

# **Health Committee**

## **6th Report 2005, (Session 2)**

### **Stage 1 Report on the Smoking, Health and Social Care (Scotland) Bill**

#### **Volume 1: Report**

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# The Scottish Parliament

## **Health Committee**

### **6th Report 2005, (Session 2)**

### **Stage 1 Report on the Smoking, Health and Social Care (Scotland) Bill**

### **Volume 1: Report**





# The Scottish Parliament

## Health Committee

### 6th Report, 2005 (Session 2)

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7 December 2004 (29<sup>th</sup> Meeting, Session 2 (2004))  
11 January 2005 (1<sup>st</sup> Meeting, Session 2 (2005))  
25 January 2005 (3<sup>rd</sup> Meeting, Session 2 (2005))  
22 February 2005 (5<sup>th</sup> Meeting, Session 2 (2005))  
1 March 2005 (6<sup>th</sup> Meeting, Session 2 (2005))  
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22 March 2005 (9<sup>th</sup> Meeting, Session 2 (2005))  
12 April 2005 (10<sup>th</sup> Meeting, Session 2 (2005))  
19 April 2005 (11<sup>th</sup> Meeting, Session 2 (2005))







# The Scottish Parliament

## Health Committee

### Remit and membership

#### **Remit:**

To consider and report on matters relating to health policy and the National Health Service in Scotland and such other matters as fall within the responsibility of the Minister for Health and Community Care.

#### **Membership:**

Roseanna Cunningham (Convener)

Helen Eadie

Janis Hughes (Deputy Convener)

Kate Maclean

Duncan McNeil

Nanette Milne (Committee member from 2 February 2005)

Shona Robison

Mr Mike Rumbles

Dr Jean Turner

David Davidson (Committee member until 1 February 2005)

#### **Committee Clerking Team:**

##### **Clerk to the Committee**

Simon Watkins

##### **Senior Assistant Clerk**

Tracey White

##### **Assistant Clerk**

Roz Wheeler

##### **Committee Assistant**

Lynn Stewart





# The Scottish Parliament

## Health Committee

### 6<sup>th</sup> Report, 2005 (Session 2)

#### Stage 1 Report on the Smoking, Health and Social Care (Scotland) Bill

#### EXECUTIVE SUMMARY

Listed below is the Committee's overall view on the various provisions contained in Smoking, Health and Social Care (Scotland) Bill.

A number of further conclusions and recommendations, together with the Committee's reasoning, are included in the body of the report.

#### INTRODUCTION

- The Committee has some concerns that the diverse nature of bills of this type increases the difficulty of carrying out effective scrutiny. The Committee recommends that the Executive bring forward bills that are more discrete in nature to avoid the difficulty of having to deal with very different subject matter. (Paragraph 10, page 6)

#### PART 1: PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES

##### Committee's Overall View

- The majority of members of the Committee are of the view that a ban on smoking in enclosed public places would impact positively on public health and that a voluntary approach to tobacco control would not ensure the same outcome. The majority of members, therefore, support the proposal contained in this part of the bill, believing that it will help to save lives. (Paragraph 26, page 9)

**PART 2, SECTIONS 9 AND 10:  
FREE ORAL HEALTH ASSESSMENTS, DENTAL CHECKS, EYE  
EXAMINATIONS AND SIGHT TESTS**

**Committee's Overall View**

- The Committee<sup>1</sup> supports the Executive's proposals to introduce free oral health assessments and eye examinations and believes that, if properly implemented, they have the potential to improve standards of oral health and reduce the number of long term sight problems in Scotland. (Paragraph 77, page 18)

**PART 2, SECTIONS 11, 12, 13, AND 14:  
GENERAL DENTAL SERVICES**

**Committee's Overall View**

- The Committee supports the proposals in sections 11 to 14 on general dental services and the wider policy intention stemming from 'Modernising NHS Dental Services in Scotland' of enabling health boards to take a more active role in securing and providing general dental services. The Committee believes that, if properly funded and implemented, the policy will provide for better access to a wider range of general dental services at a local level. (Paragraph 103, page 23)

**PART 2, SECTIONS 15, 16 AND 17:  
LISTING ADDITIONAL CATEGORIES OF DENTAL PRACTITIONERS,  
OPTOMETRISTS AND OPHTHALMIC PRACTITIONERS**

**Committee's Overall View**

- The Committee supports the Executive's proposals to extend health board lists to include all dentists and ophthalmic medical practitioners and believes they will allow health boards to ensure all practitioners are regulated and can be held directly accountable for their actions. (Paragraph 117, page 25)

**PART 3:  
PHARMACEUTICAL CARE SERVICES**

**Committee's Overall View**

- The Committee supports the Executive's proposals for the provision of planned pharmaceutical care services. The Committee believes that, if properly implemented the proposals could ensure the provision of a wider range of pharmaceutical services throughout Scotland on the basis of the needs of individual communities. (Paragraph 130, page 28)

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<sup>1</sup> One member of the Committee dissented from this position

**PART 4:  
DISCIPLINE**

**Committee's Overall View**

- The Committee supports the Executive's proposals to strengthen the disciplinary procedures contained within part 4 of the bill. (Paragraph 139, page 29)

**PART 5, SECTION 24:  
HEPATITIS C PAYMENTS**

**Committee's Overall View**

- The Committee supports the Executive's proposal to provide a firm legal basis under Scots law for the making of payments to Hepatitis C sufferers. (Paragraph 150, page 31)

**PART 5, SECTIONS 25, 26 AND 27:  
AMENDMENT OF REGULATION OF CARE (SCOTLAND) ACT 2001**

**Committee's Overall View**

- The Committee supports the Executive's proposal under sections 25-27 of the bill. (Paragraph 180, page 35)

**PART 5, SECTIONS 28 AND 29:  
DE-REGISTRATION WITH THE CARE COMMISSION**

**Committee's Overall View**

- The Committee recognises the case for making this legislative arrangement, but regrets the need to do so due to the oversight in implementing the previous legislation. (Paragraph 184, page 35)

**PART 5, SECTION 30:  
AUTHORISATION OF MEDICAL TREATMENT**

**Committee's Overall View**

- The Committee supports the Executive's proposal to extend the types of professionals who can issue an incapacity certificate. (Paragraph 188, page 36)
- The Committee does not support the extension of the maximum duration of a certificate from 1 year to 3 years. (Paragraph 189, page 36)

**PART 5, SECTION 31:  
JOINT VENTURES**

**Committee's Overall View**

- The Executive intends to provide for new powers to form and participate in joint ventures in the health service by introducing potentially wide-ranging enabling legislation. (Paragraph 225, page 40)
- Much of the evidence available to the Committee related to the experience of NHS LIFT projects in England. While a number of these projects are now underway, the Committee is of the view that it is too soon to make an objective judgement about the performance of this model. The Committee is also aware that other joint venture models are possible under the Executive's proposals; however, it appears that a limited amount of consideration has been given to alternative models by the relevant public sector agencies. The Committee considers it important that a range of alternative joint venture models are considered, including the mutual model. (Paragraph 226, page 40)

**PART 5, SECTION 32:  
SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST**

**Committee's Overall View**

- The Committee supports the Executive's proposal to convert the Scottish Hospitals Endowments Research Trust from a Non-Departmental Public Body to a charitable trust. (Paragraph 246, page 44)



# The Scottish Parliament

## Health Committee

### 6<sup>th</sup> Report, 2005 (Session 2)

#### **Stage 1 Report on the Smoking, Health and Social Care Bill**

The Committee reports to the Parliament as follows—

#### **INTRODUCTION**

1. The Smoking, Health and Social Care (Scotland) Bill was introduced by the Scottish Executive on 17 December 2004. The Health Committee immediately issued an open call for evidence on the bill with a deadline of 11 February 2005. The Committee received 46 written submissions on the various elements of the bill, the majority relating to the smoking proposals in part 1.
2. The Committee had previously considered the Prohibition of Smoking in Regulated Areas (Scotland) Bill, introduced by Stewart Maxwell MSP. The Committee gathered a considerable amount of evidence on this bill at stage 1 and published a report of its deliberations and conclusions in January 2005. It agreed to take on board the evidence received as part of its consideration for this bill in examining the Smoking, Health and Social Care (Scotland) Bill.
3. The Committee heard oral evidence on the Smoking, Health and Social Care (Scotland) Bill on 11 January 2005 from Executive officials and agreed to focus its subsequent evidence-taking on the most potentially contentious sections of the bill.
4. The Committee heard oral evidence on different sections of the bill on 22 February and 1, 8 and 15 March. Some of these evidence sessions were undertaken in the form of a 'round table' with a number of groups interacting at the table at the same time. Other sessions were undertaken in a more formal format. The Committee took evidence from 38 organisations in total. A number of those organisations were represented on more than one occasion.
5. The Committee received oral evidence on all parts of the bill from the Minister for Health and Community Care, Andy Kerr MSP, on 22 March.

6. The Committee was very keen to receive the patients' perspective through the evidence. Unfortunately the abolition of local health councils on 1 April meant that it was not possible to involve all those bodies who had contributed to the original Executive consultations.
7. In order to better understand the smoking provisions of the bill, the whole Committee visited Ireland in early February to examine the implementation of the smoking ban there. The Committee visited both urban and rural areas and spoke to opponents of the ban as well as those who had introduced it or were responsible for its implementation.
8. The Committee received reports from both the Finance and Subordinate Legislation Committees (attached at Annex A). Where relevant these reports are referred to in the text on the various sections on the bill.
9. The Smoking, Health and Social Care (Scotland) Bill is very varied in its provisions. It includes not only the smoking proposals but major changes to dental, ophthalmic and pharmacy services, the tightening of disciplinary procedures for professional health staff, changes to the law regarding the issue of certificates of mental incapacity, a legal basis for the making of payments to Hepatitis C sufferers, and the introduction of significant powers to create joint ventures.
10. The Committee has some concerns that the diverse nature of bills of this type increases the difficulty of carrying out effective scrutiny. **The Committee recommends that the Executive bring forward bills that are more discrete in nature to avoid the difficulty of having to deal with very different subject matter.**
11. Because of the complexity and wide-ranging nature of the bill, in this stage 1 report each of the main components of the bill is dealt with in turn. For each component, the following is considered:
  - the purpose of that part of the bill – what it does
  - the overall views of those submitting evidence – in favour or not
  - the Committee's overall view – in favour of the proposal or not
  - specific issues raised by those submitting evidence (together with the Committee's view on each of them, where appropriate, in bold).



**PART 1:  
PROHIBITION OF SMOKING IN CERTAIN  
WHOLLY ENCLOSED PLACES**

**Purpose of This Part of the Bill**

12. This part of the bill seeks to prohibit smoking in certain wholly enclosed public places, by making it an offence for a person in charge of no-smoking premises to knowingly allow others to smoke there, or for an individual to smoke where smoking is prohibited. The bill also seeks to ensure that no-smoking signs are displayed conspicuously inside and outside no-smoking premises.
13. The bill defines no-smoking premises as premises that are wholly enclosed and –
  - i) to which the public has access;
  - ii) which are being used wholly or mainly as a place of work by persons who are employees;
  - iii) which are being used by and for the purposes of a club or other unincorporated association; or
  - iv) which are being used wholly or mainly for the purposes of health and care services.
14. The bill also makes provision for Scottish Ministers to prescribe in regulations premises to be included in or excluded from the ban.
15. The Executive's action plan on tobacco control (*A Breath of Fresh Air for Scotland*, 2004) includes a commitment 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. The Policy Memorandum accompanying the bill states that–

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.<sup>2</sup>

**Overall Views of Those Submitting Evidence**

16. The Committee recently gathered a significant volume of evidence on the consequences for health of exposure to environmental tobacco smoke and the potential impacts of a partial smoking ban, when considering the general principles of the Prohibition of Smoking in Regulated Areas (Scotland) Bill<sup>3</sup>. In its call for evidence on the Smoking, Health and Social

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<sup>2</sup> Smoking, Health and Social Care (Scotland) Bill, Policy Memorandum, p3

<sup>3</sup> The Prohibition of Smoking in Regulated Areas (Scotland) Bill, introduced as a members' bill by Stewart Maxwell MSP, proposed a ban on smoking in enclosed public places where food is served and consumed.

Care (Scotland) Bill the Committee asked those with an interest in proposals for a smoking ban to focus on the specific proposal contained in the bill.

17. The Committee received a range of views on the proposed smoking ban.
18. Opponents of the bill include the Scottish Licensed Trade Association, the Against an Outright Ban Group<sup>4</sup>, the Tobacco Manufacturers' Association, and a number of companies operating in the food, drink and leisure industry. Opposition to the ban rests on a number of arguments, including: a perceived lack of public support; the potential for displacement activity which may increase levels of smoking and drinking in the home; questions about whether an outright ban would have a greater impact on smoking cessation rates than a phased reduction in tobacco use in public places; the potential for the introduction of better ventilation to protect non-smokers from exposure to environmental tobacco smoke; and the potential adverse economic impact on the leisure industry. Amicus, a private sector trade union representing members in a variety of sectors, also opposes the ban on a number of these grounds.
19. As drafted the bill includes clubs and other unincorporated associations in the scope of the smoking ban. The Committee heard oral evidence from two members of the Committee of Registered Clubs Association (CORCA), one representing the Coal Industry Social Welfare Organisation (CISWO), the other representing Royal British Legion Clubs. Both witnesses described a range of views among members of their own organisations and members of CORCA, varying from support for the ban on health and safety grounds, support for the ban with an exemption for private clubs, and opposition to the ban. (HC Col 1794)
20. Similarly, in oral evidence Ian Tasker of the Scottish Trades Union Congress (STUC) indicated that, while the STUC 'broadly supports a smoking ban on the basis of the impact on the health of Scottish citizens' there is not a consensus among its affiliated trade unions on the policy. He also flagged up concerns about the timescale for implementation of the proposed ban. (HC Col 1822)
21. Supporters of the bill include a number of health boards, a range of health related charities and voluntary sector organisations, various trade unions, including public service union UNISON, and professional organisations representing health sector staff. Support for the ban focuses on the need to tackle the adverse health effects of exposure to environmental tobacco smoke; the potential for smoking rates (in term both of number of smokers and the amount smoked) to decline in response to the ban, with positive health benefits; public support for further tobacco control measures; and potential economic benefits.

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<sup>4</sup> The AOB Group was formed in autumn 2004. Its members include the Scottish Licensed Trade Association, the Scottish Beer and Pub Association and the Scottish Wholesalers' Association.

22. The British Hospitality Association (BHA) Scotland Committee also supports the proposed smoking ban on the basis that: it would be unambiguous, making enforcement easier; it splits responsibilities and penalties equitably between operators and customers; it even-handedly applies to hospitality establishments and other workplaces; and it provides clear health benefits (BHA written submission). The BHA raised some concerns about the practical implications of the bill's provisions, which are explored in the 'issues raised' section below.
23. The provisions contained in this part of the bill are also supported by the Confederation of Scottish Local Authorities (COSLA) and the Royal Environmental Health Institute of Scotland (REHIS). Both organisations have an interest, among other things, in the way that the bill is enforced. Their evidence, together with that of the Association of Chief Police Officers in Scotland (ACPOS), highlights a number of issues that could impact on the effective enforcement of a smoking ban, as outlined below in the 'issues raised' section.
24. The Committee's thinking on enforcement and other implementation issues was also informed by a study visit to Ireland in February 2005 where members witnessed first hand the operation of the workplace smoking ban introduced the previous year. During that visit members met with licensed vintners' representatives, enforcement officers, trade union representatives and health department officials and officials from the Office for Tobacco Control.

### **Committee's Overall View**

25. **In its stage 1 report on Prohibition of Smoking in Regulated Areas (Scotland) Bill<sup>5</sup> the Committee accepted 'that evidence exists of adverse health effects from passive smoking' (paragraph 29) and that reducing exposure to environmental tobacco smoke, through a partial ban on smoking, would have a positive impact on health. The Committee remains of the view that this is the case.** The majority of the Committee also concluded that a partial ban on smoking in enclosed public places (as proposed in the earlier bill) would not be sufficient to achieve the health benefits that the bill's proposer sought and that, therefore, the bill did not go far enough.
26. The majority of members of the Committee are of the view that a ban on smoking in enclosed public places would impact positively on public health and that a voluntary approach to tobacco control would not ensure the same outcome. **The majority of members, therefore, support the proposal contained in this part of the bill, believing that it will help to save lives.**

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<sup>5</sup> HC 1st Report 2005, Stage 1 Report on the Prohibition of Smoking in Regulated Areas (Scotland) Bill, SP Paper 263

27. **The Committee recommends that action is taken to monitor the health impacts from a ban should the bill be enacted.**
28. **Members of the Committee have a number of outstanding concerns about enforcement of the proposed ban, which are outlined below.**

### **Specific Issues Raised by Those Submitting Evidence**

#### Health Impact of Passive Smoking

29. A number of those submitting evidence on proposals for a ban on smoking in enclosed public places offered conflicting views about the health impacts of passive smoking, rehearsing arguments put to the Committee during its earlier consideration of the Prohibition of Smoking in Regulated Areas (Scotland) Bill.

#### Displacement

30. The Scottish Licensed Trade Association (SLTA) cited anecdotal evidence from Ireland of a shift from pub sales to 'take-home' alcohol trade (HC Col 1776) and expressed concern that smoking in a domestic setting would increase, with potential adverse health consequences for the children of smokers. The Committee requested official research findings on this issue during its study visit to Ireland, but was advised that none exist.
31. In its evidence ASH Scotland indicated that it had concerns about passive smoking in the home in relation to impacts on children's health. Shelia Duffy told the Committee—

It is important that we communicate clearly to people the reason why the bill is under consideration, because people who understand why smoking has ended in public places in Scotland are unlikely to expose their children to smoke at home. (HC Col 1819)

32. **The Committee acknowledges that there are some concerns about a potential impact on exposure to passive smoke in a domestic setting arising from the ban although no specific evidence was available. It recommends that any implementation of a ban on smoking in enclosed public places be monitored to establish the impact on exposure to passive smoking in the home and that public information campaigns continue to highlight this issue.**

#### Exemptions

33. The Draft Smoking, Health and Social Care (Scotland) Act 2005 (Prohibition of smoking in Certain Premises) Regulations 2005, among other things, prescribe a number of no-smoking premises and exemptions.

34. The BHA Scotland Committee supports the proposed exemption for 'designated hotel rooms', however, in its evidence it makes the case for all hotel bedrooms to be included in the exemption. The BHA expressed concerns about the difficulties of enforcing the ban on smoking in hotel bedrooms which it says are by nature private places. In a supplementary written submission the BHA states—

It would clearly be impossible for a hotelier reasonably to detect whether an individual is smoking in a bedroom. Random checks by enforcement officers would interfere with privacy and clearly be unacceptable without a warrant. Logically it would be practically unworkable for them to enforce a ban on smoking in hotel bedrooms.

35. The BHA favours including an exemption for all hotel bedrooms either on the face of the bill or in the regulations.
36. In his evidence, the Minister for Health and Community Care indicated that the list of exempt premises contained in the draft regulations to the bill had been compiled on 'largely humanitarian' grounds. Adult hospices are included on the draft list of exemptions on this basis, as are psychiatric hospitals. It is intended that, as long as a smoking policy is in place, premises considered to be peoples' homes will be exempt from a ban on smoking. Similarly adult residential homes (but not children's homes) are intended to be exempt. (HC Col 1838)
37. On the basis that hotel bedrooms are considered to be a client's home for the night or nights of occupancy, where an hotelier opts to have smoking rooms, designated hotel bedrooms (but not public areas) are intended to be exempt from the ban. However, adult day care centres are not included in the draft list of exemptions because, according to the Minister, visits there are only temporary in nature. (HC Col 1838)
38. **The Committee is of the view that, as long as a smoking policy is in place, an exemption on humanitarian grounds should be extended to adult day care centres. These centres provide important respite services for the carers of vulnerable adults and effectively fall into the category of 'home for the day'.**
39. **The Committee supports an exemption from the proposed smoking ban for designated hotel rooms.**

#### Alternatives

##### *Partial Ban*

40. In May 2004 the SLTA asked the Executive to introduce legislation with three elements: a smoking ban at the bar counters in all pubs in Scotland; a smoking ban wherever hot food is served, within three years; and a commitment that 50% of the total floor space in all pubs in Scotland be given over to non-smoking areas. It was also suggested that a review be

conducted at the end of the third year and appropriate further steps taken. (HC Col 1764)

41. ASH Scotland opposes this approach, which it says lacks an evidence base. Sheila Duffy told the Committee–

Such partial policies are costly and, by delaying effective protection, they lead to increases in health inequalities. (HC Col 1814)

42. When considering the Prohibition of Smoking in Regulated Areas (Scotland) Bill the Committee concluded that a partial ban on smoking would not go far enough to achieve the public health objectives to which that bill aspired. **The Committee<sup>6</sup> remains of the view that a partial ban on smoking in public places does not go far enough.**

#### *Ventilation*

43. The Tobacco Manufacturers' Association (TMA) acknowledged that there are health risks associated with smoking, making it 'quite right that that public health authorities promote risk awareness programmes'. While disputing that it had been conclusively proven that exposure to environmental tobacco smoke results in death or disease, the TMA did concede that second hand smoke can be 'annoying and, indeed, irritating to non-smokers'. For that reason they propose the creation of designated smoking areas with proper ventilation in a range of public places. (HC Col 1765)
44. Having reviewed a range of evidence about the efficacy of ventilation systems when considering the earlier Prohibition of Smoking in Regulated Areas (Scotland) Bill, the Committee concluded that ventilation did not provide an adequate alternative to a smoking ban in terms of health objectives. **The Committee<sup>7</sup> remains of the view that ventilation would not provide an adequate alternative, because it does not remove carcinogens.**

#### Timing

45. The SLTA advocated the introduction of a phased ban on smoking, alluding to positive experiences in other countries in this regard and suggesting that this would offer health benefits while minimising financial damage to business interests. (HC, Col 1774)
46. In its written evidence the STUC expressed concerns about the timescale envisaged for the introduction of a ban on smoking in public places, suggesting an alternative lead-time of three years. A longer lead-time would, it argued, allow transitional arrangements to be put in place to minimise potential job losses and provide an opportunity for joint

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<sup>6</sup> One member of the Committee dissented from this position

<sup>7</sup> One member of the Committee dissented from this position

campaigning to address smoking rates among those who work in the hospitality industry.

