud being committed. The Tribunal would continue to be able to make a national suspension on either ground. Any practitioner subject to suspension proceedings will have the right to a hearing and, if suspended, will continue to be paid.

108. In the case of pharmaceutical bodies corporate and appliance suppliers the disciplinary arrangements for individual practitioners are no longer appropriate with the introduction of the new pharmacy contract. Any failure to comply with the contract with the Health Board can, however, be pursued as a breach of contract in the normal way.

109. At present a Health Board must remove practitioners from its list in certain circumstances. One of these is where the practitioner has been convicted of murder. At present this only applies to convictions of GPs and dentists in the UK. The policy is to extend this to bring in pharmacists, optometrists and ophthalmic medical practitioners. In addition, the policy is that Health Boards will be required to refuse any application for entry to its lists from a practitioner who has been convicted of murder in the UK.

110. At present Health Boards must also remove practitioners from its list where a GP or dentist is convicted of a criminal offence and sentenced to imprisonment for 6 months or longer. This rule is inflexible. Thus, the policy intention is that instead the Health Board will consider the implications of any conviction of any family health service practitioner. If necessary, the Health Board may then refer the matter to the Tribunal which could disqualify or conditionally disqualify the practitioner. The policy is for these arrangements to also apply to applications for admission to lists.

Alternative approaches

111. One alternative approach would be to leave the provisions relating to the Tribunal and to NHS Boards as they stand. This would not however afford patients the same level of protection as the proposed changes. Additionally, a public interest ground for suspension of family health service practitioners is already used in England and Wales (by primary care bodies) and there is an unsuitability ground under which practitioners may be de-listed.

Consultation

112. These proposals have been the subject of a wide ranging public consultation exercise¹⁹ which attracted a total of 59 responses. These were generally in favour of the policy.

¹⁹ Scottish Executive, *Further Measures to Improve the Provision of Primary Care Services* (2004)

PAYMENTS TO CERTAIN PERSONS DEVELOPING HEPATITIS C AS A RESULT OF NHS TREATMENT

Policy objectives

113. Scottish Ministers have made a commitment to participate fully in the UK scheme for making ex gratia payments to patients who became infected with the hepatitis C virus following NHS treatment prior to September 1991, that involved receipt of blood tissue or blood products.

114. The scheme has been established and has commenced making payments. At present Scottish Ministers are making ex gratia payments to the above mentioned patients using common law powers. Since it is anticipated that there will be continuing payments over a period of time, Scottish Ministers consider it appropriate that express statutory powers to make the payments be obtained.

Alternative approaches

115. No alternative approach has been considered as statutory powers are considered the only appropriate approach to ensure that payments can continue over a period of time.

Consultation

116. The provision of financial payments to patients affected in this way was a primary recommendation of the 17th Report (2001) of the Health and Community Care Committee²⁰ and this was subsequently reinforced by a similar recommendation made in March 2003 by the Expert Group on Financial and Other Support (chaired by Lord Ross). In the light of these recommendations no further consultation was deemed necessary on the issue of making the necessary legal provision to make payments of this nature.

AMENDMENT OF REGULATION OF CARE (SCOTLAND) ACT 2001 AND CHILD CARE AGENCIES AND HOUSING SUPPORT SERVICES

Introduction

117. The Regulation of Care (Scotland) Act 2001 (the 2001 Act) established a new independent body to regulate care services in Scotland; that body is known as the Scottish Commission for the Regulation of Care (the Care Commission). It also established a system of care regulation, encompassing the registration and inspection of care services against a set of national care standards and the taking of any enforcement action.

118. It also established a further new independent body to regulate the social service workforce and to promote and regulate their education and training; that body is known as the Scottish Social Services Council (the Council).

119. This section of the policy memorandum also covers the provisions in relation to child care agencies and housing support services which are free standing provisions in the Bill.

²⁰ 17th Report, 2001, *Hepatitis C*, SP Paper 398

Policy objectives

Amendments affecting the Care Commission

Independent health care services

120. The Care Commission regulates care services defined in section 2 of the 2001 Act. This includes “an independent healthcare service” which is further defined at section 2(5) of the Act. The original policy intention was that independent healthcare services including hospitals, clinics and medical agencies would be brought within the scope of regulation by the Care Commission.