47. Witnesses representing ASH Scotland conceded that there would be a 'busy job ahead' in relation to communicating the reasons why a ban is being considered, but suggested that a longer lead time may not be necessary given that Scotland was in a position to learn from the experience of bans in other countries. (HC Col 1818)
48. In oral evidence the Minister maintained that it was possible to introduce a smoking ban in Scotland quickly because of the benefit of experience from elsewhere. He also stressed that preparatory work is underway under the auspices of the Smoke-free Areas Implementation Group and indicated that resources were being put into a 'comprehensive set of public awareness and information campaigns'. (HC Col 1894)
49. **The Committee<sup>8</sup> believes that the timetable for implementing the smoking ban is not unreasonable. However, the Committee considers it important that awareness-raising about the ban and ongoing work with industry to prepare for the ban is intensified.**

#### Economic Impact and Opportunities

50. Research commissioned by the SLTA and conducted by the Centre for Economic and Business Research, concluded that, if the Irish ban was replicated in Scotland there would be a loss of revenue of more than £100 million; a loss of profit of £90 million; a negative shift in jobs of 6%; and a decrease of £56 million in the revenue take from the licensed trade (HC Col 1776). However, Committee members are aware from their discussion with representatives of the licensed trade in Ireland that a number of other factors have played into the downturn in the Irish licensed trade, including increased excise duty, new licensing restrictions and more rigorous enforcement of drink driving laws.
51. Asked about potential savings from the point of view of reduced cleaning and refurbishment costs and reduced fire risk arising from a smoking ban, Stuart Ross of the SLTA indicated that 60% of people who currently use pubs are smokers. While he acknowledged that there may be potential savings he expressed concern that there was a 'big' risk that those people will transfer their drinking habits from on-sales to the take-home trade. (HC Col 1784)
52. George Ross of the Royal British Region Scotland expressed concern that a ban on smoking could result in reduced club membership, threatening closure of some clubs. He also described a restriction faced by clubs in relation to the use of club branch funds for investment in the development of premises because of charity regulations. (HC Col 1791)

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<sup>8</sup> One member of the Committee dissented from this position

53. Committee members are aware from their study visit to Ireland that the owners of a number of licensed premises have responded to the smoking ban by applying to their local council for permission to provide tables and chairs for customers outside their premises. Similarly, a number of proprietors have invested in smoking shelters and outdoor heaters, to accommodate customers who choose to smoke. In oral evidence to the Committee, Gordon Greenhill from the City of Edinburgh Council indicated that local authorities would welcome similar moves in Scotland, on the basis that there is no medical evidence on passive smoking in the open air and as long as outdoor areas are managed properly (HC Col 1806). The Committee is, however, aware that not all no-smoking premises have the same scope for outdoor development.

54. In its consideration of the Financial Memorandum for the Smoking, Health and Social Care (Scotland) Bill, the Finance Committee was unable to come to a firm conclusion about the costs to business of a comprehensive ban on smoking in public places or about the potential benefits to business arising from a ban. It was similarly unable to form a clear view about how the SLTA's proposal for a phased ban would impact on the financial implications of the bill. However, the Minister, in evidence, maintained that he expects the bill to have a 'nil or a positive economic impact'. He went on to tell the Committee—

We cannot allow one area of business to dictate the health of the nation; hence we want to ensure that the bill is comprehensive in its scope and properly enforced. (HC Col 1837)

55. **The Committee recommends that action is taken to monitor the economic impacts arising from a ban should the bill be enacted.**

#### Compliance and Enforcement

56. A number of witnesses addressing questions of enforcement indicated that they anticipate that the majority of people would comply with a legal smoking ban. Gordon Greenhill, of the City of Edinburgh Council, indicated that having considered the Irish experience and from local experience of serving fixed penalty notices he assumed that if someone is asked to put out a cigarette they would do so (HC Col 1802).

57. Keith McNamara from the Royal Environmental Health Institute for Scotland indicated that in discussions with his Irish counterparts the importance of pre-ban promotion had been raised. He told the Committee—

Believe it or not, the ban in Ireland seems to have been widely accepted. This is largely thanks to a major promotional campaign by central Government and because local people who work on the ground visited premises to provide information and an opportunity to ask questions on a one-to-one basis. (HC Col 1802)



58. David Mellor of the Association of Chief Police Officers in Scotland indicated that he anticipated that police involvement in enforcement would be fairly insignificant. He told the Committee that the police would support an enforcement strategy that was based on environmental health officers 'gathering evidence via observation, then going back and confronting people at a later time', on the basis that this would be 'less likely to create friction and public order situations'. (HC Col 1806)
59. However, as drafted the bill introduces three offences, two of which apply to those in control of a no-smoking premises and one that relates to individuals who smoke in a no-smoking premises. There was some disagreement among witnesses about the circumstances in which environmental health officers would be expected to issue fixed penalty notices to individual smokers ignoring a ban and in which circumstances those in control of no-smoking premises would be the focus of enforcement activity, given that there is no hierarchy of offences in the legislation.
60. The Committee is very concerned that if it is left to individual local authorities to determine local enforcement strategies, inconsistency in enforcement may arise. In particular, the Committee is concerned that there may be potential public order consequences if environmental health officers seek to issue fixed penalty notices to customers in licensed premises during busy weekend opening hours.
61. **The Committee recommends that enforcement be focused primarily on the role of those in control of a no-smoking premises and that the bill is amended at Stage 2 to this effect. The Committee also recommends that guidance be issued centrally on enforcement strategy.**
62. In evidence the Minister indicated that while he saw no need to amend the offences listed in the bill guidance on enforcement would be appropriate. He also indicated that the Executive is already working with the licensed trade to raise awareness of its obligations under the legislation. (HC Col 1843)
63. In a supplementary written submission addressing enforcement issues, COSLA indicated that it plans to meet with the Association of Chief Police Officers in Scotland to discuss enforcement issues with a view to developing jointly badged enforcement guidelines to ensure a consistent approach across Scotland. **Given concern over the potential for differing enforcement strategies, the Committee welcomes this development but recommends that enforcement activity is monitored over time.**

*Cost of Enforcement*

64. In its report on the Financial Memorandum of the Smoking, Health and Social Care (Scotland) Bill, the Finance Committee raised concerns that the costs of enforcement of the proposed smoking ban are largely unknown. In evidence to the Committee, Alan McKeown indicated that COSLA would

make a further assessment of the enforcement costs for local authorities associated with the proposed smoking ban in light of information contained in the Draft Regulations (which had not be published when original estimates had been made).

65. The Committee heard it argued in Ireland that the smoking ban there was largely self-enforcing and the Executive has indicated that it expects the cost of enforcement to diminish over time. **However, to the extent that the bill will add to the duties of environmental health officers, the Committee considers it important that enforcement costs are fully funded and monitored over time in order to avoid any deterioration in other services they provide.**

*Irish Experience*

66. In Ireland the Office of Tobacco Control (OTC) was set up to assist in the implementation of policies and objectives of the government on the control and regulation of tobacco products. It is also responsible for coordinating the national inspection programme in cooperation with environmental health offices and for delivering a communication strategy in advance of and following the ban. **The Committee is of the view that the activities of the OTC contributed to high compliance rates in Ireland and notes that the bill does not propose an equivalent to the OTC for Scotland.**

Penalties

67. In Ireland, where compliance with all aspects of the smoking ban are considered to have been consistently high (note of Health Committee study visit to Ireland, 7-9 February 2005, Annex A), fines are set at the same level for individuals and people in charge of a no-smoking workplace. While there is no escalation of the fine level for repeat offenders in Ireland, fine levels are considerably higher than is proposed in the Executive bill.
68. The Minister, in evidence, maintained that the ultimate sanction for a license holder guilty of repeat offences would be a loss of licence. He told the Committee –

Speaking bluntly, I believe that it is easy to spot cases in which someone is taking an economic gamble by saying that they can afford to get caught X number of times. In cases in which a landlord is deliberately buying their way out of their obligations under the legislation by simply paying fines, the ultimate sanction of license removal would prevail. (HC Col 1846)

69. **The Committee recommends that consideration be given either to increased levels of fines or to an escalating penalty for repeat offenders.**

**PART 2, SECTIONS 9 AND 10:  
FREE ORAL HEALTH ASSESSMENTS, DENTAL CHECKS, EYE  
EXAMINATIONS AND SIGHT TESTS**

**Purpose of These Sections of the Bill**

70. Section 9 of the bill makes provision for free oral health assessments and dental examinations for all by 2007. Section 10 of the bill makes a similar provision for free eye examinations and sight tests. It is intended that the oral health assessment and eye examination will allow for a wider assessment than is provided within current dental checks and sight tests and will include an element of preventative care.

**Overall Views of Those Submitting Evidence**

Free oral health assessments

71. All those who gave oral evidence to the Committee, namely the British Dental Association, the Scottish Consumer Council, Fife Local Health Council and health boards (Glasgow and Highland) and all those submitting written evidence were in favour of the proposal. The British Dental Association did caveat its support with concerns about policy implementation. These concerns are detailed below.
72. The Scottish Consumer Council (SCC) supports the removal of charges for dental checks, stating in written evidence—

The SCC welcomes this proposal as removing the initial barrier to treatment for people who may otherwise be deterred from receiving services because of fear of the cost.

73. The British Dental Association (BDA) supports the proposed free oral health assessment. BDA Director Andrew Lamb, stated in oral evidence—

The properly funded health assessment will require more than just a quick look at a patient's oral tissue; it will require an assessment of the individual patient's needs, and the ability to talk through with the patient their particular problems and to focus on a preventative approach. (HC Col 1628)

Free eye examinations

74. All those who gave oral evidence to the Committee, namely Optometry Scotland, the Scottish Consumer Council, Fife Local Health Council and health boards (Glasgow and Highland) and all those submitting written evidence were in favour of the proposal. Optometry Scotland did caveat its support with concerns about the lack of information on the exact nature of the eye examinations. These concerns are outlined below.

75. In support of the proposal, the Royal College of Nursing stated in written evidence that—

We believe that the introduction of free eye examinations and sight tests will help to identify visual problems earlier which should help to reduce the number of serious sight problems experienced by people in Scotland in the long term.

76. In oral evidence Hal Rollason, Optometry Scotland, stated that the proposal when implemented would—

produce considerable health gains to the nation by introducing improvements in the eye care that is available to the public; better preventative eye care, which leads to a reduction in visual impairment; and a meaningful step towards the long-term goal of eliminating avoidable blindness...Such measures will also achieve a significant reduction of inappropriate referrals to hospital eye departments. (HC Col 1629)

### **Committee's Overall View**

77. **The Committee<sup>9</sup> supports the Executive's proposals to introduce free oral health assessments and eye examinations and believes that, if properly implemented, they have the potential to improve standards of oral health and reduce the number of long term sight problems in Scotland.**

### **Specific Issues Raised by Those Submitting Evidence**

#### Implementation of proposal for free oral health assessments

78. A number of organisations raised issues concerning the capacity of existing dental services to deliver the more detailed 'oral health assessment' which may take longer, cost more to provide and have a higher uptake level than existing exams when available for free. In oral evidence, Andrew Lamb, Director of the BDA, outlined the current shortage of dentists and the resulting waiting lists and limited access for patients. He went on to state that—

Given this situation, the BDA are of the view that the proposed oral health assessments for all cannot be provided by existing dental services. (HC Col 1635)

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<sup>9</sup> One member of the Committee dissented from this position

79. The Minister suggested in evidence that the funding and measures recently announced in the Executive's 'Action Plan for Improving NHS Dentistry' should help to address these existing barriers to implementation (HC Col 1852). However, the Finance Committee report on the Financial Memorandum records—

dissatisfaction that the Ministerial Statement on dental services was not made prior to the introduction of this legislation as this could have provided a policy and funding context for some of the provisions of the bill.

80. **The Committee shares the concerns raised by the BDA about the capacity of existing dental services to implement the proposal.**
81. **While the Committee welcomes the funding brought forward in the Executive's Action Plan to seek to address this issue, the majority of the Committee supports the view of the Finance Committee that this information should have been available at the bill's introduction.**

#### Funding

82. The costing provided for the provision of both oral assessments and eye examinations is based 'on an increase of up to 25% on the numbers of people who currently pay for checks' (Financial Memorandum, paragraph 212). When questioned on the logic behind this calculation, the Minister stated that it was—

based on our experience of the change in the public's behaviour when we introduced the free sight-check for the over-60s. That was the only sound piece of evidence that showed how people behaved once a check became free. (HC Col 1852)

83. When questioned on the increase in cost caused by the introduction of the oral health assessment, Dr Hamish Wilson, Scottish Executive Health Department, stated that—

We intend to discuss with the dental profession the nature and frequency of the oral health assessment and the effect that that might have on the existing dental check. (HC Col 1851)

84. **The Committee believes the Executive's calculation does not take into account the additional cost of providing oral health assessments and eye examinations in place of standard dental checks and sight tests. The Committee reiterates its support for the view of the Finance Committee, namely that information on the cost of these assessments and examinations should have been available at the bill's introduction.**
85. **The Committee seeks assurances from the Executive that additional funds will be made available should the cost of implementation of this proposal exceed the amount outlined in the Financial Memorandum.**

86. **The Committee is of the view that negotiations with the dental and ophthalmic professions to agree the nature of the oral health assessment and eye examination should have occurred in advance of the introduction of the bill. In the absence of this information, the Committee is unable to scrutinise accurately the cost of the proposal and is therefore only in a position to approve the policy in principle.**
87. **The Committee recommends that the Executive should update the Committee on further negotiations with the professions and the impact on the cost of the proposal of decisions taken in these discussions.**

Uptake of services

88. Hal Rollason, Optometry Scotland, noted in oral evidence that there are no difficulties with access to the current sight test in Scotland as there is no shortage of optometrists. However, when asked about the uptake of existing NHS entitlement to a free sight test, Hal Rollason noted that there are 'all sorts of "at risk" groups who do not currently have proper care' (HC Col 1632). This information suggests that some of the groups most likely to get the health benefit from proper eye examinations and oral health assessments are the groups currently not taking advantage of free sight tests and dental checks.
89. **The Committee recommends that, in order to maximise the benefit of the proposals, the Executive should undertake follow-up work to ensure its effective implementation. This work should include educating and advertising on the availability of and the nature of the new eye examination and oral health assessment. It should also undertake the collation of information on uptake levels.**
90. **The Committee also strongly recommends that the Executive should work with health boards in targeting those vulnerable groups which are already eligible for free sight tests.**
91. **The Committee strongly recommends the introduction of a comprehensive dental and sight screening programme for children at the start of primary and secondary school education, in order to treat problems at an early stage and encourage the habit of receiving oral health assessments and eye examinations. The Committee strongly recommends that Ministers bring forward amendments to legislate for such screening programmes at Stage 2.**

Definition of eye examination and oral health assessment

92. In written evidence Optometry Scotland noted that sight tests are effectively available to all at present as 65% of the population are eligible for free NHS tests and the remainder can receive free tests from commercial opticians. In the absence of a definition of eye examination within the bill to demonstrate the distinction between a sight test and the proposed examination,

Optometry Scotland argued that the proposal would confer no health gain. However, in oral evidence, Optometry Scotland accepted that the proposals would confer a health gain.

93. **The Committee believes that detailed definitions of both the eye examination and the oral health assessment could usefully have appeared on the face of the bill to clarify that they are more extensive in nature than the existing tests and checks.**
94. **The Committee is aware that for enabling legislation such as this ‘the devil is in the detail’ and therefore encourages the Executive to actively engage with professional bodies, patient representatives and health boards in the production of the subordinate legislation which will define the nature of eye examinations and oral health assessments.**
95. **The Committee also recommends that the Executive provides the Committee, at the earliest opportunity, with draft regulations defining the examination and the assessment to allow members to comment on the regulations before they are formally laid before Parliament.**

## **PART 2, SECTIONS 11, 12, 13, AND 14: GENERAL DENTAL SERVICES**

### **Purpose of These Sections of the Bill**

96. These sections of the bill are intended to make changes to the way health boards support general dental services as a result of the Executive’s consultation on ‘Modernising NHS Dental Services in Scotland’. The overarching policy intention is to allow health boards to take a more active role in securing and providing general dental services, including—
  - making arrangements with dentists to provide general dental services or to provide such services themselves; and
  - providing financial assistance to support service providers including assisting with the cost of premises or upgrading infrastructure.
97. The specific provisions of the bill are as follows—
  - Section 11 would remove the existing link between the treatment provided and the fee charged for the service, allowing for the introduction of a more flexible charging system;
  - Section 12 would enable NHS boards to enter into arrangements for general dental services with dental bodies corporate;
  - Section 13 makes provision for health boards to provide financial assistance as detailed above; and
  - Section 14 would allow health boards to make arrangements with dentists to allow them to provide services that are currently provided in

alternative setting, for example migraine or snoring treatments. These arrangements are described in the bill as 'co-management schemes'.

### **Overall Views of Those Submitting Evidence**

98. All those providing oral evidence and submitting written evidence supported the proposals, including health boards (Glasgow and Highland), patient representatives and the British Dental Association (BDA). A number of those providing evidence had made a submission to the consultation from which the proposals stem.

#### Section 11

99. The Scottish Consumer Council supports the removal of the link between the item of service and the fee in section 11. Martyn Evans stated in oral evidence—

there is a treadmill effect at the moment. Because of the fee payment structure, dentists have to see their patients more often and have to do work that is not clinically necessary. The bill will alter that fee structure. We do not know what the structure will be, but it will be de-linked from patient charges...[and] that is an important and progressive measure. (HC Col 1640)

#### Section 12

100. Highland NHS Board approves of health boards taking an active role in providing services, including from dental bodies corporate. In oral evidence, Catherine Lush stated—

I support the concept of flexibility for boards. Within Highland NHS Board, we have already enjoyed an element of flexibility in contracting with general dental practitioners to provide emergency dental services, which has been beneficial for patients in that they have been able to access care locally. Some flexibility at board level will be an important catalyst for change in service delivery. (HC Col 1643)

#### Section 13

101. In relation to financial assistance from health boards, Martyn Evans, Scottish Consumer Council, stated in oral evidence—

We welcome the assistance and support that health boards will be able to give dentists...This particular provision will lead to a reasonable public investment in more accessible services. (HC Col 1642)



Section 14

102. Greater Glasgow NHS Board support the proposals, including the introduction of co-management schemes. Dr Iain Wallace stated in oral evidence—

the co-management schemes that section 14 allows and the flexibility to have personal dental services, community dental services and GDS working together with salaried GPs are important. Our experience in Glasgow with sedation services and services for the elderly is that such flexibility is beneficial in targeting particular groups. (HC Col 1643)

**Committee's Overall View**

103. **The Committee supports the proposals in sections 11 to 14 on general dental services and the wider policy intention stemming from 'Modernising NHS Dental Services in Scotland' of enabling health boards to take a more active role in securing and providing general dental services. The Committee believes that, if properly funded and implemented, the policy will provide for better access to a wider range of general dental services at a local level.**
104. **While the Committee welcomes the funding brought forward in the Executive's Action Plan which is intended to implement the policy, the Committee supports the view of the Finance Committee that this information should have been available at the bill's introduction.** (Finance Committee paragraphs 20-30).

**Specific Issues Raised by Those Submitting Evidence**

New charging system

105. The BDA makes suggestions about the alternative charging system for treatment in written evidence stating—

The BDA believes the current system of charging is too complex and difficult for patients and dentists alike to comprehend. Any new system must be transparent and easy to understand...easy to operate and avoid unnecessary bureaucracy.

106. **The Committee supports the BDA's view and recommends that the Executive actively engages with professional bodies, patient representatives and health boards when considering the specific details of the new charging system.**

107. **The Committee also recommends that the Executive provide the Committee, at the earliest opportunity, with draft regulations defining the new system to allow members to comment on the proposed system before the regulations are formally laid before Parliament.**

Appropriate premises

*Physical access*

108. In oral evidence Martyn Evans, Scottish Consumer Council, raised the issue of physical accessibility to dental practices. He stated that—

in our study on access to primary care services, dentists were the least physically accessible. Indeed, 75 per cent of the dentists whom we reviewed were located up a flight of steps. (HC Col 1642)

109. **The Committee is concerned that only 25% of services are physically accessible for those with restricted mobility, making it difficult for these individuals to find suitable local dental services. The Committee recommends that the Executive ensures that the accessibility of premises is treated as a priority by health boards when providing financial assistance to practices under section 13.**

*Professionals complementary to dentistry*

110. Research commissioned by the Committee entitled 'Access to Dental Health Services in Scotland' included findings on the benefits of employing professionals complementary to dentistry. The research found that a dental therapist could increase a dentist's output by 45% and that a dental hygienist could increase a dentist's output by 33%.

111. Catherine Lush raised the issue of premises development in relation to the provision of services complementary to dentistry in oral evidence stating—

I expect dentists to continue to head up the teams, but we will make much better use of professionals complementary to dentistry, who will need premises. The dental therapists and dental hygienists will need to work in surgeries, so the challenge is not only to create the workforce and skill it up, but to ensure that we have the premises for the workforce to work in. (HC Col 1643)

112. **The Committee appreciates the importance of employing professionals complementary to dentistry in order to maximise levels of service delivery and to allow for an increase in the provision of preventative care. The Committee therefore recommends that health boards ensure that, when providing financial assistance for the establishment of new dental practices, the premises for these practices can accommodate professionals complementary to dentistry.**

**PART 2, SECTIONS 15, 16 AND 17:  
LISTING ADDITIONAL CATEGORIES OF DENTAL PRACTITIONERS,  
OPTOMETRISTS AND OPHTHALMIC PRACTITIONERS**

**Purpose of These Sections of the Bill**

113. Sections 15 to 17 of the bill extend the requirement to register on health board lists to all dentists and ophthalmic medical practitioners. At present non-principal providers such as locums or those assisting in general ophthalmic or general dental services do not require to register. This provision would require these individuals to satisfy the same rules of suitability to register as those currently on the list. Once on a list, these individuals would be subject to the discipline procedures of statutory Discipline Committees and the NHS Tribunal.

**Overall Views of Those Submitting Evidence**

114. All those who gave oral evidence to the Committee, namely Optometry Scotland, British Dental Association, the Scottish Consumer Council, Fife Local Health Council and health boards (Glasgow and Highland) and all those submitting written evidence were supportive of the proposal to extend health board lists.

115. For example, in oral evidence Catherine Lush, Highland NHS Board stated—

It is important that we respond to patients, who are looking for increased accountability. I see the proposals as an important part of that. (HC Col 1645)

116. Martyn Evans added the Scottish Consumer Council's support for the proposal in oral evidence—

The Scottish Consumer Council approves of the extension. We think that it is sensible to have provisions on fitness to practice and to have all those who are practicing on a list. (HC Col 1644)

**Committee's Overall View**

- 117. The Committee supports the Executive's proposals to extend health board lists to include all dentists and ophthalmic medical practitioners and believes they will allow health boards to ensure all practitioners are regulated and can be held directly accountable for their actions.**

### Specific Issues Raised by Those Submitting Evidence

118. Sections 15 – 17 require new entrants onto health board lists to provide certain information such as an enhanced criminal record certificate (provided by Disclosure Scotland) and to declare gifts and financial interests which might influence service delivery. These sections also allow the Executive to apply this disclosure requirement to existing practitioners should the Executive choose to do so.

119. During a roundtable discussion on this issue, Martyn Evans, Scottish Consumer Council, asked Executive officials—

why those who are on the list currently will not be subject to the same disclosure requirement, as it is in patients' interest to know that there is nothing for them to be concerned about in relation to a person's fitness to practise. (HC Col 1644)

120. When questioned on this issue during the Minister's evidence session, Executive official Dr Hamish Wilson stated that—

the potential volume of checks if we were suddenly to include all existing practitioners as well as all new practitioners is relevant. We need a sensible and practical approach to allow us to do the most effective thing quickly. (HC Col 1859)

**121. The Committee believes that those on the existing health board lists should be required to disclose the same information as new entrants to ensure that all those on the extended lists are regulated on the same basis. The Committee recommends that individuals on existing lists should be required to disclose information under the same timescale as those newly required to register.**

## PART 3: PHARMACEUTICAL CARE SERVICES

### Purpose of This Part of the Bill

122. Section 18 places responsibility for planning services on health boards, namely identifying the service need and securing or providing pharmaceutical care services (PCSs). This is a shift away from the existing system where pharmacists apply to set up a business and health boards consider such requests. It also shifts financial accountability for these services onto health boards, the intention being for the central budget to be distributed between boards.

123. Section 19 provides for NHS contracts between health boards and pharmacists to provide PCSs where each contractor will provide 'essential' services and can opt to provide 'additional' services should health boards

identify a need. Section 19 also provides for a process for the resolution of disputes between health boards and contractors.

124. Section 20 makes provision for a pharmaceutical list held by health boards to include all 'principal pharmacists' currently listed as practising and all 'non-principal' pharmacists. This provision is similar to those included in sections 15 to 17 on persons providing dental or ophthalmic services, and were similarly supported in all oral evidence and written submissions received. The Committee's conclusions and comments in relation to sections 15-17 therefore apply to the provisions in section 20 of the bill (see paragraphs 113 – 121).
125. Section 21 enables health boards to provide financial support to those providing or proposing to provide pharmaceutical care services.

### **Overall Views of Those Submitting Evidence**

126. All those who gave oral evidence supported the provisions in Part 3, namely the Scottish Pharmaceutical General Council, the Scottish Pharmaceutical Federation, the Scottish Consumer Council, Fife Local Health Council, Greater Glasgow NHS Board and Highland NHS Board. All those who submitted written evidence also supported the provisions.
127. The Scottish Pharmaceutical General Council, which has already formally agreed the framework for the PCS contract with the Scottish Executive, broadly supports the provisions in Part 3. Alex MacKinnon, SPGC, stated in oral evidence—

We fundamentally support the overarching aim of improving patient care through better use of pharmacists' key skills. The proposals represent a major service redesign and a major change in the way in which community pharmacists work. They will move from providing pharmaceutical services to providing pharmaceutical care services. I fundamentally believe that we will reposition community pharmacy as an integral part of the modernising primary care team. (HC Col 1647)

128. The Scottish Pharmaceutical Federation broadly supports the provisions in Part 3. In relation to the introduction of health board planned services, James Semple stated in oral evidence—

We are happy that the Executive has not gone down the route favoured by the National Consumer Council, which was the OFT route of having a free market. The best idea is for health boards to maintain the ability to plan services properly and to put them where they are needed, not just where the nearest honey pot is to which all contractors will rush to make money. (HC Col 1646)

129. Mary Morton, Highland NHS Board, supported this point in oral evidence, noting the benefits of planning pharmaceutical services in remote areas

instead of relying on whether contractors wish to provide services in these areas (HC Col 1648).

### **Committee's Overall View**

130. **The Committee supports the Executive's proposals for the provision of planned pharmaceutical care services. The Committee believes that, if properly implemented the proposals could ensure the provision of a wider range of pharmaceutical services throughout Scotland on the basis of the needs of individual communities.**

### **Specific Issues Raised by Those Submitting Evidence**

#### Regulations

131. The Scottish Pharmaceutical Federation (SPF) and the Scottish Pharmaceutical General Council (SPGC) both raised the issue of the importance of the detail of the regulations in Part 3 in clarifying the specific nature of 'pharmaceutical care services'. James Semple, SPF, commented—

Although we completely support the thrust of the bill, the devil is in the detail. We need to wait until we see the regulations, as that is where the day to day problems might arise. We warn against the law of unintended consequences....Representatives of the profession must be involved at all points in the process. (HC Col 1649)

132. **Executive officials have agreed to provide the draft regulations to the Committee for Stage 2. The Committee recommends that the Executive actively engage with professional bodies, patient representatives and health boards when considering the specifics of the new system.**

#### National criteria and guidelines

133. Representatives of the SPGC and Highland NHS Board both highlighted the importance of national criteria and guidelines to aid consistent delivery of services across all health board areas. Alex McKinnon, SPGC, stated—

we take the view that where something is agreed on a national basis according to national service frameworks and standards, that should not be diluted as it goes down through the boards. It is important that we have a national set of criteria and guidelines against which the pharmaceutical care services can be formulated. (HC Col 1647)

134. **The Committee recommends that the Executive, in consultation with the key stakeholders, produce national criteria and guidelines on pharmaceutical care services to support the effective implementation of the legislation.**

## **PART 4: DISCIPLINE**

### **Purpose of This Part of the Bill**

135. This part of the bill strengthens the disciplinary powers over family health service practitioners (general practitioners, dentists, pharmacists and opticians). In particular, it introduces a new ground for disciplinary action, 'unsuitability by reason of professional or personal misconduct', and ensures that anyone who is barred from practising for one health board will in future be barred from practising for all.

### **Overall Views of Those Submitting Evidence**

136. The main professional bodies representing those covered by the new disciplinary provisions are supportive of them. These include the British Medical Association (BMA), the British Dental Association (BDA), the Royal Pharmaceutical Society of Great Britain, and Optometry Scotland.
137. The proposals are also supported by those patient representative bodies who responded to the call for evidence. These included the Scottish Consumer Council, Forth Valley Local Health Council, and Borders Local Health Council, whose chair outlined the need for 'twenty-first century legislation that enables clear and unambiguous approaches to dealing with issues of suspension and discipline of all professional groups that are involved in health care. The public expects no less.' (HC Col 1662).
138. The proposals are also supported by the Scottish NHS Confederation. In its written evidence the Confederation states, 'We fully support the bill's provisions to strengthen the grounds and procedures for the discipline of Family Health Service Practitioners. We believe that these are sensible and logical changes which are necessary both to strengthen the protection of patients across Scotland and to meet the expectations of the public'.

### **Committee's Overall View**

139. **The Committee supports the Executive's proposals to strengthen the disciplinary procedures contained within part 4 of the bill.**

### **Specific Issues Raised by Those Submitting Evidence**

140. A number of those submitting evidence raised concerns about the implementation of the discipline aspects of the bill.

#### Link with Regulatory Bodies

141. The main issue raised in evidence was the need to ensure a link between the criteria and evidence applied by the professional regulatory bodies in undertaking disciplinary procedures and those adopted by the NHS in Scotland. This point was made by both the BMA and the BDA in oral evidence. (HC Col 1663, HC Col 1667)
142. Allied to this concern is a lack of a definition of 'unsuitability by reason of professional or personal misconduct'. The BMA, in its written evidence, points out that the General Medical Council and the other regulatory bodies already have clear definitions for such conduct and that these should be adopted by the Executive to allow proper harmonisation between procedures.
143. The Minister, in evidence, indicated that consultations are on-going at a UK level to ensure that there is no duplication of work between the regulatory bodies and the NHS Tribunal, but that the outcome of these are unlikely to be known prior to conclusion of consideration of the bill. (HC Col 1861)
144. **The Committee recommends that the Executive should strive to ensure that the disciplinary process created by the bill, and the definitions under which it operates, are harmonised with those of the professional regulatory bodies.**

#### Remuneration Whilst Under Suspension

145. In oral evidence a number of issues arose in regard to the treatment of professionals whilst under suspension, and the principle of them continuing to receive their net income. Some professionals (e.g. GPs) are salaried and will continue to receive their net income from the NHS, whereas others (e.g. opticians) are not, and do not appear to be catered for. Officials present agreed that the Executive accepts the principle of professionals continuing to receive income whilst under suspension, and agreed to consider the issue in consultation with the individual professions. (HC Col 1668)
146. The Minister, in evidence, reported that this was being discussed with the professional bodies and that his intention overall was that suspension should have a neutral effect since it suggests that any allegations have yet to be investigated and conclusions reached (HC Col 1861).
147. **The Committee recommends that the Executive should ensure that the treatment of the different professions covered, whilst suspended, should be equitable.**



**PART 5, SECTION 24:  
HEPATITIS C PAYMENTS**

**Purpose of This Section of the Bill**

148. This part of the bill creates a statutory basis for the making of payments to those with Hepatitis C who have been infected through NHS treatment. These payments are already being made under common law by the Skipton Fund on behalf of the Scottish Executive (and all other UK administrations).

**Overall Views of Those Submitting Evidence**

149. The Haemophilia Society Scotland and the Royal College of Nursing Scotland both supported the proposal contained within the bill. There was no opposition expressed in any written or oral evidence to the proposal.

**Committee's Overall View**

150. **The Committee supports the Executive's proposal to provide a firm legal basis under Scots law for the making of payments to Hepatitis C sufferers.**

**Specific Issues Raised by Those Submitting Evidence**

151. The Haemophilia Society Scotland, in both written and oral evidence, raised a number of specific criticisms concerning the criteria and operation of the payment scheme.

Exclusion of Those Who Died Before 29 August 2003

152. The Haemophilia Society objects to the exclusion from the scheme of dependants of those who died prior to 29 August 2003, which is set out in section 24, paragraph (1), sub-para (c). This view is supported by the Royal College of Nursing.
153. **The Committee has some sympathy with this view and invites the Executive to consider the issue.** From the limited evidence available there would seem to be a modest number of potential claimants whose dependants have been excluded from an ability to claim through the adoption of this inevitably arbitrary date.
154. The administrators of the Skipton Fund also indicated in oral evidence that the total number of claims UK-wide is likely, in their opinion, to be closer to 6,500 rather than 8,000 as originally estimated (HC Col 1701). On this basis, the funds currently set aside for payments by the Scottish Executive are unlikely to be exhausted.

155. The Minister, in evidence, maintained that he did not believe that the date should be changed as it was intended to focus the scheme on the living. He told the Committee—

We must also bear in mind what this is all about - trying to assist those who are suffering as a result of contracting hep C through past engagement with the NHS. Sadly, it is not about those who, unfortunately have passed away; it is about supporting those who are still with us. (HC Col 1862)

156. The Minister also indicated that he was not inclined to keep the matter under review, but that the amount devoted to the fund is likely to remain in place as there will be a long tail to the fund.

#### Appeals Procedure

157. One of the Haemophilia Society's criticisms of is that there is no appeals process in place yet. This will inevitably be a concern to those who have been turned down for acceptance under the scheme. Given that the Fund has been operating since July 2003, this appears to the Committee to be a reasonable criticism.

158. The Minister, in his written submission, expressed the hope that he would soon be able to confirm a date by which the appeals panel would be operational. In oral evidence the Minister indicated that, as this is subject to agreement by all the UK administrations, he had spoken to John Reid, the UK Secretary of State for Health, on the issue. (HC Col 1863)

159. **The Committee believes that an appeals procedure should be put in place as soon as possible.**

160. **The Committee recommends that the bill be amended to include the requirement for an appeals procedure, and that detail of the appeals procedure should be included in the regulations.**

161. The Haemophilia Society also suggested that the proposed appeals panel should contain a haematologist rather than a GP. **It would seem to the Committee that there should be scope for including both a haematologist and a GP on the appeals panel.**

#### Structure of the Skipton Fund

162. A number of concerns were raised about the nature and structure of the Skipton Fund as a private company. However, in evidence the Committee heard that its administration costs were 0.25% of payments, that its Directors are not remunerated, and that it is projecting zero profits over the medium-term.

163. **The Committee is content, from the evidence that it has heard, concerning the Skipton Fund's management of public funds.**

Definition of Scottish Claimant

164. The Haemophilia Society suggested that those who can claim should be defined according to whether they were infected as a consequence of treatment by NHS Scotland rather than their place of residence at the time of making a claim, as is currently proposed in the bill (section 24 (2)(b)). This would, for instance, avoid difficulties where claimants move homes.
165. The Minister clarified in his written evidence and confirmed in oral evidence (HC Col 1864) that a claimant only has to be resident at the time of making the claim, and may subsequently move without affecting the claim. He also clarified that if they move, for instance to England, they could claim there if they had not already done so in Scotland.
166. **Given the evidence, the Committee believes that the definition of Scottish claimant in the bill should be amended to reflect those who have been infected by NHS treatment in Scotland, irrespective of current residence.**

Taking Into Account of Skipton Fund Payments in Other Payments

167. The Haemophilia Society pointed out in oral evidence that guidance from the Skipton Fund indicates that these payments will not be affected by payments received by beneficiaries from litigation or other schemes. However, it argued, that the wording of section 24(3) (b) of the bill appears to allow for Skipton Fund payments to be taken into account in any other claims. (HC Col 1690)
168. In his written submission the Minister stated, 'Clearly this section must properly reflect what has previously been said by Scottish Ministers. I will consider this section and amend as appropriate.'
169. **The Committee welcomes the Minister's clarification on the issue, and looks forward to the submission of an amendment to ensure that sufferers receive the full benefit of Skipton Fund payments.**

Role of Clinicians in Completing Application Forms

170. The Committee was disappointed to learn that difficulties appeared to have been encountered by some claimants in receiving assistance from clinicians, and particularly consultants, in completing application forms to the Fund (HC Col 1683). The Skipton Fund representatives reassured the Committee that this issue now appeared to have been dealt with.
171. The Minister, in evidence, outlined that some problems had been experienced, particularly in the Greater Glasgow NHS Board area, but indicated that these now appear to have been resolved.
172. **The Committee believes however that this matter should be kept under review and that should problems reoccur, the Executive,**

**through the Chief Medical Officer should write to all consultants underlining their responsibility.**

Claims by Dependants

173. The legal advisers to the Haemophilia Society also questioned the Skipton Fund rule which states that if eligible persons died after 5 July 2004, they must have made a claim whilst alive in order for their dependants to benefit.
174. In his oral evidence, the Minister recognised this point as valid and gave a commitment to examine the issue and return to the Committee with clarification. (HC Col 1865)
175. **The Committee welcomes this commitment.**

**PART 5, SECTIONS 25, 26 AND 27:  
AMENDMENT OF REGULATION OF CARE (SCOTLAND) ACT 2001**

**Purpose of These Sections of the Bill**

176. This part of the bill proposes a number of amendments to the Regulation of Care (Scotland) Act as a result of difficulties that have arisen since its implementation.
177. The changes are that:
- certain independent health services be able to be exempted from the Care Commission regime;
  - a duty be placed on the Care Commission to take into account representations that it receives in response to notices that it issues; and
  - a duty be placed on social work employers to provide information to the Scottish Social Services Council where employees have left their employment due to misconduct.

**Overall Views of Those Submitting Evidence**

178. The Committee took evidence from Executive officials on these sections of the bill on 11 January 2005. These sections of the bill were not consulted on by the Executive but, according to the Policy Memorandum, the proposals are supported by the main bodies affected; the Care Commission and the Scottish Social Services Council.
179. The Royal College of Nursing Scotland (RCN) submitted written evidence on this part of the bill. The RCN expressed some concerns about the proposed exemption of independent care services, but supported the new duty proposed for social work employers. No other written evidence was received on this matter.

**Committee's Overall View**

180. **The Committee supports the Executive's proposal under sections 25-27 of the bill.**

**PART 5, SECTIONS 28 AND 29:  
DE-REGISTRATION WITH THE CARE COMMISSION**

**Purpose of These Sections of the Bill**

181. These sections of the bill propose to amend the care and housing legislation to retrospectively make lawful the provision of care housing support services by bodies whose registration with the Care Commission lapsed inadvertently.

**Overall Views of Those Submitting Evidence**

182. The Committee took oral evidence from Executive officials on 11 January who explained that these sections of the bill were necessary to cover for an oversight which allowed the registration of a large number of bodies providing care and support services to fall in 2003. Technically the services and payments made by them at this time became unlawful. The situation arose inadvertently, and the Executive wishes to ensure that the legal situation is remedied so that all this activity is deemed lawful.
183. No written submissions were received on these sections of the bill.

**Committee's Overall View**

184. **The Committee recognises the case for making this legislative arrangement, but regrets the need to do so due to the oversight in implementing the previous legislation.**

**PART 5, SECTION 30:  
AUTHORISATION OF MEDICAL TREATMENT**

**Purpose of This Section of the Bill**

185. This part of the bill seeks to amend the Adults with Incapacity (Scotland) Act 2000 in two ways. It extends the types of health professionals who can issue a certificate that an individual is incapacitated (and therefore allows medical treatment to be administered without their express permission). Dentists, nurses and ophthalmic opticians would, therefore, be allowed to

authorise treatment in their respective disciplines. It also extends the duration of such certificates from a maximum of 1 year to 3.

### **Overall Views of Those Submitting Evidence**

186. None of those bodies representing patients who would be covered by the provisions of the bill object to it. Alzheimer Scotland is content to support the proposals, Enable has no objection to it, and the Scottish Association for Mental Health is not opposed to the main provisions, subject to some important conditions.
187. The professional bodies affected by the proposals are all supportive of them. These include the Royal College of General Practitioners, the Royal College of Nursing, the British Dental Association, and Optometry Scotland.

### **Committee's Overall View**

188. **The Committee supports the Executive's proposal to extend the types of professionals who can issue an incapacity certificate.**
189. **The Committee does not support the extension of the maximum duration of a certificate from 1 year to 3 years.**
190. The Committee's reasoning is outlined below.

### **Specific Issues Raised by Those Submitting Evidence**

#### Training

191. The arrangements regarding incapacity certificates, which this part of the bill seeks to amend, were introduced in 2000 by the Adults with Incapacity (Scotland) Act. None of the bodies that gave evidence to the Committee believe that those professionals who had to administer the certificate had been given adequate training since the Act was introduced.
192. The written evidence of Alzheimer Scotland reflects the general view. It states that the Act 'was introduced without doctors being provided with the necessary guidance and training on the assessment of mental capacity. This has not yet been remedied.'
193. In oral evidence, the Minister and Executive officials admitted that the take-up of training under the 2000 Act had been 'patchy'. (HC Col 1867)
194. The Scottish Association for Mental Health argues in its written evidence that, 'It should be a requirement that health professionals, to whom powers are to be extended, undertake accredited training in assessing capacity before they are empowered to sign incapacity certificates.'

195. The Minister and officials, in evidence, indicated that training would be made available for all groups covered by the bill, and that individuals would not be empowered to sign off incapacity certificates unless they have been through the training.
196. **The Committee believes that the introduction of this legislation and the extension of powers to dentists, nurses and ophthalmic opticians must be accompanied by accredited training for these groups.**
197. **The Committee supports the proposal that professionals will not be empowered to sign off incapacity certificates until they have received accredited training.**
198. There is also a need to ensure that all doctors already covered by the legislation have been properly trained in its implementation.
199. **The Committee supports the view expressed by witnesses that this training should be provided on a multi-disciplinary basis by NHS Education. It also recommends that the patient representative bodies be consulted on the design of the training. This does not appear to have happened to date.**
200. **The Committee recommends that the requirement for training be included in the regulations covering this section of the bill, and requests that draft regulations be published before the bill is considered at stage 3.**
201. **The Committee notes that there is no provision within the Financial Memorandum for the costs of training that will be necessary under the bill.**

Extension of Range of Health Professionals who can issue Incapacity Certificates

202. At present only a registered GP can sign an incapacity certificate. All the patient groups that gave evidence indicated that they were aware that this could lead to delays in treatment and the alleviation of pain, e.g. in receiving dental treatment.
203. Subject to the proviso above on training, the Committee has no objection to the extension of the ability to sign incapacity certificates to dentists, nurses and ophthalmic opticians.
204. The Scottish Association for Mental Health argues in its written submission that the power to issue a certificate should be restricted to senior grades of nurse only. The Committee does not support this view, but believes rather that nurses should be eligible on the basis of whether they have received proper accredited training.