121. The scope of the legislation currently goes further than the original policy intention. As it stands, once section 2(5) of the 2001 Act is fully commenced, the Care Commission's regulatory powers would encompass a wider area of the independent health care sector than that originally envisaged. For example, the Care Commission would be responsible for regulating services from a doctor or dentist provided under arrangements by a third party such as occupational health services or medical consultations and examinations for insurance companies. Any private services being provided by NHS general practitioners would also be covered by the current definition.

122. The power to except services from a definition already exists (where relevant) for other care services defined in the 2001 Act. The Bill's policy intention is to amend section 2(5) of the 2001 Act to give Scottish Ministers the power to define by regulations the independent healthcare services that will be regulated by the Care Commission.

Implementation of certain decisions

123. Under the 2001 Act, anyone who wants to provide a care service must register that service with the Care Commission. The Care Commission has powers to make a range of decisions both in relation to applications for registration and services which are already registered. In relation to initial applications, registration may be granted either unconditionally, subject to such conditions as the Care Commission thinks fit to impose, or refused. For services which are already registered, the Care Commission may issue a condition notice (which is a notice that the Care Commission proposes to vary, remove or impose an additional condition); propose to cancel registration; or propose to refuse an application by the provider (a) to vary or remove a condition in force in relation to the service or (b) to cancel registration. The Care Commission notifies its decision in writing. The person to whom the notice is issued can make written representation to the Care Commission concerning any matter that they wish to dispute.

124. The original policy intention was that the Care Commission would consider any representations from those who are notified and then decide whether or not to do the thing proposed. This is not reflected in the current legislation.

125. The policy intention is to amend section 16(2) of the 2001 Act to make a technical change which will ensure that where representations are made to the Care Commission, these will be considered and that the Care Commission will then decide whether or not to follow the action proposed in the notice.

Amendments affecting the Scottish Social Services Council

126. The Scottish Social Services Council's (the Council) duties include maintaining a register of social service workers as prescribed within the 2001 Act and in any orders made by Scottish Ministers. An application for registration may be granted unconditionally or subject to conditions imposed by the Council. The Council has also, subject to Scottish Ministers' consent, issued a Code of Practice for Social Service Workers and Employers, which employers will take into account when making any decision about the conduct and competency of a social service worker.

Implementation of certain decisions

127. The original policy intention in relation to applications for registration was, and still remains, that, where the Council intends to grant conditional registration, the applicant will be notified of the Council's decision and be given the opportunity to make any representations before the Council implements their decision. The applicant would also have the right to appeal to the Sheriff against any decision made by the Council in relation to the application for registration.

128. The Executive believes that the 2001 Act does not fulfil the policy intention as currently drafted because, even where representations are made, the Council is obliged to implement the original proposal and it is unclear whether all decisions can be appealed against.

129. The Executive's policy is to amend the 2001 Act to make the technical changes to fulfil the original policy intention. This will ensure that where representations are made by applicants, the Council will consider them and then decide whether or not to take the action originally proposed, and also remove any ambiguity so that there is a right of appeal against all decisions made by the Council in relation to an application for registration.

Provision of information to the Scottish Social Services Council

130. With regard to the Code of Practice, the original policy intention, which remains, is that employers would take account of the Code and its contents when dealing with conduct and competency issues relating to a social service worker. Whilst some employers appear to be doing so, recent high profile investigations into social work services highlighted a need to reinforce the original intention.

131. The proposed changes to the 2001 Act will clarify the requirements for the provision of information regarding social service workers by employers to the Council. This will remove any weakness or ambiguity of when and how an employer should take account of the requirements of the Code of Practice, including co-operating with the Council in relation to registration issues.

132. The amendments will support an individual's right to a fair hearing and protect the users of social services.

Child care agencies and housing support services

133. The definitions at section 2 of the 2001 Act are gradually being commenced as the Care Commission takes on responsibility for regulating care services on a phased basis. The policy is

to put in place for each service sector, as its definition is commenced, subordinate legislation specifying transitional provisions for registration. These provisions deem services to be registered for certain periods which it is intended will ensure that their providers have enough time to submit their applications for registration and the Care Commission in turn has enough time to consider them and either grant or refuse registration.