205. The question of whether the power to issue an incapacity certificate should be extended to other groups was raised with the Committee. In their written evidence the BMA advocates the inclusion of clinical psychologists, and the Chartered Society of Physiotherapists advocates the inclusion of physiotherapists. In oral evidence, the Minister indicated that he was open to the further extension of groups able to issue certificates, if persuaded of the case. (HC Col 1866)
206. **The Committee believes that the principle that it is the individual's level of capacity that is being assessed, and not their need for treatment must remain paramount.**

Extension of Duration of Incapacity Certificate to 3 Years

207. The extension of the maximum duration of an incapacity certificate from 1 year to three years was supported by the professional bodies who gave evidence, including the Royal College of General Practitioners, the BMA, and the Chartered Society of Physiotherapists.
208. The patient representative bodies that submitted evidence expressed a number of reservations about this provision.
209. Enable suggested in written evidence that where a three year certificate were granted an annual review should still be undertaken. In its written submission the Scottish Association for Mental Health argued that whilst longer certificates might apply to those with advanced dementia or profound learning disabilities, they should not apply to those with mental health problems.
210. Alzheimer Scotland raised a concern in its submission that the proposed extension of the duration of the certificate would diminish the importance of regular and comprehensive reassessment of any ongoing treatment.
211. It also raised a parallel concern over the inappropriate prescribing of psychotropic medication to people with dementia in care homes – a group who might be expected to be subject to longer-term incapacity certificates. In his oral evidence, Dr Jacques of Alzheimer Scotland, argued that 'lengthening the period of certification might be seen to encourage very long-term use of medication without review'. (HC Col 1712)
212. The Committee has received additional evidence on inappropriate prescribing from Mr Hunter Watson and shares Alzheimer Scotland's concern with regard to the bill.
213. In its written evidence, Enable stressed that its primary concern is to 'make sure any changes to the legislation provide a definite benefit to adults with incapacity rather than health or other professionals.'



214. **The Committee shares Enable’s view that changes to the legislation should be governed by patient welfare and for this reason is not minded to support the extension of incapacity certificates to 3 years.**
215. **The Committee believes that, even with tight regulation, there is a significant risk of three year certificates being employed much more extensively than is intended, with a consequent reduction in patient care. If it is good practice to carry out an annual review for patients, then the assessment of capacity and issue or not of a certificate should remain part of that process.**

## **PART 5, SECTION 31: JOINT VENTURES**

### **Purpose of This Section of the Bill**

216. This part of the bill proposes new powers to allow the formation of joint ventures for the provision of facilities or services and for the exploitation of intellectual property rights in the NHS.
217. Section 31 (subsection 1) seeks 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 infrastructural developments.
218. Section 31 (subsection 2) seeks to allow Scottish Ministers to form or participate in companies for the purpose of developing and exploiting intellectual property generated by the NHS. It is intended that this power is restricted to the purpose of making more income available to the health service.

### **Overall Views of Those Submitting Evidence**

#### Facilities and Services

219. The NHS Confederation supports the principle of allowing joint ventures, which it considers will give boards additional options for the development of premises and facilities and will allow the NHS to take part in the kinds of joint ventures that are already undertaken by local authorities.
220. COSLA is also in favour, in principle, of joint ventures to the extent that they recognise advantages in shared premises for health and local authority services. COSLA, however, raised some concerns about the practical application of the policy and about the level of involvement of local authorities in policy development discussions in this area.

221. Witnesses representing private sector contractors Turner & Townsend Management Solutions and EC Harris, both with experience of health sector PFI/PPPs (public finance initiative/public private partnerships) and joint venture initiatives using the English LIFT (local improvement finance trust) model, were in favour of the proposal. Support was expressed in terms of: benefits arising from private investment in and joint planning of health and social care facilities; improved performance of PFI and joint venture initiatives, based on increased public sector experience; and flexibility.
222. However, the Royal College of Nursing indicated that it was unconvinced by the experience in England and both the Scottish Trades Union Congress and the public sector union, UNISON, oppose the policy, questioning whether it represents value for money for the public.

### Intellectual Property

223. In its written submission the NHS Confederation expresses support for the potential to use joint venture companies as a vehicle for exploiting intellectual property development in the health service, describing this as an 'untapped resource that the NHS has neither the time nor expertise to take forward.'
224. In its written evidence, Universities Scotland also indicated support for this proposal, which it views as a 'catching-up exercise' in relation to similar powers held by Ministers at Westminster.

### **Committee's Overall View**

225. The Executive intends to provide for new powers to form and participate in joint ventures in the health service by introducing potentially wide-ranging enabling legislation.
226. Much of the evidence available to the Committee related to the experience of NHS LIFT projects in England. While a number of these projects are now underway, the Committee is of the view that it is too soon to make an objective judgement about the performance of this model. The Committee is also aware that other joint venture models are possible under the Executive's proposals; however, it appears that a limited amount of consideration has been given to alternative models by the relevant public sector agencies. The Committee considers it important that a range of alternative joint venture models are considered, including the mutual model.

### **Specific Issues Raised by Those Submitting Evidence**

#### Joint Venture Models

227. It was clear from the evidence received by the Committee, and confirmed in correspondence with the Minister for Health and Community Care, that the

NHS LIFT model operated in England is only one model that could be applied in Scotland under the powers proposed in the bill. In a written submission to the Committee, the Minister indicated that, 'The powers we are seeking are generic and do not restrict either Scottish Ministers or NHS Boards to one particular model'. However, the Minister also indicates that while it will be possible for alternative models to be developed, there are cost and time implications in doing so, both nationally and for local partners.

228. The Committee was advised in oral evidence from Howard Forster, of EC Harris, that 42 NHS LIFT projects are currently being pursued at different stages of progress, and that few as yet have been completed.
229. The Committee was also informed, in correspondence from the Minister, that the National Audit Office is due to issue a report in April on the NHS LIFT initiative in England.

### Risk and Cost

230. Responding to questions about risks and costs associated with joint venture initiatives, a number of witnesses expressed the view that previous public and private sector experience in handling PFI/PPP contracts offered lessons that could be positively applied to any future joint venture initiatives.
231. David Fox outlined to the Committee the key stage review process implemented by the Scottish Executive, which helps ensure that promoters of PFI/PPP projects 'get it right' (HC Col 1724). Howard Forster, EC Harris, told the Committee that—

In the mainstream PFI market, cost escalations are mainly due to delays in projects and inflationary pressures during those delays. That has not been apparent in the LIFT market; on the whole, the first 42 schemes that have been bid on have been straightforward. (HC Col 1723)

232. Susan Aitken, of the NHS Confederation told the Committee—

The NHS came rather late in the day to joint ventures, which gives us some advantages. We can learn lessons that Scottish local authorities have already learned from being involved in joint ventures. Through the LIFT scheme in England, we have learned that we can use the best bits of models and discard the bits that have not worked. (HC Col 1741)

233. However, it was apparent to the Committee that representatives from COSLA and the NHS Confederation had only limited knowledge of existing NHS LIFT projects in England.
234. In response to a written question from the Committee about how public finance and public service delivery will be safeguarded should a joint venture company initiative fail, the Minister indicated that the risk exposure of a joint venture will depend on the structure it takes and that sharing of risk provides an incentive for partners to make the joint venture a success.

He also indicated that standardised documentation will be used to ensure that any partnering agreement between the public and private sectors requires a joint venture to perform its obligations without recourse to government or public funds.

#### Jobs and Conditions

235. In evidence to the Committee, Howard Forster of EC Harris indicated that the facilities management (FM) content in NHS LIFT schemes in England has so far been limited to the provision of 'hard' facilities management, such as building services (HC Col 1727). To date, therefore, there has been no transfer of employees from one service provider to another.

236. It is not clear to the Committee, however, that this will always be the case. Dave Watson, of UNISON, suggested to the Committee that differences in health service delivery in Scotland might increase the prospects of soft facilities management being included in joint venture initiatives here. He told the Committee—

There are more health centres in Scotland, particularly in the major cities, whereas there are more private GP practices down south. Health centres are traditionally health board premises that have health board staff – both soft FM and hard FM, to use the PFI jargon. The other difference between Scotland and England is that there is far more direct staff provision in Scotland in local authorities and in health boards, whereas in England there has been far more use of contractors. Those differences lead us to be concerned that there might be more staffing problems in Scotland. (HC Col 1752)

237. **The Committee, therefore, welcomes the Minister's confirmation, in a written submission, that the Scottish PPP staffing protocol will apply to joint venture companies established under the bill's provisions, on the basis that public private joint ventures are a form of PPP.**

#### Commercial Pressures and Conflict of Interest

238. In evidence, witnesses from UNISON and the STUC raised concerns about potential conflicts for public sector employees serving as directors of joint venture companies. Dave Watson, of UNISON, raised the issue of directors' fiduciary duties to share holders and potential pressure to pursue commercial activity over health related functions where, for example, a higher rent for premises was offered by a commercial operator as compared to a health related service provider, such as a doctor. (HC Col 1756)

239. In evidence the Minister indicated that he had been impressed by projects that offered investment in areas where community regeneration has otherwise been at a standstill. He told the Committee—

If we aggregate public sector expenditure, bringing in health services—say, a dentist, a doctor and a physiotherapist—a post office, a police station, a newsagent's and a hairdresser's, that is good news for the community. (HC Col 1870)

240. In earlier correspondence with the Committee, the Minister indicated that 'influence on the direction taken and prioritisation of the scheme would be achieved through the governance arrangements established for the joint venture company. In the context of a LIFT type development, the Strategic Partnering Board fulfils this role via the Strategic Development Plan'.
241. Dave Watson, of UNISON, also raised a concern that local priorities may become distorted because of the need to ensure the 'critical mass' necessary to attract private finance. (HC Col 1751)
242. **The Committee notes that, as drafted, the bill does not guarantee that appropriate governance arrangements will be established to ensure that health related priorities are given sufficient weight in joint venture companies. The Committee invites Ministers to address this point at Stage 2.**

#### **PART 5, SECTION 32: SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST**

##### **Purpose of This Section of the Bill**

243. This part of the bill proposes to convert the Scottish Hospitals Research Trust (SHERT) from a non-departmental public body (NDPB) to a charitable trust. The main motivation for this proposal is that SHERT risks losing charitable status if it remains an NDPB. SHERT receives endowments, donations and bequests and allocates them to support medical research in Scotland.

##### **Overall Views of Those Submitting Evidence**

244. The Committee took oral evidence from Executive officials on this part of the bill on 11 January 2005. The officials confirmed that the pre-legislative consultation has elicited positive responses to this proposal on the basis of the importance of charitable status, and no objections.
245. The only organisation to submit specific written evidence on this part of the bill was the Royal College of Nursing (RCN) Scotland. The RCN raised some issues about the narrowness of the criteria for the distribution of SHERT funds, but was supportive of the proposal contained in the bill.

**Committee's Overall View**

246. **The Committee supports the Executive's proposal to convert the Scottish Hospitals Endowments Research Trust from a Non-Departmental Public Body to a charitable trust.**

## **ANNEX A: REPORTS FROM SECONDARY COMMITTEES AND HEALTH COMMITTEE STUDY VISIT TO IRELAND**

### **Finance Committee**

#### **Report on the Financial Memorandum of the Smoking, Health and Social Care (Scotland) Bill**

The Committee reports to the Health Committee as follows—

#### **Introduction**

1. Under Standing Orders, Rule 9.6, the lead committee in relation to a Bill must consider and report on the Bill's Financial Memorandum at Stage 1. In doing so, it is obliged to take account of any views submitted to it by the Finance Committee.
2. This report sets out the views of the Finance Committee on the Financial Memorandum of the Smoking, Health and Social Care (Scotland) Bill, for which the Health Committee has been designated by the Parliamentary Bureau as the lead committee at Stage 1.
3. At its meeting on 8 February 2004, the Committee took evidence from representatives from the Scottish Licensed Trade Association (SLTA), COSLA and the Scottish NHS Confederation. Oral evidence for this meeting can be viewed by clicking [here](#).
4. The Committee then took oral evidence from officials from the Scottish Executive on 1 March 2005. Oral evidence for this meeting can be viewed by clicking [here](#). In addition to receiving written submissions from the SLTA, COSLA and the Scottish NHS Confederation, the Committee also received submissions from: ASH Scotland, the British Dental Association, the Care Commission, Health Scotland, Optometry Scotland, the Scottish Social Services Council and the Scottish Hospital Endowments Research Trust.
5. The Committee would like to express its thanks to all those who submitted their views.

#### **Objectives and the Financial Memorandum**

6. The Bill is split into 5 distinct parts. Part 1 of the Bill deals with the Prohibition of Smoking in Certain Wholly Enclosed Places. Part 2 looks at General Dental Services, General Ophthalmic Services and Personal Dental Services, Part 3 deals with Pharmaceutical Care Services, Part 4 deals with Discipline and Part 5 deals with miscellaneous provisions such as joint ventures and amendments to the Regulation of Care (Scotland) Act 2001.
7. The Committee agreed that it would concentrate on 3 specific parts of the Bill – Parts 1, 2 and 3. The additional costs of these provisions as estimated by the Executive are laid out in the Bill's Financial Memorandum and are summarised as follows:

Policy Area	Cost on Scottish Administration	Health Boards	Local Authorities	Cost on Other Bodies	Para Reference
Smoking	£2m for communications ahead of implementation and £1m p.a. for 3 years following implementation.  £50,000 - £100,000 in the first year for compliance line. Ongoing costs not known	Gross savings of £5.7m to £15.7m p.a. on NHS costs in the longer term	Enforcement costs to be developed in full RIA.	Between £104m cost to £137 benefit to hospitality sector p.a.	193, 195, 197, 203, 207
Free Eye and Dental Checks	£7.5m - £17.9m p.a. for eye checks and £9.1m - £12.4m p.a. for dental checks	Nil	Nil	Not known	212
Dentistry	N/A	£500,000 p.a. additional professional and administrative costs.	Nil	Nil	224
Listing	Nil	Nil	Nil	£10,000-£20,000 one-off NSS database costs.	230

*Part 1 – Prohibition of Smoking*

8. This part of the Bill seeks to ban smoking in wholly enclosed public places. In the Financial Memorandum, the Executive states that it will cost £2m for communications ahead of any ban and £1m per annum for 3 years following implementation. In addition, it will cost between £50,000 and £100,000 in the first year for a compliance line to be set up. The Executive has also estimated that as a result of the ban, there would be a cost of £104m to the hospitality sector which



would be offset by benefits of £137m<sup>10</sup>. In terms of enforcing the Bill, the Financial Memorandum does not provide costs as precise details of the enforcement role have yet to be determined through consultation with COSLA.

9. The SLTA fundamentally disagreed with the costs to business as estimated by the Executive and questioned the research upon which the Executive's figures were based. The SLTA claim that research carried out by the University of Aberdeen is incomplete as it only considered one study based on California which does not have a complete smoking ban. In addition, they claim that the study examined hotels and restaurants but not pubs. The SLTA noted that there were only three countries where outright smoking bans have been implemented – Ireland, New Zealand and Norway.

10. For their part, the SLTA produced research which they had commissioned which suggested that “annual profits in licenses premises may decline by £86m”, that “employment in the licensed trade can be expected to decline by 2,300 jobs” and that “some 142 average-sized licensed premises may close down as a result of decreased trade”.<sup>11</sup>

11. However, the Committee noted that these figures were based on those available in Ireland and the SLTA had previously made it clear that the Irish ban had not been in place long enough for a full evaluation<sup>12</sup>. When asked about their apparently contradictory position, the SLTA stated:

“We have been put in that position by the timing of the bill. We are saying that we should wait for at least a year to see what the Irish experience throws up, because it is the closest experience to home on which we can work”<sup>13</sup>

12. In their submission to the Committee, Health Scotland questioned the comments made by the SLTA with regard to the research carried out by the University of Aberdeen. They said:

“The SLTA claim that the research was incomplete but fail to identify any studies that the evidence review missed.

All of the evidence reviewed related to the health and economic impacts of the regulation of smoking in public places and was entirely relevant. It is true that there was little evidence relating to impact on bars and this is made clear in the report. We excluded evidence from New York relating to the one year follow up of the comprehensive ban on smoking because it was not published in a peer reviewed source. However, it should be noted that this report showed a positive impact on bars and restaurants but did not show results for the sectors separately. As with all aspects of the research, the authors have been careful not to overstate the case for regulation.”<sup>14</sup>

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<sup>10</sup> Smoking, Health and Social Care (Scotland) Bill: Explanatory Notes page 30

<sup>11</sup> Submission from the Scottish Licensed Trade Association

<sup>12</sup> Waterson, Official Report, 8 February 2005. Col 2310

<sup>13</sup> Waterson, Official Report, 8 February 2005, Col 2312

<sup>14</sup> Submission from Health Scotland

13. Subsequent to the publication of the Bill, the Executive published a Regulatory Impact Assessment (RIA) which gave a cost benefit analysis of 3 options – a voluntary approach, smoke-free legislation and legislation but with exemption for the hospitality sector which gives further details on potential costs to business and benefits to both business and the health service.

14. It is difficult for the Committee to come to a firm conclusion on the costs to business of an outright ban, given the contradictory figures which have been submitted to it not just on costs to business but also with regard to the potential benefits to business from attracting non-smokers into pubs. It is also difficult to make a precise assessment of the potential savings to the health service if the legislation succeeds in helping to reduce the number of smokers and smoking-related diseases. The Committee notes that the SLTA is proposing that a phased ban be introduced. This is a matter of policy and therefore is for the lead Committee to consider but it was not clear from the evidence how much of an impact a phased ban would have on the financial implications of the Bill.

15. The other cost of a smoking ban which the Committee scrutinised was the cost of enforcing the ban. COSLA estimated that enforcement could cost £6m pa for the first two years of the ban although they emphasised that their figures may need to be adjusted in light of the consultation. This cost includes estimates for training and recruitment costs, including the cost of paying for staff and introducing new systems, associated legal costs, additional out-of-hours and street-cleaning costs, the security cost for staff and other associated training<sup>15</sup>

16. The Committee raised concerns over the increased litter and noise levels outside pubs that might arise as a result of a ban and therefore, an increased need for enforcement. Gordon Greenhill from the Society of Chief Officers of Environmental Health explained that it was already an offence to drop litter and that the Executive has already provided funding to have environmental wards to enforce the legislation on litter. However, he also pointed out that the funding was temporary and would require to be made permanent. He also said that loud shouting in the street is already an offence and that he did not believe that there would be a major problem with increased litter and noise levels.<sup>16</sup> The Committee was not convinced by this argument. The Committee was also sceptical about the Executive's claim in the Financial Memorandum that the costs of enforcement will diminish over time.

17. Assuming the enforcement will rest predominantly with local authorities, the Committee was concerned about the current difficulties in recruiting and retaining Environmental Health Officers and the impact that any staff shortages could have on the implementation of this part of the Bill.

18. The Executive responded that COSLA had raised these concerns and that "there is an issue about how to get people in at the right level but, as COSLA noted, one does not have to have a fully qualified environmental health officer to provide corroboration or to serve a fixed penalty notice. COSLA and the Executive

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<sup>15</sup> McKeown, Official Report, 8 February 2005, Col 2318

<sup>16</sup> Greenhill, Official Report, 8 February 2005, Cols 2314 and 2315

have to think about whether there is room for being creative – in the best possible sense of the word – in that area.”<sup>17</sup>

19. However, the Committee remains very concerned that the costs of enforcement are largely unknown. The Committee certainly welcomes the fact that there will be consultation between the Executive, COSLA and the hospitality sector to establish these costs, however, it is extremely difficult for the Committee to carry out its scrutiny function when the costs are unknown. The Committee acknowledges that some figures have been incorporated into the RIA subsequently published by the Executive. This RIA assesses costs over a 30 year period and assumes £1m in 2006 and £5m in 2007. Costs are then predicted to fall to £2.5m in 2008 and to £1m thereafter for the rest of the 30 year period.<sup>18</sup> The draft RIA states that the figure of £6m in the first two years is based on a submission by COSLA but that figure must be regarded as approximate because, in the absence of detailed Regulations, COSLA were not able to provide a more precise figure. The Executive confirmed that “the outcome of those discussions [with COSLA] will be reported to you [the Committee] in due course and will be incorporated into the final version of the RIA [Regulatory Impact Assessment] later in the year.”<sup>19</sup>

*Part 2 – General Dental Services, General Ophthalmic Services and Personal Dental Services*

20. This part of the Bill has various provisions, including introducing free eye and dental check-ups, extending the range of general ophthalmic services, improving dental services and providing a national framework for charging for dental services.

21. The current cost of providing free NHS eye and dental checks is £15.2m and £7.7m respectively. The Financial Memorandum estimates that the cost of extending these free checks will be an additional £7.5m - £17.9m for eye checks and £9.1m - £12.4m for dental checks.

22. The Bill provides for a new system of charging to be established. However, the Bill itself does not specify the new payment arrangement and therefore, the Financial Memorandum does not state exactly what the cost implications will be for the Executive. The Memorandum does say that it expects any changes through the General Dental Services contract to be cost neutral. It estimates that NHS boards will require additional staff and that this will cost £500,000 across all NHS boards. In addition, it is estimated that National Services Scotland will incur initial development costs of between £10,000 and £20,000.

23. The Executive explained that the costs of providing free dental check-ups are based on dental examinations for the existing number of registered patients. These costs have then been increased by 25 per cent to reflect the fact that more people might seek dental check-ups if they are free.<sup>20</sup> The Executive did not offer

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<sup>17</sup> Davidson, Official Report, 1 March 2005, Col 2425

<sup>18</sup> Scottish Executive, Draft Regulatory Impact Assessment, published 10 March 2005

<sup>19</sup> Davidson, Official Report, 1 March 2005, Col 2422

<sup>20</sup> Wilson, Official Report, 1 March 2005, Cols 2432 and 2433

any evidence as to the basis for this additional 25 per cent figure and the Committee recommends that the lead Committee pursues this with the Minister.