134. From 1 April 2003 the child care agency definition at section 2(7) of the 2001 Act was commenced in full (having been partially commenced from 1 April 2002 to ensure continued registration of the few agencies registered as childminders under the previous regulatory system) as was the definition of housing support service at section 2(27). The transitional provisions provided that persons providing those services on 1 April 2003 were deemed to be registered from that date until 30 September 2003 but where a person applies for registration before 1 October the service is deemed to be registered until 31 March 2004. Section 21 of the 2001 Act makes it an offence for a person to provide a service while it is not registered with the Care Commission.

135. Due to the complexity of services, discussions between the Care Commission and providers on the number and form of applications required under the 2001 Act took much longer than anticipated. During the course of those discussions the deemed registration period ran out by which time very few providers had applied to the Commission for registration. This had the consequence that many providers were inadvertently acting illegally under the terms of the 2001 Act. This did not come to light until it was too late to take action to extend the deemed registration period in subordinate legislation. The Lord Advocate granted the providers affected an amnesty against prosecution for providing unregistered services, provided they submitted applications before 30 September 2004.

136. The policy intention is to make retrospective provision to ensure that the providers of the services affected are treated as if they continued to provide them legally during the periods in question. It ensures that where a person was deemed to be registered on 1 April 2003 that deemed registration, where necessary, does not cease until 1 April 2006, provided applications for registration were made before 30 September 2004.

Grants in respect of housing support services

137. Grants are paid to local authorities by Scottish Ministers under section 91(1) of the Housing (Scotland) Act 2001 towards expenditure incurred by them in providing or contributing towards the provision of prescribed housing support services. In turn, local authorities pay grants to providers of these services. Terms and conditions for payment were set out in secondary legislation. Existing services were deemed to be registered until 30 September 2003 and, provided they had applied to be registered by that date, until 31 March 2004. Services which were care services in terms of the relevant order under the Housing Act, required to be registered with the Care Commission to receive housing support grant until that requirement was removed on 19 August 2004 by a further amending Order.

138. The lapsing of deemed registration of certain housing support services on 1 October 2003 due to difficulties in the registration process meant that payments were made by local authorities to service providers after that date who were not registered. The policy intention is

for a new retrospective provision to ensure the lawfulness of payments made over the period 1 October 2003 to 19 August 2004.

Alternative approaches

139. No alternative approach has been considered as statutory powers are considered to be the only appropriate approach to ensure that the policy intentions would be fulfilled.

Consultation

140. The changes to the 2001 Act are all technical and consultation was not considered to be necessary. The Care Commission and the Council are aware of, and support, the proposed changes to the 2001 Act.

141. In relation to the change to section 2(5) of the 2001 Act the policy intention is that, prior to making regulations, consultation will be carried out on which, if any, services should be excepted from the definition of an independent healthcare service before these provisions are commenced.

142. In relation to the changes with regard to the implementation of certain decisions (affecting the Care Commission and the Council), the policy intention is to advise care service providers and social service workers of the proposed changes.

143. The intended policy on provision of information to the Council is to ensure that the Council has all relevant information available to enable it to properly carry out its regulatory functions. It follows from the Minister for Education and Young People's announcement in the Scottish Parliament in May 2004 relating to the high profile investigation into the Borders that the statutory position of the Code would be strengthened. Despite recommendations on good practice in the Code, the present inability of the Council to require information from an employer on the conduct of a social services worker and concerns of employers about possible infringement of data protection obligations if information was passed on, were recognised as matters that required to be specifically addressed by legislative change. Employers are aware of the forthcoming change and are supportive of it.

144. For the policy relating to child care agencies and housing support services, known providers of these services were informed that the Lord Advocate had granted them an amnesty against prosecution, provided they submitted an application for registration to the Care Commission by 30 September 2004; they were also told that legislative steps were being progressed to rectify the situation retrospectively. Local authorities were also informed. The Executive also announced the action being taken in a news release on 23 July 2004.

AUTHORISATION OF MEDICAL TREATMENT

Policy objectives

145. The Adults with Incapacity (Scotland) Act 2000 (the 2000 Act) regulates the way in which decisions may be taken on behalf of adults who are incapable, either by reason of mental

disorder or physical impairment, of making such decisions themselves. It sets out a regulatory regime designed to protect welfare and property. In the case of medical treatment and research (Part 5 of the 2000 Act) it provides a clear statutory framework for regulating what may be done by medical practitioners and others acting with their authority.