24. However, the new oral health assessments proposed by the Bill are likely to be more extensive than the current dental examinations<sup>21</sup> and therefore it can be assumed they will take longer and are more likely to uncover dental problems which in turn will have to be treated. The Financial Memorandum does not quantify the costs associated with the additional dental hours that will be required as a consequence of the introduction of this part of the Bill. When asked about this, the Executive responded that “we are still working through with the dental profession the details of that oral health assessment and any possible manpower consequences”.<sup>22</sup>

25. When pressed on this, the Executive stated that an external quantification of the current gap in the number of NHS dentists was 215.<sup>23</sup> In addition, an approximation of the number of additional dental hours required was as follows:

“it has been roughly calculated that about 1 million examinations might be substituted by new oral health assessments. At present, approximately 2 million examinations are done under the NHS.. and given that it will take an average of, say, 20 minutes for an oral health assessment, we might be talking about 300,000 hours of dentist time, which might come down to about 150 dentists.”<sup>24</sup>

26. The Executive went on to say that other factors could come into play such as professionals<sup>25</sup> other than dentists being able to carry out follow-up treatment.

27. Leaving aside the debate about whether it will be possible to recruit the additional number of dentists which will be needed, the Committee is deeply concerned that it is being asked to scrutinise the financial implications of a Bill where the staffing and service implications which crucially determine the cost do not appear to have costed in a manner that gives the Committee confidence in the figures.

28. There will be consultation not only about the form of new oral health examinations, but also on the issues of fees, capitation and allowances. The Executive has said that the specific costs that are allied to charges under the heading of “provision of General Dental Services” will be cost neutral, but that general improvements in dental services will have a cost and that improvement measures and funding for them will be included in a Ministerial announcement. The Committee deeply regrets that such an announcement was not made prior to the introduction of this Bill.

29. The Committee recognises that there are broader issues of dental services which are not necessarily a direct consequence of the Bill. However, it would argue that the number of additional dentist hours required and the results of the

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<sup>21</sup> Wilson, Official Report, 1 March 2005, Col 2430

<sup>22</sup> Wilson, Official Report, 1 March 2005, Col 2430

<sup>23</sup> Wilson, Official Report, 1 March 2005, Col 2430

<sup>24</sup> Wilson, Official Report, 1 March 2005, Col 2431

<sup>25</sup> Wilson, Official Report, 1 March 2005, Col 2432

consultation on a new charging framework are a direct consequence of the Bill and therefore, it is unacceptable that the Executive is not able to provide even a “best estimate” of costs. When scrutinising the Transport (Scotland) Bill, the Committee raised concerns over the major difficulties in scrutinising legislation where consultations on provisions have not yet been concluded. The Committee is dismayed that the same problems have arisen with this bill. The Committee is extremely concerned that Parliament is being asked to authorise the release of funds when it is not certain of what the cost of legislation is likely to be.

30. Following the evidence given by officials, the Deputy Minister wrote to the convener explaining that she believed that Financial Memorandum was adequate and appropriate. The Deputy Minister argued that the more extensive oral health assessments are part of the dental modernisation package and therefore the cost of these would be part of the overall financial package underpinning the modernisation of dental services. The implication of this being that this is not being directly proposed by the Bill. However, the fact remains that this will flow from the Bill (and indeed the Policy Memorandum makes specific mention of the consultation) and therefore, even if the figures were not included in the Financial Memorandum, then some indication of the likely costs should have been given. The Deputy Minister confirmed that the Ministerial statement would be made on 17 March. However, the Committee would reiterate its point that such a statement should have been made prior to scrutiny of the Bill, to provide a necessary policy context.

### *Part 3 – Pharmaceutical Care Services*

31. This part of the Bill deals with expansion and changes to pharmaceutical care services. The Financial Memorandum estimates it will cost £500,000 across all NHS boards for administrative support for the new planning and monitoring role. The cost of delivering any new or enhanced services will depend on what a Board’s plan actually contains but the Financial Memorandum estimates revenue provision of around £85,000 if a full range of pharmaceutical services is to be delivered and additionally, gives a range of between £30,000 and £85,000 for fitting out premises. The cost to the NSS for the maintenance of “virtual” pharmaceutical lists is estimated to be £10,000 for initial development costs.

32. The Committee raised concerns that £500,000 did not seem adequate for the work that is likely to be involved and also questioned whether health boards will have to make changes, and therefore spend money, or would expenditure be optional. The Executive responded that not all services would add cost and that efficiencies could be sought. When asked what the costs actually represented, the Executive responded that:

“The £500,000 is for support staffing in health boards. As for additional service costs, the planning process that health boards will be required to follow will identify gaps. We cannot quantify those gaps at present because that planning process has not taken place. That is the chicken-and-egg situation again.<sup>26</sup>”

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<sup>26</sup> Naldrett, Official Report, 1 March 2005, Col 2439

33. The Committee welcomes the fact that the Executive confirmed that if resource implications are identified during the course of negotiations on the contract's implementation then the case will be taken to Ministers<sup>27</sup> but once again, it is not clear what these final costs are likely to be.

### **Conclusions**

34. The Committee notes that there are contradictory figures about the potential loss to business from a ban on smoking and recommends that the lead Committee pursue this issue with the Minister.

35. The Committee, whilst welcoming the fact that the Executive will be fully consulting with COSLA and the hospitality industry on enforcement, is very concerned that no firm figures have been produced, and will not be produced until the consultation has concluded, albeit that estimates have now been published in the draft Regulatory Impact Assessment. The Committee has raised this issue of principle with the Minister for Parliamentary Business and with the Minister for Finance and Public Sector Reform and hopes to have early discussions to resolve what is becoming a familiar problem. However, the Committee recommends that the lead Committee seeks assurances from the Minister that the results of such a consultation be reported as soon as possible and certainly before Stage 3.

36. The Executive did not offer any evidence as to the basis for the additional 25 per cent figure it has assumed in calculating the costs of introducing free oral health checks and the Committee recommends that the lead Committee pursues this with the Minister.

37. The Committee was even more concerned about the lack of information with regard to the provision of free oral health assessments. It records its dissatisfaction that the Ministerial Statement on dental services was not made prior to the introduction of this legislation as this could have provided a policy and funding context for some of the provisions of the Bill. As with the enforcement of a smoking ban, the Committee strongly recommends that the lead Committee seeks assurances from the Minister on this matter.

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<sup>27</sup> Naldrett, Official Report, 1 March 2005, Col 2439

## **Subordinate Legislation Committee**

### **Smoking, Health and Social Care (Scotland) Bill at Stage 1**

The Committee reports to the lead Committee as follows—

#### **Introduction**

1. At its meetings on 22 March and 12 April 2005, the Subordinate Legislation Committee considered the delegated powers provisions in the Smoking, Health and Social Care (Scotland) Bill at stage 1. The Committee submits this report to the Health Committee, as the lead committee for the Bill, under Rule 9.6.2 of Standing Orders.
2. The Executive provided the Committee with a memorandum on the delegated powers provisions in the Bill, which is reproduced at Appendix 1.
3. The Committee's correspondence to the Executive and the Executive's response to points raised are reproduced at Appendix 2.

#### **Delegated powers provisions**

4. The Committee considered each of the delegated powers provisions in the Bill. The Committee approves without further comment: sections 3(3), 9(2), 10(3), 11(2)(a) and (c), 15, 16, 17, 19, 20, 22(2)(b), 23, 25, 30(2)(b), 30(2)(e)(ii), 30(2)(f)(ii), 33(1), 37(3), paragraphs 2, 5(1), 6(2), 13 and 14 of schedule 1 and paragraphs 1(4), 1(7), 1(9) and 2 of schedule 2.

#### **Section 4(2) and 4(7) Meaning of “smoke” and “no-smoking premises”**

5. The Committee noted that the bill creates offences of smoking or permitting smoking in no-smoking premises and that what constitutes no-smoking premises is left entirely to regulations made under section 4(2) and 4(7). Section 4(2) of the Bill provides for “no-smoking premises” to be prescribed by regulations and section 4(7) allows the Scottish Ministers to modify section 4(4), in order that kinds of premises may be added or removed.

6. The Committee recognised the need for the definition of no-smoking premises and exemptions to be contained in regulations rather than on the face of the bill, in order to provide the necessary flexibility. The Committee, however, was concerned that draft affirmative procedure simply allows for the approval or rejection of an instrument in its entirety and raised with the Executive that the proposed regulations should perhaps be subject to further scrutiny, such as that which a “super-affirmative” procedure would allow.

7. In its response to the Committee, the Executive stated that the first regulations made under section 4 will be subject to a higher level of scrutiny than would normally be the case for an instrument subject to draft affirmative procedure. The Committee, however, was concerned that there is no guarantee that future regulations made under this section will be subject to the same level of public scrutiny before being laid. Although by virtue of section 34(4) the Scottish

Ministers must “consult such persons as they consider appropriate” before laying regulations under section 4(2) and (7), they are not required to circulate a draft instrument as part of that consultation.

**8. The Committee agreed that it did not wish for any enhanced scrutiny to overburden the enactment of what may be minor amendments to the regulations in future. However, the Committee held concerns in relation to consultation on future regulations that may potentially make significant changes to the bill and highlights this issue to the lead Committee. The Committee has also agreed to write to the Minister to highlight its views in advance of stage 2 of the bill.**

### **Section 11: Charges for certain dental appliances and general dental services**

9. Subsections (2), (3), (5) and (6) amend existing regulation making powers to give Scottish Ministers the power to make regulations regarding the way in which certain dental charges are made or recovered. Currently the patient charge for dental treatment and appliances is linked to the item of service fee paid to dentists and unless the patient is exempt or remitted from charges he/she pays 80% of that item of service fee. The effect of the proposed powers will be to break this link with the aim of providing more flexibility and transparency to the charging system.

10. The Committee questioned whether negative procedure provided the best level of parliamentary scrutiny, given that although the existing powers are subject to annulment there are certain constraints on their use. It was suggested that the Executive may wish to consider using affirmative procedure for the first substantive exercise of the powers. The Executive in its response considered that negative procedure had worked well for governance of dental charges in balancing the needs of flexibility and parliamentary scrutiny and was not persuaded of the need for a more onerous procedure for the first exercise of the power. **The Committee was content with the Executive’s explanation.**

### **Section 18: Health Boards’ functions: provision and planning of pharmaceutical care services**

11. Section 18 inserts new sections 2CA and 2CB into the 1978 Act to place a duty on Health Boards to provide or secure the provision of pharmaceutical care services for persons in their area, and provide for the way in which Health Boards plan to discharge that duty.

12. The Committee asked the Executive whether the new direction making powers in section 2CA(7) of the Drug Tariff should be incorporated into a more formal document, subject to parliamentary procedure. The Executive’s response provided helpful information as to the practical operation of these direction-making powers and the lengthy and technical nature of the directions. **The Committee accepts the points made by the Executive in its response.**



**Section 24: Payments to certain persons infected with hepatitis C as a result of NHS treatment**

13. This section makes provision for the making of a scheme by the Scottish Ministers for payments to persons infected with hepatitis C as a result of NHS treatment. Details of the contents of the scheme are set out in the section and there is a requirement on Ministers to publish the scheme. However, the Committee noted that the scheme itself will not be a statutory instrument nor is there any provision for any Parliamentary scrutiny of the scheme.

14. The Committee asked the Executive why it had chosen that the scheme should not be subject to parliamentary procedure. The Executive responded with additional information on the background to section 24, and considers that the obligations on the Ministers set out in that section, along with the fact that the Executive is accountable via the usual auditing and accounting controls, mean that the scheme is subject to an appropriate level of scrutiny.

**15. The Committee was not persuaded by the Executive's argument and recommends that the scheme should be subject to some form of parliamentary procedure to allow it to be formally brought to the attention of the Parliament. It therefore brings this matter to the attention of the lead Committee.**

**Section 28: Registration of child care agencies and housing support services**

16. This power gives Scottish Ministers the flexibility to extend the period of deemed registration of Housing Support services and Childcare Agency services should that prove to be necessary. Subsection (4)(e) gives Scottish Ministers the power to make an Order to substitute a later date than that specified in that subsection. The power is exercisable by statutory instrument subject to negative procedure.

17. The Committee queried the use of negative procedure for the enabling power at section 28(4)(e) of the Bill, as it allows for the substitution of a date that appears on the face of the Bill, and is therefore a "Henry VIIIth" power. The Executive advised the Committee that it does not anticipate that the power at section 28(4)(e) will ever be used, and informed the Committee that it is included as purely a safety measure should the Care Commission be unable to process all applications for registration before the date.

18. The Executive considered the procedure appropriate as the power is very specific and limited in scope and it gives the Scottish Ministers more time and flexibility to extend the date if unforeseen circumstances in processing by the Care Commission were to arise.

**19. The Committee was content with the Executive's response and that negative procedure offers the most appropriate level of scrutiny.**

**APPENDIX 1**

**Smoking, Health and Social Care (Scotland) Bill  
Memorandum to the Subordinate Legislation Committee**

**Purpose**

This memorandum has been prepared by the Scottish Executive to assist consideration by the Subordinate Legislation Committee, in accordance with Rule 9.6.2 of the Parliament's Standing Orders, of provisions of the Smoking, Health and Social Care (Scotland) Bill conferring power to make subordinate legislation. It describes the purpose of each such provision and explains why the matter is to be left to subordinate legislation.

**Outline and Scope of the Bill**

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

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.

The Bill also makes provision for the introduction of free eye and dental checks for all, and modernises the frameworks for the delivery of certain 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.

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.

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.

The subordinate legislation powers contained in the Bill divide between those that are completely new and those that are required to replace existing powers in legislation being amended by the Bill. The Bill contains subordinate legislation making powers in the following Parts:

- Prohibition of smoking in certain wholly enclosed places (Part 1);
- Free dental and eye examinations (Part 2);
- Charges for dental appliances and general dental services (Part 2);
- Listing of persons undertaking to provide or approved to assist in the provision of general dental services, general ophthalmic services and performing personal dental services (Part 2);
- Pharmaceutical care services (Part 3);
- Discipline (Part 4);
- Amendment of Regulation of Care (Scotland) Act 2001, and child care agencies and housing support services (Part 5);
- Authorisation of medical treatment (Part 5).

### **Subordinate Legislation Powers**

Sections 3 and 4 have subordinate legislation making powers in relation to the prohibition of smoking in certain wholly enclosed places (“the new powers”). The new powers will enable Scottish Ministers to make provision for the display of warning notices and to prescribe premises, parts of premises and classes of premises which are excluded from the definition of “no-smoking premises”. It is considered appropriate that these new powers would be subject to the affirmative resolution procedure of the Parliament.

Sections 9 to 23 of the Bill include a number of primary health care provisions containing powers to make subordinate legislation. The modernising of the existing regime, mentioned above, is achieved by amendment of the National Health Service (Scotland) Act 1978 (“the 1978 Act”) and so the new powers will be inserted into the 1978 Act. Therefore, section 105 of the 1978 Act will apply to the new powers. Accordingly, references in the new powers to anything being “prescribed” means prescribed by regulations made by the Scottish Ministers and regulations made under the new powers will be subject to annulment in pursuance of a resolution of the Parliament. It is believed that negative resolution procedure continues to be appropriate in respect of the new powers. The new powers are not simply adding to existing subordinate legislation making powers as some existing powers are being repealed by the Bill.

Sections 25 and 28 of the Bill include a number of provisions to make subordinate legislation relating to the Regulation of Care (Scotland) Act 2001 (“the 2001 Act”). The new powers in section 25 enable Scottish Ministers to except certain independent health care services from the requirements of the 2001 Act. It is believed that negative resolution procedure is appropriate in respect of the new powers. Section 28 enables Scottish Ministers to make an order to substitute a day for 1 April 2006 where required to prevent childcare agencies and housing support services from inadvertently committing an offence under the 201 Act.

Section 30 of the Bill include a number of provisions to make subordinate legislation relating to the Adults with Incapacity (Scotland) Act 2000 (“the 2000 Act”). The new powers allow Scottish Ministers to extend the range of health professionals who may sign certificates of incapacity and to prescribe

circumstances when the certificates can extend beyond 1 year. It is believed that negative resolution procedure is appropriate in respect of the new powers.

Section 33 of the Bill enables the Scottish Ministers by order to make incidental and other ancillary provision for the purposes of the Bill or in consequence of it.

Section 34 provides that any order under section 34 (except where section 34(3) applies) will be subject to annulment by a resolution of the Parliament. Section 34(3) provides for orders to which it applies to be laid in draft for approval by resolution of the Parliament. Affirmative procedure is seen as appropriate given the nature of the orders specified in section 34(3) but otherwise it is considered negative resolution procedure is the most appropriate procedure for the other orders under section 34.

Section 37(3) of the Bill confers power on the Scottish Ministers to make the necessary commencement order(s). As this is a commencement provision there is no parliamentary procedure.

### **Section 3 - Display of warning notices in and on no-smoking premises**

<b>Relevant provision:</b>	<b>Section 3(3).</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Affirmative resolution procedure of the Scottish Parliament.</b>

Section 3(3) of the Bill gives the Scottish Ministers powers to make regulations to make further provision as to the detail of the manner of display, form and content of the no-smoking signs which are required to be conspicuously displayed inside and outside no-smoking premises. The Executive will draft and consult on these regulations, in compliance with section 34(4) of the Bill, to coincide with the Bill's passage through Parliament. It is considered appropriate to confine this sort of detail to subordinate legislation rather than primary legislation because it may be necessary over time to change the notice display requirements.

In deciding whether to adopt negative or affirmative resolution procedure, careful consideration has been given to the degree of parliamentary scrutiny that is felt to be required for the regulations, balancing the need for the appropriate level of scrutiny with the need to avoid using up parliamentary time unnecessarily. Affirmative procedure is used where the order or regulation making powers allow for the modification of any enactment or where there is significant public interest. In view of the public interest in the subject matter, the regulations under this provision will be subject to affirmative resolution procedure.

### **Section 4 - Meaning of “smoke” and “no-smoking premises”**

<b>Relevant provisions:</b>	<b>Subsections 4(2) and 4(7).</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>

**Parliamentary procedure: Affirmative resolution procedure of the Scottish Parliament.**

Section 4(2) of the Bill provides for “no-smoking premises” to be prescribed by regulations made by the Scottish Ministers. The kind of premises to be prescribed as “no-smoking premises” are those which are wholly enclosed and, as set out in section 4(4), (a) to which the public or a the section of the public has access, (b) which are being used wholly or mainly as a place of work by persons who are employees, (c) which are being used by and for the purposes of a club or other unincorporated association, or (d) which are being used wholly or mainly for the provision of education or of health or care services. The regulations will set out detailed provisions, including any exemptions which may be prescribed, but the scope of the prohibition is intended to be comprehensive. Again, it is not felt to be appropriate for primary legislation to contain such detail.

The regulations to be made under section 4(2) may also define or elaborate the meaning of certain expressions used, namely “premises”, “wholly enclosed”, “the public” and “has access”. The regulations may also define or elaborate the meaning of “premises” by reference to the person or class of person who owns or occupies them and so as to include vehicles, vessels, trains and other means of transport (except aircraft). Section 4(8) allows the regulations to provide as to how the no-smoking notice statement is to be expressed in the case of each of the means of transport referred to in the regulations, allowing bespoke no-smoking signs to be created for each means of transport most appropriate to that particular form of transport.

Section 4(7) allows the Scottish Ministers to modify section 4(4) so that other kinds of premises may be added, or existing kinds removed. The effect of this would be to add to or remove from the kinds of premises which may be prescribed as “no-smoking premises” under section 4(2).

Again it is considered to be more appropriate for detailed provisions to be confined to subordinate legislation as requirements may change over time. Again, the Scottish Ministers intends to draft and consult on regulations as the Bill proceeds through Parliament, and the regulations will be subject to affirmative resolution procedure.

**Section 9 - Free oral health assessments and dental examinations**

<b>Relevant provision:</b>	<b>Amends section 70A(2) and 71 of the 1978 Act and section 20 of the NHS (Primary Care) Act 1997.</b>
<b>Powers conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act and section 39(4) of the 1997 Act).</b>

This section modifies current regulation making powers and excludes the power to make provision prescribing charges for oral health assessments and dental

examinations provided after 1 April 2006. . These provisions will allow for such dental checks to be provided free of charge under both general dental services and personal dental services (pilot and permanent arrangements).

### **Section 11 - Charges for certain dental appliances and general dental services**

<b>Relevant provisions:</b>	<b>Subsection (2) amends section 70 ; Subsection (3) amends section 70A(2); Subsection (5) repeals section 71A; and Subsection (6) amends paragraph 2 of Schedule 11.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Powers exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

This section amends existing regulation making powers and gives Scottish Ministers the power to make regulations regarding the way in which certain dental charges are made or recovered. Currently the patient charge for dental treatment and appliances is linked to the item of service fee paid to dentists and unless the patient is exempt or remitted from charges he/she pays 80% of that item of service fee. Breaking this link would provide more flexibility and transparency to the charging system. These provisions will allow for such flexible charging in both general dental services and personal dental services (pilot and permanent arrangements). The regulations will provide for a more flexible charging regime.

### **Section 15 - Lists of person undertaking to provide or assist in the provision of general dental services**

<b>Relevant provision:</b>	<b>New subsection (2) and (2B) substituted for section 25(2) to (2B) of the 1978 Act.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Powers exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

Currently, under section 25(2) of the 1978 Act regulations as to arrangements for the provision of general dental services shall provide for only those individual dentists who have undertaken to provide general dental services in a Health Board area to be included in a list prepared and published by the Health Board. New subsection (2) gives Scottish Ministers the power to make regulations to provide for a list in two parts, to provide for the listing of dental practitioners and dental bodies corporate who undertake to provide general dental services in the first part of the list and the listing of those who are approved to assist in the provision of general dental services in the area of the Health Board in a second part of the list.

By subsection (2A) such regulations may provide for matters that may be provided for in the preparation, maintenance and publication of the list including that the first part of the list be further sub-divided to distinguish, for example, those persons

who will not undertake to provide the full range of GDS. They may also include provision as to eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Health Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

New subsection (2B) gives Scottish Ministers the power to make regulations to provide that a person who assists in the provision of general dental services, and does not undertake to provide such services, in a Health Board area, cannot so assist unless he/she is on the second part of the list for that area.