146. Following concerns expressed about the workload implications for general practitioners under the new legislation, a consultation exercise was launched in March 2003. Other health professionals, especially dentists were also concerned that they were unable to treat patients attending their surgery, often in pain, because a certificate was not already in place to allow that treatment to proceed. Qualitative research was undertaken on the early operation of Part 5. As a result of this careful consideration and further engagement with health professionals and other stakeholders the intention is to amend certain aspects of Part 5.

147. The policy intention is to make two amendments to section 47 of the 2000 Act. The first will extend the authority to grant a certificate under section 47(1) to health professionals who have relevant qualifications and training to assess the capacity of patients. This group is in addition to “registered medical practitioners” who are capable of making an assessment of the patient’s capacity as required in terms of section 47. Importantly, the certificate will only be valid within their specialism, for example a dentist could only authorise dental treatment. The authority to issue a certificate will be expanded in terms of the Bill to include dentists, ophthalmic opticians and registered nurses, but there is provision also to extend to other professional groups by regulation. Consequential changes will be made to other sections in Part 5 of the Act.

148. The second amendment will extend the maximum duration of a section 47 certificate from 1 year to 3 years. This will be dependent on the nature of the illness from which the patient is suffering, for example the new maximum duration could be applied where, in the view of the registered medical practitioner, a patient was suffering from a progressive degenerative condition with no chance of improvement. This would make better use of the scarce resource of the medical practitioner’s time (and knowledge of the patient) without placing the patient at risk.

149. A principal objective in this process has been to ensure that the changes do not erode the protections the current legislation gives to a vulnerable group of people. The changes should help to ensure that those patients who cannot give consent to treatment will, none the less, receive parity of care with those who can.

Alternative approaches

150. An alternative was to give the operation of the 2000 Act a longer period to settle before taking amending action. But in the light of the written comments received and discussion with key stakeholders the balance of advantage was considered to lie in taking the steps now proposed which will improve the administrative processes without diminishing the protections conferred by the 2000 Act.

Consultation

151. The Scottish Executive conducted a wide-ranging consultation²¹ on possible amendments to the Code of Practice and changes to the Act. The Executive commissioned an analysis of the responses²² to the consultation exercise and commissioned qualitative research into issues arising from the implementation of Part 5²³. The Executive also met key stakeholders (representing medical professionals, voluntary organisations and carers) to consider the outcome of the consultation and to agree a common approach to the issues. The finding of the consultation was that the general consensus among respondents was support for the two substantive changes to the 2000 Act.

JOINT VENTURES

Introduction

152. The policy intention is to allow Scottish Ministers and NHS bodies to form or participate in joint venture companies for two purposes. Firstly, for the provision of facilities and services and, secondly, for the exploitation of intellectual property.

Facilities and services

Policy objectives – background

153. The policy objective is to amend the National Health Service (Scotland) Act 1978 (the 1978 Act) to enable Scottish Ministers and NHS bodies to enter into joint venture agreements with contractors, local authorities and private sector providers to support primary and community care and joint working premises, and other infrastructure development.

154. This policy is set within a context of increasing investment in health services and reforms to deliver improved health and better integrated health services that are more responsive to the needs of patients and communities. Key initiatives include: the introduction of a new contract for GPs, involving measures to reduce the barriers for GPs needing to move or develop existing premises; the establishment of Community Health Partnerships; and the introduction of new joint working powers²⁴ for Health Boards and Local Authorities. Investment currently comes from independent contractors funded through their individual contract remuneration arrangements; NHS capital; Local Authority funds; private capital; and the Primary and Community Care Premises Modernisation Programme.

155. The Bill will enable Health Boards and their public sector partners to access a greater range of sources of investment to support the development of infrastructure and better integration in service planning.

²¹ Scottish Executive, *Adults with Incapacity (Scotland) Act 2000: Review of Code of Practice for Part 5 Medical Treatment and Research - and Related Issues* (2004)

²² Scottish Executive, *Review of the Code of Practice for Part 5 of the Adults with Incapacity (Scotland) Act 2000 and Related Issues: Analysis of Written Submissions to Consultation* (2004)

²³ Davidson *et al*, *Review of the Implementation of Part 5 of the Adults with Incapacity (Scotland) Act 2000: A Qualitative Study of Implementation and Early Operation* (2004)

²⁴ *Community Care and Health (Joint Working etc.)(Scotland) Regulations 2002*

Policy objectives – specifics

156. Provision of premises for the delivery of Primary Care is the responsibility respectively of the independent contractors concerned, in relation to the services they are contracted to deliver, or of the Health Board in respect of community health or salaried Primary Care Services. Premises tend to be owned either by contractors or the Health Board, or leased from a third party. General Medical Practitioners are eligible for direct reimbursement of the costs of premises provision. Under current contracts General Dental Practitioners and Community Pharmacists are expected to meet their premises costs from the activity based fees and allowances paid to them for provision of NHS services.

157. Work undertaken within the Executive in 2001 to assess issues around primary care premises development concluded that there is a need for greater flexibility in the provision of primary care premises and services, that must be recognised by any new investment vehicle; that premises should support greater joint working between care providers; and also measures that allow flexible tenure and occupation arrangements for users.

158. Subsequently, the Scottish Executive Short Life Working Group on Primary Care Premises Development highlighted the changing nature of the primary care premises environment and recommended action to change systems and practice to reflect service change. Its report²⁵, recommended adoption of the joint ventures policy objective and that this should form part of a formal consultation. The consultation would also address the suitability for Scotland of Local Improvement Finance Trusts (LIFT) being implemented by the Department of Health in England. This would be on the basis of their potential flexibility for joint premises developments. The Working Group also recommended that the Executive develop and publicise innovative procurement options. As a consequence the Executive commissioned a report on procurement focussing particularly on the suitability of implementing LIFT in NHS Scotland.

159. The Executive has concluded that the decision on the development approach most suitable for each Health Board area in Scotland is one to be taken locally in conjunction with other partners. Introduction of LIFT type entities may offer an appropriate way forward in some parts of Scotland, particularly where there is an urgent need to find a way to address the strategic planning deficit in closer collaboration with the private sector and other public sector agencies. In other areas partners may decide that their objectives for the medium term are already sufficiently well scoped and that a variety of delivery vehicles may offer an appropriate way forward. These may still involve joint ventures with the private sector or wholly within the public sector. The Executive intends that once these powers are in place all Health Boards and local authorities will be invited to confirm how they intend to deliver their respective infrastructure development strategies to identify whether joint ventures may offer an appropriate vehicle for this.

Alternative approaches

160. In the period since publication of the working group's report Health Boards, contractors and other partners have continued to apply the financial tools available to deliver purpose built or adapted premises to address needs already identified within local strategies. These have included

²⁵ Scottish Executive, *Joint Future Agenda: Short Life Working Group on Joint Premises Development in Primary and Community Care* (2003)

projects funded wholly or mainly by NHS and other public capital, augmented or substituted by leasehold developments led by GPs.

161. This has enabled significant progress in modernising primary/community care premises and in bringing into service model premises that enable innovative joined up service delivery. For example, the Executive has spent £50m over the past 5 years to specifically address primary and community care premises development. Progress is not however uniform across Scotland and relies on a steady stream of well conceived and viable projects, with contractors willing to take on a leading role in development. These arrangements do not, however, fully promote effective forward planning, exploitation of the potential for joint working with partners, their capacity to develop complicated schemes, the role expected of contractors and the realisation of benefits of partnerships with the private sector.

Consultation

162. A formal consultation²⁶ sought views on both the concept of joint ventures generally and the appropriateness of LIFT as a delivery vehicle for Scotland. In summary²⁷ there was broad support for the policy objectives and the desirability of the NHS having the power to invest in joint ventures with private and public sector partners. There were, however, mixed views about whether the specific LIFT model as already deployed in England would represent an appropriate, universal way forward in Scottish circumstances. These reservations are consistent with the policy intention that joint ventures would be one of a number of delivery vehicles available to support the development of facilities.