There are already regulation-making powers in current section 25(2) and 25(2B), both subject to negative resolution and both providing a degree of flexibility for responding to changes. The provisions which substitute section 25(2) and (2B) similarly also contain regulation-making powers subject to negative resolution and this will also allow flexibility. For example, by subsection (2A)(c), the documents to be supplied on application or the procedure for applications to be made and dealt with may be changed or expanded in light of experience.

#### **Section 16 - Lists of persons performing personal dental services under section 17C arrangements or pilot schemes**

<b>Relevant provision:</b>	<b>Inserts a new section 17F(1) in the 1978 Act.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Powers exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

Section 17F(1) gives Scottish Ministers the power to make regulations providing that a person may not perform personal dental services, whether under permanent arrangements under section 17C of the 1978 Act or through pilot schemes, unless they are included in a list maintained by the Health Board. By section 17F(2), such regulations may also provide for matters that may be included in relation to such lists, including their preparation, maintenance and publication. They may also include provision as to eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Health Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

A regulation-making power subject to negative resolution is seen as the appropriate approach, rather than making provision in the 1978 Act itself, due to the flexibility of such a power to take account of changing circumstances. For

example, by subsection (2)(c), the documents to be supplied on application or the procedure for applications to be made and dealt with may be changed or expanded in light of experience.

### **Section 17 - Lists of person undertaking to provide or assist in the provision of general ophthalmic services**

<b>Relevant provision:</b>	<b>New subsections (2) and (2B) substituted for section 26(2) of the 1978 Act.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Powers exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

Currently, under section 26(2) regulations as to arrangements for the provision of general ophthalmic services shall provide for only those ophthalmic medical practitioners or opticians who have undertaken to provide general ophthalmic services in a Health Board area to be included in a list prepared and published by the Health Board. New section (2) gives Scottish Ministers the power to make regulations to provide for a list in two parts to provide for the listing of opticians and ophthalmic medical practitioners who undertake to provide general ophthalmic services in the first part of the list and the listing of those who are approved to assist in the provision of general ophthalmic services in the area of the Health Board in a second part of the list.

By subsection (2A), such regulations may provide for matters that may be provided for in the preparation, maintenance and publication of the list, including that the first part be further sub-divided to distinguish, for example, those who provide domiciliary visits to nursing homes and similar establishments. They may also include provision as to eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Health Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

New subsection (2B) gives Scottish Ministers the power to make regulations to provide that a person who assists in the provision of general ophthalmic services, and does not undertake to provide such services in a Health Board area, cannot so assist unless he/she is on the second part of the list for that area.

New section 26(2)(b) provides a power for Scottish Ministers to make regulations as to arrangements which include provision conferring on any person in accordance with a procedure prescribed by the regulations, a right to choose the medical practitioner or ophthalmic optician by whom his eyes are examined or his sight tested or from whom any prescription for the supply of optical appliances is to be obtained.



There are already regulation-making powers in current section 26(2) subject to negative resolution and providing a degree of flexibility for responding to changes. The provisions which substitute section 26(2) similarly also contain regulation-making powers subject to negative resolution. For example, by subsection (2A)(c), the documents to be supplied on application or the procedure for applications to be made and dealt with may be changed or expanded in light of experience.

**Section 18 - Health Boards' functions: provision and planning of pharmaceutical care services**

<b>Relevant provisions:</b>	<b>Inserts new sections 2D and 2E into the 1978 Act.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

This section inserts new sections 2D and 2E into the 1978 Act. These new sections places a duty on Health Boards to provide or secure the provision of pharmaceutical care services for persons in their area, and provide for the way in which Health Boards plan to discharge that that duty.

**New section 2D(3)**

This allows the Scottish Ministers to prescribe the information that must be published by a Health Board in relation to the pharmaceutical services provided or secured by that Health Board. The purpose of this is to make provision to ensure patients receive detailed information about the pharmaceutical care services available to them.

It is not thought appropriate that the Bill should specify the detailed information which requires to be published. It is considered appropriate that the Scottish Ministers should have the flexibility to amend the detail of the information to be provided in light of experience or other changes.

**New section 2D(5)**

This allows regulations to be made that set out what are and are not to be regarded as pharmaceutical care services for the purposes of the 1978 Act and which a Health Board has a responsibility to provide.

New section 2D(6) sets out examples of the sort of provision regulations under subsection (5) of that section may make. Sub-section (a) of this section allows Scottish Ministers to classify which pharmaceutical care services are to be classified as 'essential' and 'additional'. 'Essential' services are those that will be provided in accordance with nationally negotiated contract terms. The kinds of services that it is anticipated that the Regulations will be used for are as follows: for Essential it is expected that they will collectively comprise a chronic medication service; minor ailments service; acute medication service and a public health service. 'Additional' services will largely comprises services that are, as now,

negotiated locally, e.g. domiciliary oxygen therapy and methadone dispensing services.

Regulations under sub-section (b) of new section 2D(6) would detail the manner or circumstances in which the services will be provided. For example, regulations may prescribe that the chronic medication service will be provided to suitable patients who choose to opt for that service and will include patient medication reviews and counselling in accordance with agreed clinical protocols.

Regulations under sub-section (c) may provide that pharmaceutical care services may include for example the act of dispensing and that the prescribable and dispensable medicines and appliances will be specified in a list directed by Scottish Ministers. In this regard, new section 2D(7) requires Ministers to publish directions under regulations provided by section 2D(5) in a document to be known as the Drug Tariff. The Drug Tariff already exists and, inter alia, lists or details the drugs, medicines and appliances that can be ordered and dispensed as part of the provision of pharmaceutical care services. It is frequently necessary to amend the detail in the Drug Tariff and given this requirement it is considered that the most appropriate way of dealing with such matters is by means of direction.

Sub-section (d) of new section 2D(6) will, where the pharmaceutical care service includes the act of dispensing, detail the persons who can order medicines and appliances, e.g. a registered medical or dental practitioner, and provide for the circumstances in which those items may be ordered.

The above illustrates the sort of detailed provision that might be made under new sections 2D(5), (6) and (7), which it is thought demonstrates it is more appropriate for subordinate legislation.

### **New section 2E(1)**

This section allows regulations to provide for the way in which Health Boards should prepare and maintain a plan to discharge their duty at new section 2D(1) to provide and secure pharmaceutical care services for persons in their area

New section 2E(2) sets out examples of the sort of provision regulations under subsection (1) of that section may make and provides that they cover both substantive matters, under section 2E(2)(a) with regard to what the plan should identify and contain and, under subsections (b) to (g), procedural matters, such as the manner in which the plan should be prepared, kept under review, etc..

The need to prepare and maintain a pharmaceutical care services plan is a new duty for Health Boards and one where the matters to be taken into account and reviewed will be informed by practice and experience. It is expected that, initially at least, it will be necessary to amend the detail of such matters in light of experience of the new regime and, in the circumstances, subordinate legislation will give the required level of flexibility to respond to developments in an appropriate and timeous way.

New section 2E(3) provides that regulations under subsection (2)(a) to that section may be specified by direction. Subsection 2(a) lists examples of what a Health

Board pharmaceutical service plan should identify. It may be necessary to amend the detail of such matters in light of experience of operation of the new regime and to clarify any areas of uncertainty. Given the level of detail and the likely need for flexibility it is considered that the most appropriate way of dealing with such matters is by means of direction.

### **Section 19 - Pharmaceutical care service contracts**

<b>Relevant provisions:</b>	<b>Inserting new section 17R(1); Inserting new section 17S(1) and (2); Inserting new section 17U(1) and 4(b); and Inserting new section 17V(1) and (2) into the 1978 Act.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

Section 19 inserts new sections 17Q to 17V into the 1978 Act, replacing the existing sections on general pharmaceutical services arrangements. The new sections govern the terms and content of the pharmaceutical care service (PCS) contracts and who may provide or PCS under the contracts. They contain broad regulation making powers, which will be used to set out the detail of the rights and obligations under the new PCS contract. When making regulations under the new sections it is intended to replace the extensive and heavily amended NHS (Pharmaceutical Services) (Scotland) Regulations 1995.

#### **New section 17R(1)**

This section provides a power to set in regulations those services which must be provided under the contract - the essential services. New subsection (2) allows these services to be described by reference to the manner or circumstances in which they are provided. This power may be used for example to separate out of hours services from those provided during the normal daytime period. Currently section 27 to 28 of the 1978 Act, which are repealed by the Bill, allow for provision to be made in regulations defining the pharmaceutical services to be provided under general pharmaceutical services arrangements.

Subordinate legislation is considered more appropriate for this sort of detail than primary legislation. This is especially the case here as it may be necessary to amend the detail of such matters in light of experience of operation of the new PCS contract.

#### **New sections 17S(1) and (2)**

New section 17S(1) sets out the persons with whom a Health Board may enter into a PCS contract and confers power for the Scottish Ministers to prescribe the conditions that would apply in relation to a Health Board entering into a PCS contract with a contractor. The conditions may relate to the suitability of the contractor to hold a PCS contract: for example, that the persons or firms eligible to

provide PCS under the contract should not have been convicted of certain offences, or been disqualified from providing or performing NHS services.

New subsection (2) enables regulations to set out what effect a change in membership of a partnership is to have on a PCS contract which is with a partnership. The intention is to allow the membership of the partnership to change without requiring a new contract to be entered into merely because such a change in membership has taken place.

The matters in new section 17S(1) and (2) are considered to be more suitable for secondary legislation than primary legislation, given the level of detail required and the fact that there is a need for flexibility as new circumstances arise.

### **Section 17U(1) and (4)(b)**

Section 17U(1) confers a broad regulation making power on the Scottish Ministers allowing the imposition of further requirements that must be included in all PCS contracts.

Although there may be differences, in many respects it is intended that the regulations made under this section will cover areas that are similar to those currently set out in the NHS (Pharmaceutical Services) (Scotland) Regulations 1995.

Section 17U(2) sets out examples of the sort of provision regulations under subsection (1) of that section may make, which it is thought demonstrates it is more appropriate for subordinate legislation.

Section 17U(3) sets out details of the type of provision that might be made in regulations making the sort of provision suggested in subsection (2)(d) of that section, so that it is clear provision can be made about when a provider under a PCS contract can or must accept a patient and when they can end their responsibility to that patient.

Section 17U(4) expands on the sort of provision that might be made in regulations making provision of the sort envisaged in subsection 2(f) including clarification in subsection (4)(b) that such regulations may include provision allowing the suspension or termination of any duty under the contract in relation to services of a prescribed description.

Section 17U(5) further expands on the way in which services prescribed under section 17U(4)(b) might be prescribed i.e. by reference to the manner or circumstances in which they are provided.

It is clear that regulations made under 17U may contain considerable detail and that it may be necessary to amend the detail of those regulations from time to time. As a result, it is considered that the most appropriate way of dealing with such matters is by means of subordinate legislation.

### **New section 17V(1) and (2)**

Section 17V(1) creates a regulation making power to set national procedures for internal dispute resolution of disputes as to the terms of the proposed PCS contracts. The regulations may provide for the proposed terms to be referred to the Scottish Ministers and for the Scottish Ministers, or a person appointed by them, to determine what the terms of the contract should be. Regulations as to disputes as to the terms of an actual contract may be made under new section 17U(1) as explained in 17U(2)(j).

Section 17V(2) creates the regulation making power to enable the parties to a PCS contract to opt instead to have the contract treated as an “NHS Contract” entered into under existing section 17A for any purposes of that section.

Subsection 17V(4) provides for regulations to set out the application of section 17A in cases where a partnership elects to become a health service body; and where there is a change in the membership of the partnership.

It may be necessary to amend the detail of such matters in light of experience of operation of the new PCS contract. Given the level of detail and the likely need for flexibility it is considered that the most appropriate way of dealing with such matters is by means of subordinate legislation.

### **Section 20 - Persons performing pharmaceutical care services**

<b>Relevant provisions:</b>	<b>Inserting new section 17W(1) into the 1978 Act.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

#### **New section 17W(1)**

Section 20 inserts new section 17W(1) into the 1978 Act. The new section provides regulation-making powers governing the way in which persons performing pharmaceutical care services (PCS) are listed. The restructuring brought about by the Bill of the way in which PCS are secured or provided for by Health Boards amends the current listing arrangements that list the providers of pharmaceutical services and not those that perform the services. The current regulation making powers relative to listing are contained in existing section 27, all of which is repealed by the Bill.

The regulations made under subsection (1) of new section 17W may provide that registered pharmacists may not perform pharmaceutical care services unless their name appears on a list held by the Health Board as respects whose area they will work. For example, where (A) a Health Board employs a salaried pharmacist to perform PCS provided directly by the Board; or (B) where a PCS contract holder undertakes to provide pharmaceutical care services under a PCS contract as respects a Board’s area, the registered pharmacists performing PCS in both (A) and (B) would need to have their name included on the Health Board’s list in order to be permitted to do so.

Subsection (2) of the new section 17W sets out the issues that may be included in the regulations, showing the level of detail that will require to be included in the regulations. These include, for example, how the list will be drawn up and maintained; what criteria an individual will have to meet to qualify to be on the list; the process by which decisions on applications will be made and mandatory grounds under which a Health Board would have to reject an application.

Subsection (3) of the new section 17W, explains that regulations made under the powers in section 17W(1) as explained in 17W(2)(j), i.e. provision as to disclosure of certain information, may authorise the disclosure of information by a Health Board to the Scottish Ministers, or by the Scottish Ministers to a Health Board..

As can be seen from the matters mentioned at new section 17W(2), the arrangements for listing require a considerable level of detail. That and the need to be able to have flexibility mean that these matters are more appropriate for subordinate than primary legislation.

## **Section 22 - NHS Tribunal: disqualification by the NHS Tribunal**

<b>Relevant provision:</b>	<b>Section 22(2)(b) amending section 29(4)(b) of the 1978 Act; Section 22(3)(c) amending section 29A(5) of the 1978 Act.;</b> <b>Section 22(6) amending section 32(2) of the 1978 Act; and Section 22(7)(a) inserting section 32A(7) into the 1978 Act.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

Currently under section 29(4)(b) of the 1978 Act regulations may provide, in the case of certain representations to the NHS Tribunal, the time limits within which they must be made. The representations this applies to are ones in respect of a practitioner that the second condition for disqualification by the Tribunal is met, which is that of fraud. The amendment allows regulations to prescribe the time limit within which any representations that a condition for disqualification is met must be made.

By virtue of section 29A(5) of the 1978 Act, regulations may make provision securing that a practitioner who is subject to an inquiry by the Tribunal in a fraud case may not be added to any list of practitioners held by an Health Board until the proceedings have been concluded. The amendment is to the effect that, in the future, those subject to an inquiry in any case may be prevented by the terms of regulations from being added to any list.

Regulations under section 32(1)(a) may set out the procedures of the NHS Tribunal. By virtue of section 32(2) of the 1978 Act, they may provide that in a

case where representations are made to the Tribunal against the same person on grounds of efficiency and fraud, it may inquire into one case before another and may adjourn the other, if they think it appropriate, indefinitely. The Tribunal would otherwise be required under the Act to inquire into all representations by Health Boards. The power may be exercised to allow the Tribunal flexibility in inquiring into representations. The Bill adds a third condition for the disqualification of practitioners - that of unsuitability – and the amendment ensures that the regulations may take account of it.

Section 17P(1) of the 1978 Act provides that regulations may make provision as to suspension from a list of health care professionals who perform primary medical services. Amendments made to the 1978 Act in the Bill provide that regulations under section 25(2), section 26(2), new section 17F(1), and 17W(1) may make provision as to suspension from a list of those providing and approved to assist in the provision of general dental services, providing and approved to assist in the provision of general ophthalmic services, performing personal dental services and performing pharmaceutical care services respectively.

The new subsection allows regulations to provide that where a Health Board has suspended a person in accordance with regulations made under those provisions and makes representations to an applicant for interim suspension by the Tribunal, that suspension may continue until the Tribunal determine whether or not to direct interim suspension. Other regulations which make provision as to lists and suspension and the Tribunal are subject to negative resolution and that degree of scrutiny is also considered appropriate here.

### **Section 23 - NHS Tribunal: corresponding provision in England or Wales or Northern Ireland.**

<b>Relevant provision:</b>	<b>Section 23 inserting new section 32D of the 1978 Act.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

This section inserts new section 32D into the 1978 Act. Historically, certain decisions of the NHS Tribunals in England and Wales and in Northern Ireland under provisions in force there which correspond to provisions in force in Scotland have applied in Scotland also. At present section 31 deals with decisions outwith Scotland for the disqualification of practitioners while the present section 32D applies to decisions for their suspension. Section 31 is to be repealed and the new section 32D now provides that regulations may provide for the effect of decisions in other parts of the UK which correspond (whether or not exactly) to disqualifications and suspensions by the Tribunal in Scotland.

The provisions in force in England and Wales and Northern Ireland do not correspond exactly with the Scottish regime. The Tribunal in England and Wales has been abolished. The Family Health Services Appeal Authority now has the power to direct the national disqualification of practitioners but other decisions, including those dealing with conditional disqualification, can be taken by local

health authorities. There are other differences, for example, the sanction of local disqualification whereby a practitioner is disqualified from only the list or lists where his or her name is entered for the time being and not from all similar lists will in future not apply in Scotland. Accordingly the power allows the Scottish Ministers to provide in regulations for the effect to be given to a corresponding decision, which may include providing for the effect of decisions which correspond (whether or not exactly) with a decision on conditional disqualification to be determined in a manner prescribed in regulations by the Scottish Ministers.

A regulation making power is seen as the appropriate approach rather than making provision in the 1978 Act itself. For England and Wales many of the corresponding provisions are themselves in subordinate legislation and regulations will provide a degree of flexibility to be able to respond to changes in the future. Other regulations which make provision as to lists and the procedures of the Tribunal are subject to negative resolution and that degree of scrutiny is also considered appropriate here.

### **Section 25 - Independent health care services**

<b>Relevant provisions:</b>	<b>Section 25 amends section 2(5) of the 2001 Act.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament.</b>

This section amends Section 2 (5) of the Regulation of Care (Scotland) Act 2001. It provides Scottish Ministers with a power to make regulations which except services from the definition of an ‘independent healthcare service’ in the 2001 Act.

This power already exists for other care services defined in the 2001 Act where appropriate – see for example section 2(6) concerning “nurse agencies”. The current definition in the 2001 Act goes wider than the policy intention which was to regulate wholly private services. The power to except could be used, for example, to except from the definition services provided by a General Practitioner on behalf of a third party such as examinations for insurance companies.

It is thought that it is appropriate to except services by subordinate legislation as this allows flexibility to take account of changing circumstances. As noted above there is precedent in the 2001 Act for such a power and for regulations made in exercise of such a power to be subject to negative procedure.

### **Section 28 – Registration of child care agencies and housing support services**

<b>Relevant provisions:</b>	<b>Subsection (4)(e).</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Order made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament.</b>



Subsection (4)(e) gives Scottish Ministers the power to make an Order to substitute a later day for 1 April 2006.

The purpose of the power is to give Scottish Ministers the flexibility to extend the period of deemed registration of Housing Support services and Childcare Agency services should that prove to be necessary.

**Section 30 – Amendment of Adults with Incapacity Act 2000: authorisation of medical treatment**

<b>Relevant provisions:</b>	<b>Section 30(2)(b) and 30(2)(e)(ii) .</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament.</b>

These two provisions enable Scottish Ministers (a) to extend, if appropriate, the range of health professionals who may sign certificates of incapacity under the Act and (b) to prescribe the circumstances in which certificates of incapacity can extend beyond 1 year. This follows concerns that the current provisions were unduly restrictive and reflects the views obtained in a consultation exercise and discussion with key stakeholders.

It is considered that subordinate legislation is the most appropriate approach due to the flexibility of such a power to take account of changing circumstances. Similarly, the circumstances where a certificate of incapacity can be extended beyond 1 year may also require revision at a later date after experience has been gained in applying the approach. Regulations will be by negative resolution in accordance with section 86 of the 2000 Act, which should allow the appropriate degree of Parliamentary scrutiny.

**Section 33 - Ancillary provisions**

<b>Relevant provisions:</b>	<b>Section 33.</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Order made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative Resolution of the Scottish Parliament.</b>

Section 33 provides for Scottish Ministers to make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary for the purposes, or in consequence, of the Act.

**Section 37: Short title and commencement**

<b>Relevant provision:</b>	<b>Section 37(3)</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Order made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>No parliamentary procedure.</b>

Section 37 provides for the short title and commencement arrangements for the Bill.

Section 37(3) gives the Scottish Ministers power to appoint by order a day when the provisions of the Bill shall come into force. Section 37(4) explains that different days can be appointed for different purposes.

It is standard procedure for such commencement provisions to be dealt with by subordinate legislation. Whilst the order, in common with the usual practice for such orders, is not subject to any parliamentary procedure as such, the Subordinate Legislation Committee will have the opportunity to consider the instrument in terms of its remit.

### **Schedule 1 – Fixed penalty for offences under sections 1, 2 and 3**

<b>Relevant provisions:</b>	<b>Paragraph 2; Paragraph 4(1); Paragraph 5(2); Paragraph 12; and Paragraph 13 (a) and (c).</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers.</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Affirmative resolution procedure of the Scottish Parliament.</b>

Schedule 1 sets out the details of how the fixed penalty system, introduced by section 5, will work for offences committed under sections 1, 2 and 3 of the Bill.

Paragraph 2 gives the Scottish Ministers the power to set via regulations a time limit relating to the offence after which a fixed penalty notice may not be given.

Paragraph 4(1) allows the Scottish Ministers to prescribe by means of regulations the amount of the fixed penalty for an offence under section 1, 2 or 3.

Paragraph 5(2) allows the Scottish Ministers to prescribe by means of regulations the discounted amount for a fixed penalty offence. A lesser amount is payable by offenders, in terms of paragraph 6(1) where earlier payment is made.