Intellectual property

Policy objectives

163. Legislation currently provides the Scottish Ministers with a range of powers to make more income available for improving the National Health Service. Those powers, which have been extended to NHS bodies though a power of direction, include, among others, the manufacture and supply of goods and the provision of services (for example, the Scottish National Blood Transfusion Service manufactures blood products and diagnostic kits, supplying its products to over 50 countries throughout the world). However, there is currently no power in Scotland for these “income generation powers” to be exercised through the medium of a company.

164. The Executive’s policy intention is to amend the Health and Medicines Act 1988 (the 1988 Act) to make specific provision to allow Scottish Ministers to form or participate in forming companies, or to participate in companies. It also allows Ministers to make financial provision to or in respect of companies, including by means of loans, guarantees and investments. The use of this power is restricted to the purpose of making more income available for the Health Service.

²⁶ Scottish Executive, *Consultation on the use of Joint Ventures to deliver Primary Care/Joint Premises* (2004)

²⁷ Scottish Executive, *Consultation on the use of Joint Ventures to deliver Primary Care/Joint Premises: Summary Report* (2004)

165. The intention is to enable the Scottish Ministers and NHS bodies to make the most of the ideas and intellectual property generated by the NHS by developing and exploiting those ideas commercially. Whilst such “exploitation” could be achieved through other routes such as licensing or selling innovations using existing powers, for certain technologies requiring a further degree of development and financial investment, the more appropriate – and sometimes only possible – route to successful exploitation would be the establishment of joint venture companies to bring external finance and commercial skills to supplement the NHS expertise. This is how universities typically exploit this type of technology in partnership with the private sector. As things presently stand, however, the NHS cannot contribute its continuing scientific expertise to such a company to allow the further development of the innovation. The removal of the restriction on this type of exploitation would also allow these companies to apply for Scottish Executive business growth and innovation grants.

166. The new power is not restricted to the exploitation of intellectual property; it will extend to any of the activities listed in section 7 of the 1988 Act, such as the provision of services. The Scottish Ministers, under the power in section 7(3), intend issuing a direction to NHS bodies about the exercise of this new power. They will set out the circumstances in which the exercise of this power is appropriate along with clear directions on the issues, such as the assessment of the viability and value of the particular proposal, which must be considered in advance of its use.

Alternative approaches

167. As noted above, alternative means of exploiting NHS innovations, such as through licensing or sales, are currently available. For certain technologies, however, there will be a need for further product development and trialling in a clinical setting to determine both their scientific and commercial value. These steps can be costly and there is often a high risk of failure. Attracting commercial funding and know-how through product specific “spin out” companies is therefore often the only way to finance these steps. This new power is therefore necessary to ensure that the Scottish Ministers and through them NHS bodies can engage with and participate in such commercially funded companies for mutual scientific and financial benefit.

168. As an interim arrangement NHS bodies currently seek to progress their innovations – including through spin-outs – through a contractual arrangement with Scottish Health Innovations Ltd (SHIL), a company established by the Scottish Economic Development Agencies to support NHS innovation. This might suggest that the new powers are not needed. The limitations of such an approach, however, are evidenced by the fact that neither the Scottish Ministers nor the NHS bodies can participate directly in this company set up solely for their benefit. They only have observer status and, without the new power, cannot direct SHIL’s activities. In the case of a spin-out company, SHIL is therefore currently obliged to license technologies from NHS organisations and then enter into quite separate arrangements with commercial funders – currently the NHS body is not allowed to be directly involved in the company established to progress its own innovation. The power for the Scottish Ministers to participate directly in companies is therefore required.

Consultation

169. Following the Health and Social Care Act 2001 making a similar amendment for NHS bodies in England and Wales, the Scottish Ministers announced their intention to seek similar

changes in Scotland. This proposal was included in the draft Research Strategy which was the subject of public consultation in 2002²⁸ and it appeared in the final Research Strategy²⁹ published in July 2003. It commands wide support throughout the NHS.

SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST

Policy objectives – background

170. The Scottish Hospital Endowments Research Trust (SHERT) was originally constituted under the Hospital Endowments (Scotland) Act 1953 to receive and hold endowments, donations and bequests and to make grants from these funds available to support medical research in Scotland. SHERT is presently governed by the National Health Service (Scotland) Act 1978. Currently, SHERT supports research into diseases of high incidence in Scotland and is committed, in doing so, to supporting only the highest quality research.

171. SHERT is empowered by the National Health Service and Community Care Act 1990 to engage in fundraising activities for the purposes of the Trust and is required by the Health and the Medicines Act 1988 to develop and exploit ideas and intellectual property.

Policy objectives – specifics

172. Although a Non Departmental Public Body (NDPB), the Trust is entirely self-financing and thus receives no financial support from the Scottish Executive and members receive no fee or remuneration. Members are appointed by Scottish Ministers and operate with a large measure of autonomy.

173. Following the outcome of a Policy and Financial Management Review (PFMR) and Consultation exercise, the Executive's view is that the work of the Scottish Hospital Endowments Research Trust, as a self financing public body, is such that it is sufficiently distant from Ministers to make continuing Ministerial involvement inappropriate. It is therefore the policy intention that SHERT's NDPB status should be removed.

Consultation and Policy and Financial Management Review

174. In line with established policy, all Non-Departmental Public Bodies are subject to a comprehensive PFMR at least once every five years. SHERT's PFMR was conducted in 2003. The PFMR examined whether the functions of SHERT are still required and whether the NDPB model continues to be the appropriate governance for delivery of the functions.

175. Subsequent to the Policy and Financial Management Review a written consultation exercise on the future status of the Research Trust was held. Parties directly consulted included SHERT grant holders, its scientific advisers and the administering institutions for SHERT funded research. In addition, consultation material was placed on both the SHERT and Scottish Executive Chief Scientist Office's websites inviting views on SHERT's future status.

²⁸ Scottish Executive, *Draft Research Strategy for NHS Scotland* (2002)

²⁹ Scottish Executive, *Research Strategy for Health and Healthcare* (2003)

176. The main thrust of the conclusions flowing from the PFMR centred on the fact that the tax benefits of charitable status are vital to the continued operation of SHERT. In noting that SHERT could exist without Ministerial control, and that such control might jeopardise its charitable status in the future, the PFMR recommended that SHERT's status as a public body, linked and accountable to Ministers, should be removed. Those who replied to the consultation unanimously supported the recommendation of the PFMR that SHERT's public body status should be removed.

177. Following the outcome of the Policy and Financial Management Review and the Consultation exercise, Ministers took the view that the work of SHERT, as a self financing public body, is such that it is sufficiently distant from Ministers to make continuing Ministerial involvement inappropriate. It was for this reason that Ministers concluded that SHERT's NDPB status should be removed. SHERT also supported this recommendation.

Alternative approaches

178. In line with the position that SHERT should continue as an independent charity a number of alternatives were explored within the PFMR process.

179. The first option considered the donation of the funds to an existing medical research charity. In conclusion it was considered that most Scottish charities would not be well placed to manage the investments and wide ranging research portfolio on the scale undertaken by SHERT. Also, singling out one charity for such a substantial portfolio ran the risk of leading to dissatisfaction in the rest and the wider research community.

180. The second option considered the creation of a new organisation for SHERT's functions. SHERT is a "virtual" Trust with no staff and no premises. Against this background it was considered unlikely that an organisation could be created that would fulfil the full range of functions at existing administrative costs. In addition, as the proportion of funds used by charities for administrative purposes is an issue under considerable scrutiny, it seemed likely that any new or existing charity could manage the SHERT portfolio without increasing overheads.

181. In conclusion, the approach of removing Ministerial involvement in terms of the existing legislation was considered the most appropriate means of achieving the PFMR objectives.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

Equal opportunities

182. The Bill's provisions are not discriminatory on the basis of gender, race, disability, marital status, religion or sexual orientation.

Human rights

183. The Executive is satisfied that the provisions of the Bill are compatible with the European Convention on Human Rights.

184. The provisions of the Bill which prohibit smoking in certain public places will help to protect the public from the known carcinogens contained in environmental tobacco smoke. The Bill does not prohibit people from smoking, other than in certain defined no-smoking premises, and is therefore a proportionate action which balances the rights of smokers to continue smoking if they wish to do so whilst protecting the health of others.

185. In particular, the Regulation of Care provisions of the Bill will improve the transparency of the Regulation of Care (Scotland) Act 2001 and will secure the rights of individuals and bodies to make representations to the Commission or the Council, as appropriate, and to receive a fair hearing.