Paragraph 12 allows the Scottish Ministers to make regulations about the application by councils of fixed penalties, also about keeping accounts and the preparation and publication of statements of account, relating to fixed penalties.

Paragraph 13 empowers the Scottish Ministers to make regulations prescribing the circumstances in which fixed penalty notices may not be given and the methods for payment of penalties. Paragraph 13 also allows the Scottish Ministers to modify paragraphs 4(2) and 5(1) of the Schedule so as to modify the period for payment of the fixed penalty and the period for when payment of the discounted amount is to be made to qualify for the discount respectively.

Once again, the detail of the provisions are such that it is more appropriate for secondary rather than primary legislation. Regulations made under the relevant provisions of Schedule 1 will again be subject to affirmative resolution by the Scottish Parliament.

**Schedule 2: Minor and consequential amendments.**

<b>Relevant provision:</b>	<b>Paragraph 1(7) amending section 32(1)(a) of the 1978 Act. Paragraph 1(9) amending section 32E(1) of the 1978 Act</b>
<b>Power conferred on:</b>	<b>The Scottish Ministers</b>
<b>Power exercisable by:</b>	<b>Regulations made by Statutory Instrument.</b>
<b>Parliamentary procedure:</b>	<b>Negative resolution of the Scottish Parliament (section 105(2) of the 1978 Act).</b>

Currently under section 32(1) regulations provide for the procedures to be followed by the Tribunal when it inquires into cases under sections 29 to 31 of the 1978 Act. Section 31 is repealed. The effect of the amendment is that the regulations will in future provide for inquiries under sections 29 to 30 to be held in accordance with such procedures as may be prescribed by or determined under regulations.

Currently under section 32E(1) regulations may provide for payments to be made to practitioners who are suspended in terms of section 32A(3) or 32D(2) dealing with suspension by the Tribunal in Scotland or under provisions in force in England and Wales or Northern Ireland respectively. The present section 32D(2) is substituted by the regulation-making power in new section 32D(3).

## APPENDIX 2

On 23 March 2005, the Committee asked the Executive for further explanation of the following matters:

### ***Section 4(2) and 4(7): Meaning of “smoke” and “no-smoking premises”***

1. The Committee notes that the bill creates offences of smoking or permitting smoking in no-smoking premises and that what constitutes no-smoking premises is left entirely to regulations made under section 4(2) and 4(7). The Committee appreciates the need for the definition of no-smoking premises and exemptions to be contained in regulations rather than on the face of the bill, in order to provide the necessary flexibility. The Committee, however, is concerned that draft affirmative procedure simply allows for the approval or rejection of an instrument in its entirety and in this instance would propose that any regulations should be subject to further scrutiny. The Committee has in the past proposed “super-affirmative” procedure for some regulation-making powers, whereby the Executive would lay its proposals in draft for consultation with the Parliament before a draft instrument was laid. The Committee considers that in this instance it would be useful for the Parliament to consider and debate proposals for the definitions of no-smoking premises before a draft instrument is laid and asks the Executive for its comments.

### ***Section 11: Charges for certain dental services***

2. The Committee considered that although the existing powers are similarly subject to annulment there are certain constraints on their use. The Committee considered that there is no such limitation to the new powers in this bill and therefore questioned whether annulment provides the correct level of parliamentary scrutiny. The Committee considered that the changes could be of sufficient importance to merit the first substantive exercise of the powers as amended being subject to affirmative procedure. The Executive is asked to comment.

### ***Section 18: Health Boards’ functions: provision and planning of pharmaceutical care services***

3. The Committee considered that the new direction making powers in section 2CA(7) of the Drug Tariff should perhaps be incorporated in a more formal document subject to parliamentary scrutiny. In the case of directions under section 2CB(3) the Committee again examined the question of whether the relevant criteria should be incorporated in a more formal document subject to Parliamentary scrutiny. The Executive is asked to comment.

### ***Section 24: Payments to certain persons infected with hepatitis C as a result of NHS treatment***

4. Although there is a requirement for Ministers to publish the scheme, the Committee asks the Executive for comment as to why it has chosen that the scheme should not be subject to some form of Parliamentary scrutiny.

**Section 28: Registration of child care agencies and housing support services**

5. The Committee questioned whether the power to amend the date specified in the bill by subordinate legislation, subject to negative procedure, provides the correct level of scrutiny given that this is a Henry VIIIth power. The Executive is asked to comment.

**The Scottish Executive responded as follows:**

**Section 4(2) and 4(7): Meaning of “smoke” and “no-smoking premises”**

1. I understand that there is still some question as to the detail of what might comprise the additional scrutiny procedure proposed as “super-affirmative”. The Minister for Parliamentary Business last year expressed continuing reservations on the issue, but undertook to review the position in light of any clarification of what the Committee envisaged a super-affirmative procedure would look like, the sort of circumstances and criteria that might justify its use and the sort of benefits that might be anticipated. Ministers would wish to examine the detail of the proposed additional scrutiny procedure to enable them to provide a fully informed response to any suggestion by the Committee that the procedure be invoked in relation to any specific regulations.

2. As regards the specific question of invoking such an additional scrutiny procedure in relation to the regulations to be made under section 4(2) and (7) of the Smoking, Health and Social Care (Scotland) Bill, Ministers appreciate that the definition of “no-smoking premises” under the regulations is an important element of the new no-smoking regime and on that basis are happy to accept that such a definition should be subject to some form of additional scrutiny. However, the draft regulations are currently out to wide public consultation for this very purpose and I am sure that the Health Committee, and indeed all MSPs, will take this opportunity to consider and comment on the detail of the way in which these sections of the Bill would operate.

**Section 11: Charges for certain dental services**

3. At the present time the level of dentists’ remuneration is linked to patient charges. Section 71 of the 1978 Act provides a regulation making power in respect of charges for general dental services (GDS). Section 71A makes provision on the calculation of charges for dental appliances and treatment.

4. In terms of certain constraints on existing powers it is assumed that the Committee is referring to section 71A (4) and (5). While the provisions as amended do not contain any express constraint that Ministers shall not provide for a charge which exceeds the amount which Scottish Ministers consider to be the cost to the health service of the dental service supplied or provided, Ministers shall, of course, not exercise the power in that way nor authorise any charges that appear to them to be inappropriate.

5. To date the negative resolution procedure has worked well for governance of dental charges and other NHS charges and in balancing the need for administrative flexibility with parliamentary scrutiny. Accordingly, the Executive does not consider that a sufficient case is made for making the powers, as amended, subject to affirmative resolution procedures in relation to the first or any particular exercise of them.

***Section 18: Health Boards' functions: provision and planning of pharmaceutical care services***

6. Section 2CA(7) requires Ministers to publish directions under regulations provided by section 2CA(5) in a document to be known as the Drug Tariff. The Drug Tariff already exists and is provided for at regulation 9 of the NHS (Pharmaceutical Services) (Scotland) Regulations 1995. Amongst other things, the Tariff lists and details the drugs, medicines and appliances that can be ordered and dispensed as part of the provision of pharmaceutical care services. It is a lengthy (over 400 pages) and largely technical document that is published quarterly but, by necessity, subject to monthly review and amendment as and where appropriate. Against this background we continue to consider that the most appropriate way of dealing with the provision made at 2CA(6)(c), as qualified by 2CA(7), is by means of direction, which is in line with current practice with regard to the Drug Tariff. In addition this level of scrutiny is consistent with the existing level of scrutiny for the Drugs Tariff.

7. In new section 2CB(2) lists what are currently considered to be the most important criteria that should be listed in regulations and thereby subject to scrutiny by the Parliament. The intention is, where necessary, to add detail to those main criteria. It is important that in working to the stated criteria, that Health Boards work to a common database in assessing and determining the relative pharmaceutical care service needs. The intention is that the direction will be used to provide, or point to, the data on which the plan must be developed. For example, they should all work to the same set of population statistics and the same categories and descriptors of epidemiology of disease or service, and they should all report using the same units of measure, e.g. the number of prescriptions for condition [X] dispensed per [10,000] of the population. As is evident, this data is of a technical nature. Additionally, the sources and measure of the data will be subject to review and change in light of practical experience. On this basis we continue to consider that this level of detail, required to support the main plan criteria stated in regulations, renders it appropriate to directions.

***Section 24: Payments to certain persons infected with hepatitis C as a result of NHS treatment***

8. Following the advice of the Expert Committee led by Lord Ross, it was agreed by the four UK administrations in 2003 that a single UK wide scheme would be established to provide ex-gratia payments to qualifying persons who had been infected with Hepatitis C through contaminated blood products. Cabinet approved the allocation of £15 million as Scotland's contribution to the fund, taking account of other pressures on the NHS budget. The Skipton Fund Limited was

established by the Department of Health (England) as a limited company to administer the scheme on a UK wide basis on behalf of the four administrations.

9. In order to promote the efficient operation of the scheme, it was agreed that DH England would assume responsibility for the administration and funding of the scheme on behalf of all the administrations.

10. Section 24(1) of the Smoking, Health and Social Care (Scotland) Bill provides specific statutory cover for the making of payments under the scheme. Subsection (2) of that section also prescribes certain matters which must be included in any scheme, such as the procedure to be followed in making a claim under the scheme and how claims are to be determined. Scottish Ministers remain accountable to the Scottish Parliament for all payments made to the Skipton Fund, and this is reflected in section 24(4) of the Bill. The use of funds by the Skipton Fund will additionally be subject to scrutiny by the Scottish Executive via the usual auditing and accounting controls. Nevertheless, the scheme remains a non-statutory, ex gratia arrangement entered into jointly by the four administrations.

11. In light of all of the above, it is felt that an appropriate level of scrutiny is assured.

### ***Section 28: Registration of child care agencies and housing support services***

12. Section 28 of the Bill is concerned with persons providing certain child care agencies and housing support services (as defined under the Regulation of Care (Scotland) Act 2001) on 1 April 2003 who were deemed to have their service registered with the Care Commission until 30 September 2003. Where a provider did not make an application to the Care Commission for registration before 1 October 2003 or did not have their application granted by 1 April 2004 their deemed registration lapsed and continuation of the service was unlawful. The effect of section 28 is that where such a person applied for registration by 30 September 2004, they are to be treated as if their deemed registration had not lapsed and, subject to the earlier occurrence of certain events, they are deemed to be registered until 1 April 2006. Section 28 of the Bill also provides that, where, before 1 April 2006, the application for registration is granted or refused, registration is cancelled, or if the provider ceases providing the service, the deemed registration ceases on the date that happens.

It is not anticipated that it should be necessary to extend the deemed registration period beyond 1 April, 2006, however the use of the provision in section 28(4)(e) of the Bill is thought necessary to ensure that, if for any reason, the Care Commission is unable to process all relevant applications before 1 April, 2006, the Scottish Ministers can extend the date without the need for further primary legislation. It is considered that the use of negative procedure is appropriate for two reasons. Firstly, the scope of the power is extremely limited and, secondly, taking into account the Parliamentary time required for affirmative procedure, it affords the Scottish Ministers more time to extend the period were unforeseen difficulties in processing by the Care Commission to arise at the last minute.

## **HEALTH COMMITTEE STUDY VISIT TO IRELAND 7 – 9 FEBRUARY 2005**

### **Background**

In order to help inform its consideration of proposals for a ban on smoking in certain wholly enclosed public places, contained in the Smoking, Health and Social Care (Scotland) Bill, the Health Committee undertook a study visit to Ireland in February 2005.

The study visit involved a series of meetings in Galway and Dublin, focussing on the decision to institute a workplace smoking ban across Ireland and the subsequent implementation of the ban.

The Irish smoking ban was introduced on 29 March 2004.

Attached at Appendix A is a list of organisations and individuals with whom the Committee met. This report lists the key issues raised with members in these meetings.

### **Vintners' Federation of Ireland (Galway)**

The Vintners' Federation of Ireland (VFI) was established in 1973 from a number of smaller associations for the protection and betterment of the livelihood of the individual publican and currently has approximately 6,000 members.

During their presentation and in response to questions from Committee members, VFI representatives raised the following points:

- Pub owners are concerned about the cumulative impact on business of a series of recent policy and regulatory changes, including:
  - More vigorous enforcement of drink-driving regulations;
  - Increases in excise duty;
  - New rules in relation to the granting of licenses allowing access for children (under 18s are no longer allowed in bars after 9pm); and
  - The workplace smoking ban.These factors taken together, rather than the smoking ban alone, are considered to have had a negative impact.
- Pub owners are similarly concerned that they had previously been expected to invest in expensive ventilation equipment which they had anticipated would obviate the need for further restrictions on smoking in their premises.
- The smoking ban is exacerbating increased competition from supermarkets and other outlets in terms of the off-sales market.
- Anecdotal evidence exists that the ban had:
  - made elderly drinkers feel most disadvantaged;



- increased the amount of drinking and socialising at home thereby increasing children's exposure to alcohol and passive smoke;
  - had a differential economic impact on rural pubs, with a number either closing or opening for fewer hours during the week; and
  - had a differential economic impact on those pubs which did not have the space to erect an outside 'smokers' shelter'.
- In some areas local councils have accommodated pubs with no external property, by renting pavement space to allow out-door tables.
  - Anecdotal evidence was offered by one pub proprietor of a fall in drink sales of up to 25%. This had been partially, but not totally, offset by increased food sales.
  - A different proprietor indicated that his customer numbers had fallen by between 5 and 10% during the week. Little change in numbers had been experienced with regard to weekend trade.
  - While a number of pub proprietors are seeking to diversify, this has not been possible for all and has resulted in mixed outcomes.
  - Proprietors have received a mixed response to the ban from tourists.
  - Concern was expressed that pub proprietors can be fined under the legislation not only if a patron was caught smoking, but also if evidence was found that smoking had occurred or if their outside premises were found to be littered with cigarette butts.

### **Health Service Executive, Western Area (Galway)**

In their presentations and in response to questions from Committee members, Health Service Executive, Western Area representatives raised the following points:

- In advance of the smoking ban a series of acts were passed to limit smoking, including:
  - Tobacco (Health Promotion & Protection) Act, 1988 – which restricted tobacco sales and established a framework for regulations which restricted consumption in certain areas; Tobacco (Health Promotion & Protection) Regulations, 1995 –which prohibited smoking in cinemas, taxis, bus, schools, bingo and health centres and restrictions on smoking in restaurants, cafés, canteens; and
  - The Health (Misc. Provisions) Act, 2001 – which raised the smoking age from 16 to 18 year olds and aimed to prevent underage sales of cigarettes.
- A number of local pre-ban initiatives were also taken by the Western Health Board (now known as the Health Service Executive, Western Area) including:

- A range of research work on the health impact of environmental tobacco smoke;
  - 'Breathe Easy Bars' and 'Smoke Free Dining' initiatives;
  - Introduction of Smoke Free Schools & School Buses; and
  - Test purchasing campaigns which led to legal proceedings for non-compliance.
- Immediately prior to the 2004 workplace smoking ban a number of measures were taken, including:
    - The distribution of information packs to all licensees by the Office of Tobacco Control (OTC), containing the signage which needed to be displayed, workplace policies, information on how the ban would operate and procedures for what to do if someone is caught smoking;
    - 'Smoke Free At Work' TV & radio adverts;
    - Introduction of a national 'lo-call' compliance line;
    - Commissioning of permanent signage;
    - Briefing sessions / staff meetings;
    - Overtime agreement for Environmental Health Officers (EHO) who carry out inspections;
    - Agreement of a letter of demarcation between local authorities and health boards (on responsibilities for enforcement);
    - Development of tobacco returns software;
    - Development of an inspection protocol and inspection record; and
    - Development of a health and safety statement for inspection staff.
- During the initial implementation process the target was to inspect each licensed premise in the area twice within the first six months – with at least one inspection taking place out of hours.
  - A number of problems of definition were apparent in the early months of the ban, including the definition of 'compliance' and 'outdoor area'.
  - In 2004 the Western Health Board received 56 complaints (30 of which arose in the first 3 months) mainly regarding the hospitality sector. To date the WHB has pursued two complaints through legal proceedings: 1 regarding outdoor areas and 1 regarding after hours smoking.
  - The 2004 the WHB carried out a total of 2036 inspections in the Mayo (licensed premises -1017 visits; hotels-102 visits; and restaurants- 175 visits).
  - Inspection Compliances/Smoking Compliance – Mayo:
    - 76% licensed premises compliant;
    - 91% hotels compliant; and
    - 98% restaurants compliant.
  - Inspection Compliances/Smoking Compliance – Galway city:
    - 89% licensed premises compliant;
    - 95% hotels compliant; and
    - 94% restaurants compliant.

- The Health Service Executive, Western Area estimates the following costs associated with enforcement (in the Mayo area):
  - Overtime allocation of €18,000;
  - Overtime spending €19,000; and
  - Around a 20% decrease in food control activities.
- Smoke Free at Work Compliance Line (LoCall 1890 333 100) received 92 complaints and 7 queries for the Galway area. Information taken from the compliance line is given to the Senior Environmental Health Officer in each area for follow-up.
- Enforcement cases:
  - **Connemara Pub** - An anonymous complaint was received by EHO on 16 April 2004 regarding a bar and function room in the remote Ghaeltacht area. The complaint was that the previous night there had been many smokers in the pub. EHO visited the premises on the 20th April 2004 and found cigarette butts on the function room floor, ashtrays in the dishwasher and an absence of signage. The EHO issued a verbal warning to the person in charge followed by a formal written warning. The premises were re-inspected on the 14th May, 2004 at 9.50pm, when 3 people were found to be smoking at the bar counter and 2 ashtrays were found on bar counter (containing 5/6 butts). This resulted in a court hearing on 20 July, 2004. Owners pleaded guilty but argued that they had taken reasonable steps to prevent smoking. The evidence of active smoking and ashtrays was significant. The Connemara pub was fined €1200 and costs of €500.
  - **Fibber Magees Pub** - The most high profile case receiving national and international press coverage was Fibber Magees in Galway. The proprietor called for mass non-compliance. It was seen as a serious challenge to the legislation and to the authority of the State. The Attorney General became involved and a High Court Injunction was issued. The proprietor was fined €6,400 and cost of €3,000.
- A number of premises are exempt from the ban due to a fear of constitutional challenge, including: hotel bedrooms; nursing homes; non-acute, long stay facilities including community nursing units, community hospitals, welfare homes, district hospitals and former county homes; residential facilities for people with physical, intellectual and sensory disability; and psychiatric hospitals. However, psychiatric units attached to acute hospitals are not exempt.
- Premises exempt from the smoking ban are covered by:
  - Department of Health and Children Guidance Document;
  - Health and Safety at Work Act;
  - Common law duty of care; and
  - Are under no obligation to permit smoking or provide smoking areas.

- A number of problematic areas are apparent, including:
  - Outdoor shelters (a guidance document now being drafted);
  - Growth in incidence of after hours smoking;
  - Pubs which are compliant have been losing customers to non-compliant pubs; and
  - Taxis and hackneys - difficult to determine when a taxi becomes a workplace – for example when a taxi driver is on the way home from work in his taxi can he smoke?
  
- A number of post ban initiatives are being taken by the Health Service Executive, Western Area including:
  - “Towards a Tobacco Free West” Policy on Tobacco Risk Reduction;
  - EHO Compliance building in health care premises, school buses, etc;
  - Enforcement in relation to, underage sales, non-compliant workplace areas and facilities etc; and
  - A series of ongoing research activities on impact at work and in the home.
  
- Galway Hospitals have implemented a smoke-free hospital policy since 2003 – part of a national initiative, the ‘Minimum Standard Smoke-Free Hospital Policy’ launched by the Health Minister. The policy has the following features:
  - Strong endorsement by the Health Minister;
  - Part of the European Smoke-Free Hospitals Network;
  - Developed through a process of consultation and consensus, with an incremental approach;
  - Built on and improved implementation of earlier prohibition of smoking in hospital settings;
  - Long-term goal to achieve a totally smoke-free environment in hospital settings;
  - Implementation guided by a multidisciplinary Committee involving representatives from: nursing management, human resources, health promotion, environmental health, senior management, and the unions, as well as a consultant cardiologist, a smoking cessation officer, a staff nurse and a porter. This Committee developed and monitored the implementation of a ten-step action plan
  
- Smoking is permitted in hospital grounds and the health authorities provide ‘gazebos’ for the use of staff and patients.

**Minister of State at the Department of Health and Children (Dublin)**

In discussion with the Committee the Minister and his accompanying official raised the following points:

- There has also been a cultural shift in Ireland, it is becoming increasingly like the rest of Western Europe with a move away from entertainment and drinking being centred on the pub to being focused on drinking at home.

While there is an acknowledged economic downturn in the hospitality industry, the decline started before the smoking ban in enclosed workplaces was introduced.

- Compliance rates for the smoking ban have been very high. There have been isolated incidents of challenges to the ban including Fibber Magee's in Galway, but this was dealt with effectively by the authorities. Publicans want consistency and a level playing field.
- Introducing the legislation as a workplace health and safety measure defused some of the opposition to the ban.
- Cigarette sales decreased in Ireland by 10% in 2003 and 17% in 2004. This has led to a decrease of over €100 million in the revenue generated from cigarette sales. While Ireland has the third highest cigarette prices in Europe after Norway and the UK, the market for the illegal trade of cigarettes in Ireland is thought to be very small.
- Cross-party support for the ban, together with support from a range of voluntary organisations and trade unions, played an important part in enacting the legislation.

Responding to a range of questions, the Minister:

- Indicated that he did not think the fall in legal sales of cigarettes had been distorted by an increase in illegal sales;
- Acknowledged that urban pubs generally have a higher turnover than rural pubs and therefore have more scope for investing in outdoor areas (where space is available);
- Indicated that, despite the Health Service Executive Western Area having raised the issue of a fall in food inspections resulting from new responsibilities for environmental health officers in relation to the smoking ban, he had not received any representations on this matter;
- Acknowledged that limited work had been undertaken to assess the economic impact of the ban;
- Suggested that the ban had not led to a big increase in the number of job losses, while acknowledging that students and casual workers are the groups most likely to have been affected by employment changes in the hospitality/pub sector. Information on the impact on these groups is difficult to measure as they are often not officially registered as employees and are therefore underrepresented in official figures; and
- Indicated that there had been little experience of smokers using pubs across the border as a consequence of the ban (partly because the border is heavily policed, there is an increased emphasis on enforcement of drink

driving legislation and journeys would often require a round trip of up to 15 miles).

## **IMPACT (Dublin)**

IMPACT (the Irish Municipal, Public and Civil Trade Union) is the largest public sector trade union in the Republic of Ireland, with over 40,000 members in health, local government, education, the civil service, state-owned companies, telecommunications, aviation, and the voluntary and community sector. IMPACT organises the environmental health officers who are responsible for enforcing the smoking ban.

The IMPACT representative raised the following points:

- Up until around 3 years ago trade unions in Ireland supported a voluntarist approach to tackling environmental tobacco smoke in the workplace.
- A number of key factors in place before the ban were important in its successful implementation, including:
  - The strong health case made to the public;
  - A determined Health Minister;
  - The role played by the Office of Tobacco Control;
  - Cross party political consensus;
  - Strong support from civic society (voluntary sector, trade union and employers' organisations);
  - Intervention from the Health and Safety Authority (in the form of an authoritative report on the dangers of ETS, the inadequacy of ventilation and the particular hazards for bar workers); and
  - Strong public support (60% when the ban was first proposed)
- A number of key factors are important in the implementation and enforcement of the ban, including:
  - Relatively significant levels of fines;
  - The cumulative nature of fines for repeat offences;
  - Signage requirements in the legislation; and
  - Environmental health officers' approach – seek to support compliance rather than punish non-compliance.
- The trade unions generally accept that there has been some economic impact on business arising from the ban but, as yet, there are no conclusive figures on this in the public domain. They consider that the health and safety of their members should take precedence over the potential economic impact of the policy.
- There are outstanding concerns about lack of adequate protection for those working in exempt workplaces (such as prisons and residential care homes).

## **Dáil Select Committee on Health and Children**

A range of opinions on the smoking ban were expressed by individual members of the Dáil Select Committee on Health and Children:

- Several members claimed that the smoking ban has saved publicans money previously spent on cleaning. There were now no cigarettes or ashtrays to clean up and there had been a reduction in the frequency with which wallpaper, carpets and upholstery in pubs require to be replaced.
- One member of the Dáil Committee believed that the Gallagher tobacco group cutting 80 jobs at its plant in Lisnafillan outside Ballymena, Co Antrim was a direct result of the ban.
- It was suggested that the ban was in part responsible for increasing the number of women drinking in the home. It was suggested that women, in particular, did not like smoking in outdoor areas or pub doorsteps.
- One Dail Committee member empathised with smokers, highlighting that many now feeling like they are being treated as second class citizens. Smokers are exposed to the elements by having to stand outside pubs and suggestion was made that facilities need to be improved with regulation of outside areas becoming less stringent.
- One Dail Committee member believed that had more publicans introduced ventilation it would have been harder to impose the ban.

## **Office of Tobacco Control**

The Office of Tobacco Control (OTC) is a non-departmental public body which was set up to assist the Minister for Health and Children in the implementation of policies and objectives of the Government on the control and regulation of tobacco products. They are also responsible for coordinating the national inspection programme in cooperation with the health boards. The OTC employs 14 people.

In discussion with members of the Health Committee, the OTC's representative raised the following points:

- The national compliance figure for the first six months of the smoking ban was 94%. Compliance figures take account of the prohibition of smoking in workplaces and the regulations which allow the provision of outdoor smoking areas.
- The OTC considers that the health debate in relation to passive smoking in enclosed places has been settled through the publication of a number of reports – comparative studies looking at smoking related health issues and levels of exposure to environmental tobacco smoke in Northern Ireland and the Irish Republic are now underway.

- A significant amount of effort was invested in public awareness campaigns in advance of the ban – particularly, the public was encouraged to recognise public houses as workplaces as well as places to socialise. The campaign brought together public health issues with issues of health and safety in the workplace.
- After the announcement of the smoking ban in 2003 the OTC began to consider what information and advice it would require to issue to employers. In advance of the ban an information pack and materials for public display were issued to owners of licensed premises. Advice was also issued on ‘reasonable steps’ to be taken to avoid smoking.
- A number of provisions in the smoking legislation are yet to be implemented. For example, provisions for banning point of sale tobacco advertising are yet to be signed off by the Minister and are currently being challenged by the tobacco industry.
- Over the counter tobacco sales are falling in Ireland. Health education, increased prices and the impact of the ban have all influenced this position.
- The OTC has undertaken limited work on assessing the economic impact of the smoking ban.

**March 2005**



**Health Committee Study Visit to Ireland**

**Programme of Meetings**

**Vintners' Federation of Ireland**

Terry Tyson, Galway City Chairman, accompanied by local publicans.

**Health Service Executive, Western Area**

Seamus Mannion, Regional Manager Community Services;  
Paul Hickey, Senior Environmental Health Officer, Galway;  
Siobhain Honan, Environmental Health Officer, Mayo;  
Irene O'Byrne, Smoking Cessation Officer, UCHG; and  
Michelle Spellman, Assistant Staff Officer, Community Services.

**Sean Power TD, Minister for State, Department of Health and Children**

Accompanied by Eamon Corcoran, Principal Officer, Public Health Division,  
Department of Health and Children.

**IMPACT**

Bernard Harbour, National Secretary.

**Dáil Select Committee on Health and Children**

Dr. Jimmy Devins, Fianna Fail, Committee Vice-Chairman, accompanied by  
various members and the Committee Clerk

**Office of Tobacco Control**

Ray Mitchell, Acting Chief Executive, accompanied by Gearoid O'Dufaigh,  
Assistant Principal, Tobacco Control Unit, Department of Health and  
Children

**ANNEX B: EXTRACT FROM MINUTES**

**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**29th Meeting, 2004 (Session 2)**

**Tuesday 7 December 2004**

Present:

Roseanna Cunningham (Convener)  
Helen Eadie  
Kate Maclean  
Shona Robison  
Jean Turner

Mr David Davidson  
Janis Hughes (Deputy Convener)  
Mr Duncan McNeil  
Mike Rumbles

The meeting opened at 2.01 pm

1. **Items in private:** The Committee agreed to take item 5 in private.
5. **Proposed health bill (in private):** The Committee considered arrangements for its consideration of the bill.

The meeting closed at 3.38 pm.

**Simon Watkins**  
Clerk to the Committee

**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**1st Meeting, 2005 (Session 2)**

**Tuesday 11 January 2005**

Present:

Roseanna Cunningham (Convener)  
Helen Eadie  
Kate Maclean  
Shona Robison  
Jean Turner

Mr David Davidson  
Janis Hughes (Deputy Convener)  
Mr Duncan McNeil  
Mike Rumbles

The meeting opened at 2.00 pm

1. **Smoking, Health and Social Care (Scotland) Bill:** The Committee received a briefing on the Bill at Stage 1 from the following Scottish Executive officials—

Roderick Duncan, Tobacco Control Division, Bill Team Leader

Part 1 – Prohibition of smoking in certain wholly enclosed spaces

Colin Cook, Head of Substance Misuse Division

Mary Cuthbert, Tobacco Control Division, Team Leader;

Part 2 – General dental services, general ophthalmic services and personal dental services

Eric Gray, Primary Care Division, Team Leader, Dental and Ophthalmic Services, Fraud and Disciplinary Team

Dr Hamish Wilson, Head of Primary Care Division;

Part 3 – Pharmaceutical care services

Chris Naldrett, Primary Care Division, Team Leader, Pharmacy Issues Team

Dr Hamish Wilson, Head of Primary Care Division;

Part 4 – Discipline

Richie Malloch, Workforce and Policy Division, Team Leader, General Medical Services Team

John Davidson, Workforce and Policy Division, General Medical Services Team;

Dr Hamish Wilson, Head of Primary Care Division;

Part 5 – Miscellaneous

*Infection with hepatitis C as a result of NHS treatment*

Sylvia Shearer, Health Planning and Quality Division, Team Leader, Blood Transfusion Services Branch;

Andrew MacLeod, Head of Health Planning and Quality Division;

*Amendment of Regulation of Care (Scotland) Act 2001 and child care agencies and housing support services*

Adam Rennie, Head of Community Care Division 2

Diane White, Social Work Services Policy Division, Training and Development Team

Stephen Sandham, Regeneration, Fuel Poverty and Supporting People Division, Head of Branch;

*Authorisation of medical treatment*

Jim Brown CBE, Head of Public Health Division; and

*Joint ventures and Scottish Hospital Endowments Research Trust*

Mike Baxter, Property and Capital Planning Division, Team Leader, Private Finance and Capital Unit

Dr Hamish Wilson, Head of Primary Care Division

Patrick McGrail, Community Care Division 2, Joint Future Team

Mike Stevens, Deputy Director, Chief Scientist Office.

Executive officials agreed to provide supplementary information on the financial efficiency of NHS joint ventures in England and Wales including NHS Lift projects in St Helens and Liverpool.

The meeting closed at 4.01 pm.

**Simon Watkins**  
Clerk to the Committee

**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**3rd Meeting, 2005 (Session 2)**

**Tuesday 25 January 2005**

Present:

Roseanna Cunningham (Convener)  
Helen Eadie  
Mr Duncan McNeil  
Jean Turner

Mr David Davidson  
Janis Hughes (Deputy Convener)  
Mike Rumbles

Apologies: Kate Maclean and Shona Robison

The meeting opened at 2.01 pm

1. **Items in private:** The Committee agreed to take item 4 in private.

4. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered its approach to evidence taking at Stage 1.

The meeting closed at 4.08 pm.

**Simon Watkins**  
Clerk to the Committee

**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**5th Meeting, 2005 (Session 2)**

**Tuesday 22 February 2005**

Present:

Roseanna Cunningham (Convener)	Helen Eadie
Janis Hughes (Deputy Convener)	Kate Maclean
Mr Duncan McNeil	Mrs Nanette Milne
Shona Robison	Mike Rumbles
Jean Turner	

The meeting opened at 2.16 pm

- 2. Items in private:** The Committee agreed to take items 5 and 6 in private.
- 4. Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from—

Dr Iain Wallace, Medical Director, Primary Care Division, NHS Greater Glasgow

Mary Morton, Acting Chief Pharmacist, NHS Highland

Catherine Lush, Clinical Dental Manager, NHS Highland

Martyn Evans, Director, Scottish Consumer Council

Joyce Shearer, Voluntary Member, Fife Local Health Council

Andrew Lamb, National Director, British Dental Association

Hal Rollason, Chairman, Optometry Scotland

James Semple, Chairman, Scottish Pharmaceutical Federation

Alex MacKinnon, Head of Professional Services Development, Scottish Pharmaceutical General Council

Dr Hamish Wilson, Head of Primary Care Division, Scottish Executive Health Department

Eric Gray, Primary Care Division, Team Leader, Dental and Ophthalmic Services, Scottish Executive Health Department

Chris Naldrett, Primary Care Division, Team Leader, Pharmacy Issues Team, Scottish Executive Health Department

Executive officials agreed to provide supplementary evidence on whether the Bill requires individuals currently listed as dental, ophthalmic or pharmaceutical practitioners to disclose information for inclusion in the proposed extended lists.

In addition, Executive officials stated that the regulations on the contract for pharmacists would be available in draft for the Committee's Stage 2 consideration of the provisions on pharmaceutical care services.

5. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered the main themes arising from the evidence session.

The meeting closed at 4.27 pm.

**Simon Watkins**  
Clerk to the Committee

**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**6th Meeting, 2005 (Session 2)**

**Tuesday 1 March 2005**

Present:

Roseanna Cunningham (Convener)  
Janis Hughes (Deputy Convener)  
Mr Duncan McNeil  
Shona Robison  
Jean Turner

Helen Eadie  
Kate Maclean  
Mrs Nanette Milne  
Mike Rumbles

The meeting opened at 2.02 pm

1. **Items in private:** The Committee agreed to take agenda items on its eating disorders inquiry and its workforce planning chamber event in private. The Committee also agreed to consider themes arising from evidence on the Smoking, Health and Social Care (Scotland) Bill in private.
3. **Smoking, Health and Social Care (Scotland) Bill:** The Committee agreed to delegate responsibility to the Convener for the approval of witness expenses arising from the Committee's consideration of the Bill at Stage 1.

The Committee took evidence from—

Part 4 Discipline

Stewart Scott, Chair, Borders Local Health Council  
Margo Biggs, Member, Forth Valley Local Health Council  
Alex Matthewson, North Branch Representative, BDA Scottish Council  
Dr David Love, Deputy Chairman, BMA Scotland  
Hal Rollason, Chairman, Optometry Scotland  
Angela Timoney, Chairman, Scottish Executive, Royal Pharmaceutical Society of Great Britain  
Dr Hamish Wilson, Head of Primary Care Division, Scottish Executive Health Department  
John Davidson, Workforce and Policy Division, General Medical Services Team, Scottish Executive Health Department

Scottish Executive officials agreed to provide supplementary information on: the number of cases which have been considered at NHS tribunals; the number of complaints considered under NHS complaints procedures and whether the provisions in the Bill on discipline apply to NHS 24 staff.

Clerks agreed to seek information on the number of disciplinary cases which have been considered by regulatory bodies.



Part 5 Infection with hepatitis C as a result of NHS treatment

*Panel 1*

Philip Dolan, Chairman, Scottish Haemophilia Forum  
Dave Bissett, Vice-Chairman, Scottish Haemophilia Forum  
Frank McGuire, Legal Adviser, Scottish Haemophilia Forum

Representatives of the Haemophilia Forum agreed to provide supplementary information on the number of ex-gratia payment claims which have been delayed at the stage at which input from consultants is required.

6. **Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from—

Part 5 Infection with hepatitis C as a result of NHS treatment

*Panel 2*

Peter Stevens, Chairman, Skipton Fund  
Keith Foster, Scheme Administrator, Skipton Fund

Skipton Fund representatives agreed to provide details of the achievement rate in Scotland for ex-gratia payments to persons infected with hepatitis C as a result of NHS treatment.

7. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered the main themes arising from the evidence session. The Committee agreed to notify the Minister for Health and Community Care of outstanding issues raised during evidence on the provisions of the Bill relating to infection with hepatitis C as a result of NHS treatment.

The meeting closed at 5.10 pm.

**Simon Watkins**  
Clerk to the Committee

**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**7th Meeting, 2005 (Session 2)**

**Tuesday 8 March 2005**

Present:

Roseanna Cunningham (Convener)	Kate Maclean
Janis Hughes (Deputy Convener)	Mrs Nanette Milne
Shona Robison	
Jean Turner	

Also present: Carolyn Leckie

Apologies: Helen Eadie, Mr Duncan McNeil and Mike Rumbles.

The meeting opened at 2.01 pm

1. **Items in private:** The Committee agreed to take items 3 and 5 in private.
2. **Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from—

Part 5 Authorisation of medical treatment

*Panel 1*

Dr Alan Jacques, Convener, Alzheimer Scotland  
Nicola Smith, Legal Adviser, ENABLE  
Sandra McDougall, Legal Officer, Scottish Association for Mental Health;  
and

*Panel 2*

Dr Mairi Scott, Chair, Royal College of General Practitioners (Scotland)  
Pat Dawson, Head of Policy and Communications, Royal College of Nursing  
Robert Hamilton, Senior Dental Officer, British Dental Association.

3. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered the main themes arising from the evidence session.

The meeting was suspended at 3.18 pm and resumed at 3.51 pm.

4. **Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from—

Part 5 Joint ventures

*Panel 1*

David Fox, Director, Turner and Townsend Management Solutions  
Howard Forster, Partner, Health Sector Leader, EC Harris

*Panel 2*

Alan McKeown, Health and Social Care Team Leader, CoSLA  
Tim Huntingford, Chief Executive of West Dunbartonshire Council and Joint Chair of the Joint Premises Board, CoSLA  
Hilary Robertson, Director, NHS Confederation  
Susan Aitken, Policy Manager, NHS Confederation; and

*Panel 3*

John Park, Assistant Secretary, STUC  
Dave Watson, Head of Policy and Information, UNISON Scotland.

Janis Hughes and Carolyn Leckie both declared that they are members of UNISON Scotland.

COSLA officials agreed to seek to provide supplementary information following a visit to joint venture projects in England before the conclusion of Stage 1.

5. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered the main themes arising from the evidence session.

The meeting closed at 6.09 pm

**Simon Watkins**  
Clerk to the Committee

**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**8th Meeting, 2005 (Session 2)**

**Tuesday 15 March 2005**

Present:

Roseanna Cunningham (Convener)	Helen Eadie
Janis Hughes (Deputy Convener)	Mr Duncan McNeil
Mrs Nanette Milne	Shona Robison
Mike Rumbles	Jean Turner

Also present: Mr Brian Monteith

Apologies: Kate Maclean

The meeting opened at 2.02 pm

1. **.Items in private:** The Committee agreed to take agenda items 4 and 5 in private.
3. **Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from—

Part 1 Prohibition of smoking in certain wholly enclosed places

*Panel 1*

Paul Waterson, Chief Executive, Scottish Licensed Trade Association  
Stuart Ross, Chief Executive, Belhaven Brewery, Scottish Licensed Trade Association  
Christopher Ogden, Director of Trade and Industry Affairs, Tobacco Manufacturers' Association  
Steven Stotesbury, Senior Scientist, Imperial Tobacco, Tobacco Manufacturers' Association;

*Panel 2*

Paddy Crerar, Chairman, British Hospitality Association Scottish Committee; Ian McAlpine, Coal Industry Social Welfare Organisation, Committee of Registered Clubs Associations  
George Ross, Royal British Legion Clubs, Committee of Registered Clubs Associations;

*Panel 3*

Alan McKeown, Health and Social Care Team Leader, CoSLA  
Gordon Greenhill, Environmental Health Manager, Regulatory Services Department, City of Edinburgh Council.

Keith McNamara, President, Royal Environmental Health Institute of Scotland  
David Mellor, Deputy Chief Constable, Association of Chief Police Officers;

*Panel 4*

Dr Rachel Harrison, Senior Policy and Research Officer, ASH Scotland  
Sheila Duffy, Head of Information and Communications, ASH Scotland; and

*Panel 5*

Andy Matson, Regional Officer, AMICUS  
Ian Tasker, Assistant Secretary, STUC  
Dave Watson, Head of Policy and Information, UNISON Scotland.

The Committee agreed to conclude its consideration of petition PE819 by Paul Waterson on the implications of the proposed ban on smoking on the hospitality industry by incorporating the issues raised by the petition into its Stage 1 consideration of the Bill.

CORCA representatives agreed to provide copies of the questionnaire issued to Royal British Legion Clubs on the proposals in Part 1 of the Bill and details of the RBLC membership in Lothians, Glasgow and the West.

ASH Scotland representatives agreed to provide supplementary information on risks associated with second hand smoke and evidence from litigation cases in the USA.

Janis Hughes declared that she is a member of UNISON Scotland.

- 4. Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered the main themes arising from the evidence session.

The meeting closed at 6.22 pm.

**Simon Watkins**  
Clerk to the Committee

**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**9th Meeting, 2005 (Session 2)**

**Tuesday 22 March 2005**

Present:

Roseanna Cunningham (Convener)	Helen Eadie
Janis Hughes (Deputy Convener)	Kate Maclean
Mr Duncan McNeil	Mrs Nanette Milne
Shona Robison	Mike Rumbles
Jean Turner	

Also present: Stewart Maxwell.

The meeting opened at 2.02 pm

1. **Items in private:** The Committee agreed to take agenda items 7 and 8 in private.
2. **Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from the Minister for Health and Community Care on all parts of the Bill.

Part 1 – Prohibition of Smoking in certain wholly enclosed places

The Minister agreed to provide the following supplementary information—

- details of actions planned by the Smoke Free Implementation Group; and
- an outline of the allocation between health boards of £12m to aid smoking cessation including details of the criteria on which the calculations for the allocation are based.

Part 5, Section 24 – Infection with hepatitis C as a result of NHS treatment

The Minister agreed to seek legal advice on the provisions relating to the requirement to reside in Scotland when the application for payment from the Skipton Fund is made. The Minister also agreed to seek legal advice on how the requirement to be registered with the Skipton Fund to receive payment relates to the eligibility of those who died after August 2003 but before the Skipton Fund was established.

Part 5, Section 31 – Joint ventures

Helen Eadie declared that she is a member of the Co-operative Party.

6. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered the main themes arising from the evidence session.

The meeting closed at 5.12 pm.

**Simon Watkins**  
Clerk to the Committee

**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**10th Meeting, 2005 (Session 2)**

**Tuesday 12 April 2005**

Present:

Roseanna Cunningham (Convener)	Helen Eadie
Janis Hughes (Deputy Convener)	Kate Maclean
Mr Duncan McNeil	Mrs Nanette Milne
Shona Robison	Mike Rumbles
Jean Turner	

The meeting opened at 2.00 pm

1. **Items in private:** The Committee agreed to take agenda item 4 in private.
4. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered a draft Stage 1 report.

The meeting closed at 4.30 pm.

**Simon Watkins**  
Clerk to the Committee



**HEALTH COMMITTEE**

**EXTRACT FROM MINUTES**

**11th Meeting, 2005 (Session 2)**

**Tuesday 19 April 2005**

Present:

Roseanna Cunningham (Convener)  
Janis Hughes (Deputy Convener)  
Mr Duncan McNeil  
Mike Rumbles

Helen Eadie  
Kate Maclean  
Mrs Nanette Milne  
Jean Turner

Apologies: Shona Robison.

The meeting opened at 2.00 pm

1. **Items in private:** The Committee agreed to take agenda item 6 in private.
6. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee agreed its Stage 1 report, subject to specified changes being made.

The meeting closed at 3.19 pm.

**Simon Watkins**  
Clerk to the Committee



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