186. The provisions of the Bill which amend the Adults with Incapacity (Scotland) Act 2000 will help to reinforce the rights of some of the most vulnerable people in society to receive treatment to which they are entitled or which is appropriate in their circumstances.

Island communities

187. The provisions of the Bill apply equally to all communities in Scotland.

188. The dental services, pharmaceutical care services and joint ventures provisions have the potential to bring real benefit to communities in remote and rural locations. New powers for Health Boards to provide assistance and support for dental services will assist Health Boards to make provision for dental services where demand is underserved. The pharmaceutical care service provisions are, in part, targeted specifically at improving the quality and range of the services that are available. The joint ventures provisions create a new option for provision of premises to deliver public services and offers strong opportunities for close co-operation between Health Boards and Councils in these areas to work together.

Local government

189. The Executive is satisfied that the provisions in the Bill will have no impact on local government other than in the following areas.

190. For the smoking in public places provisions, options are currently being explored on enforcement of the regulations. Ministers will discuss with the Convention of Scottish Local Authorities (CoSLA) the practicalities of enforcement.

191. The lead on implementing the regulation of care legislation will fall to the Scottish Commission for the Regulation of Care and the Scottish Social Services Council with central support and guidance provided by the Executive. However, local authorities (and other employers of social services workers) will benefit from improved clarity in how the Codes of

Practice should be regarded. In addition, there will be a regularisation of the payments made by local authorities to child care agencies and housing support services.

192. The ability to enter into joint ventures should help promote greater co-operation between healthcare professionals, local authorities and private developers in the delivery of modern community based healthcare facilities. This could help local authorities in their wider activities, for example in terms of urban regeneration.

Sustainable development

193. *Meeting the Needs....*³⁰ describes how building a national effort to improve health, reducing inequalities in health and making the NHS a 'national health service' and not a 'national illness service', is an integral part of sustainable development. The Executive has made clear that efforts to promote health, alongside programmes on social justice, crime and transport, are central to sustainable development.

194. Central to measures to improve the nation's health are the provisions in the Bill for the prohibition of smoking in public places. The Executive is also emphasising the need for proactive planning and use of resources in identifying and meeting the needs for the delivery of pharmaceutical care and dental services across the country through this Bill.

³⁰ Scottish Executive, *Meeting the Needs....Priorities, Actions and Targets for sustainable development in Scotland* (2002)

ANNEX

GLOSSARY

BDA	British Dental Association
CDS	Community Dental Service
CoSLA	Convention of Scottish Local Authorities
CSO	Scottish Executive Chief Scientist Office
ETS	Environmental Tobacco Smoke
GDP	General Dental Practitioner
GDS	General Dental Services
GMS	General Medical Services
GOS	General Ophthalmic Services
GP	General Practitioner
IHC	Independent Healthcare Services
LIFT	Local Improvement Finance Trust
NAP	National Appeal Panel
NDPB	Non-department public body
NHS	National Health Service
NSS	NHS National Services Scotland
OFT	Office of Fair Trading
OMP	Ophthalmic Medical Practitioners
PCS	Pharmaceutical Care Services
PDS	Personal Dental Services
PFMR	Policy and Financial Management Review
PSD	Practitioner Services Division (part of NSS)
R&D	Research and Development
RoC	Regulation of Care
SCOTH	Scientific Committee on Tobacco and Health
SDR	Statement of Dental Remuneration
SHERT	Scottish Hospital Endowment Research Trust
SHIL	Scottish Health Innovations Ltd
SME	Small to Medium Sized Enterprise
SPGC	Scottish Pharmaceutical General Council
1978 Act	National Health Service (Scotland) Act 1978
1988 Act	Health and Medicines Act 1988
1995 Regulations	National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995
GDS Regulations	National Health Service (General Dental Services) (Scotland) Regulations 1996
2000 Act	Adults with Incapacity (Scotland) Act 2000
2001 Act	Regulation of Care (Scotland) Act 2001

This document relates to the Smoking, Health and Social Care (Scotland) Bill (SP Bill 33) as introduced in the Scottish Parliament on 16 December 2004

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

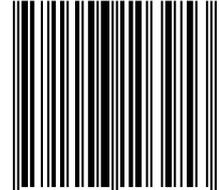
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