The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 23 February 2011

Session 3

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Printed and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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HEALTH AND SPORT COMMITTEE
3rd Meeting 2011, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Nanette Milne (North East Scotland) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Kirsty McGrath (Scottish Government Legal Directorate)
Adam Rennie (Scottish Government Directorate for Health and Social Care Integration)
Shona Robison (Minister for Public Health and Sport)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Wednesday 23 February 2011

[The Convener *opened the meeting at 10:00*]

Health and Social Care Bill

The Convener (Christine Grahame): Good morning and welcome to the third meeting in 2011 of the Health and Sport Committee. We have received no apologies. I remind everyone to switch off mobile phones and other electronic equipment.

Our first item is an oral evidence-taking session on legislative consent memorandum LCM (S3) 33.1 to the Health and Social Care Bill, which is United Kingdom Parliament legislation. As the bill, which was introduced by the Secretary of State for Health, Andrew Lansley MP, on 19 January 2011, makes provisions for purposes that lie within the competence of the Scottish Parliament or which will alter that legislative competence or the executive competence of the Scottish ministers, the Scottish Government has, as required by standing orders, lodged an LCM.

Members have received a briefing paper and several written submissions from various Scottish health sector bodies, setting out their views on the LCM. I welcome to the meeting the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, and from the Scottish Government Alastair Pringle, head of patient focus and equalities, directorate of chief nursing officer, patients, public and health professions—that is some title; Jenny Long, policy manager, health and health care improvement directorate; and Kathleen Preston, health and community care solicitor, legal directorate.

I invite the cabinet secretary to make some brief opening remarks.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): Thank you, convener. I thank the committee for giving me the opportunity to discuss the provisions of the Health and Social Care Bill for which we are seeking consent. I must apologise in advance for the fact that my opening remarks will be a bit more lengthy than usual. I hope that that is okay, but the subject matter that we are dealing with this morning is quite technical and I want to take a wee bit of time to take the committee through the key provisions.

I am sure that members are aware of this, but I still want to make it clear at the outset that this Scottish Government has no intention of replicating in Scotland the reforms to the national health service in England and that, as a result, this LCM is not about extending in any way, shape or form those reforms to Scotland. Instead, we seek to ensure that any current arrangements between the NHS here and the NHS in England can—in so far as we consider it to be in our interests—continue within the new architecture for health and social care in England. I also point out that there is still considerable uncertainty over how that new architecture will work. I must be frank with the committee and say that that uncertainty might hamper my ability to respond to some of the committee's questions. The detail will depend on how the reforms in England develop and begin to work in practice.

That said, the motion seeks approval for the UK Parliament to apply provisions in seven areas of the Health and Social Care Bill to Scotland. These relate to the continued ability of Scottish health boards to enter into arrangements with commissioners in England to secure certain specialist services for Scottish patients after the establishment of the NHS commissioning board and general practitioner commissioning consortia; the abolition of the Health Protection Agency and provisions relating to the creation of the new public health service in England, including a duty of co-operation in relation to health protection functions; amendment of the Mental Health Act 1983 relating to the secretary of state's power to pay pocket money to persons receiving treatment as in-patients; the establishment in primary legislation of the health and social care information centre; the regulation of health care professions and health and social care workers; the establishment in primary legislation of the national institute for health and care excellence; and non-consequential amendments that include powers for the Scottish ministers to enter into NHS and health and social services contracts and which allow for joint dispute determination of contracts to which English, Welsh, Scottish or Northern Irish health bodies are parties.

I will outline each of those areas as briefly as possible. First, on the NHS commissioning board and GP consortia, members will be aware that the bill makes provision for a number of structural changes to the NHS in England, chief among which is giving GP consortia responsibility for commissioning the majority of health services. The consortia will be accountable to the new NHS commissioning board. Moreover, primary care trusts and strategic health authorities will be abolished.

The bill makes provisions to amend section 17A of the NHS (Scotland) Act 1978 to include the NHS commissioning board and GP commissioning consortia. That section details the bodies that can enter into NHS contracts, and the amendment will allow Scottish health bodies to continue to enter

into arrangements with commissioners in England within the new landscape in order to secure services for patients, where that is deemed appropriate. For example, the Common Services Agency, which is also known as NHS National Services Scotland, has a service agreement with the English national specialised commissioning team to ensure access for residents of Scotland to certain specialised services that are available only in England. Such services are generally concerned with the diagnosis and treatment of rare conditions and are commissioned at a national level by the Common Services Agency.

In future, any such arrangement will be between the Common Services Agency and the new NHS commissioning board. As amendment of the 1978 act lies within the Scottish Parliament's legislative competence, it is subject to this LCM.

Secondly, with regard to the abolition of the Health Protection Agency, the bill will underpin the UK Government's proposed reforms to public health in England and the creation of the new body, public health England, which is expected to assume the HPA's functions and powers. The agency currently exercises health and radiation protection functions on behalf of the devolved Administrations, and Scotland will be able to continue to access such services through the new public health service by means of an agency agreement and a memorandum of understanding. The bill also makes provision for a duty of co-operation between the secretary of state and other people or organisations engaged in public health protection activity, including the Scottish ministers. As these provisions alter the executive competence of the Scottish ministers, they require an LCM.

Thirdly, the bill will amend section 122 of the Mental Health Act 1983 to remove the secretary of state's power to pay pocket money to those receiving treatment as in-patients in psychiatric hospitals. I point out that the Mental Health (Care and Treatment) (Scotland) Act 2003 already provides for the Scottish ministers to make such payments. Although section 122 of the 1983 act extends to Scotland, that appears to be an error that occurred when the act was drafted. This amendment will rectify that error. However, as it is technically an alteration of the Scottish ministers' executive competence, it requires an LCM.

Fourthly, the bill establishes the health and social care information centre, which is currently a special health authority, as a non-departmental public body, and makes provision to amend section 17A of the 1978 act to include it. As I explained earlier, section 17A details the bodies that can enter into NHS contracts, and the provision in the bill simply facilitates the continuation of services that the Scottish Government receives from the information centre. The main example of the kind of information that we get from the centre is data on the GP contract, which informs our position in negotiations on the contract. Again, as the provision falls within our legislative competence, it is subject to the LCM.

It is probably in the next area—the regulation of health care professions and health and social care workers—that the most substantive changes are being made. In July 2010, the Department of Health published its report on arm's-length bodies, which confirmed that the Council for Healthcare Regulatory Excellence would be removed from the arm's-length bodies sector and made more independent, and that the General Social Care Council would be abolished and its functions moved to the Health Professions Council, which is to be called the health and care professions council to reflect its new remit. Incidentally, the LCM refers to the health and social care professions council; that was the proposed name, but it has since been changed. The bill will give effect to those changes and, as certain aspects of the regulation of health care professions are reserved to Westminster and others are devolved, a number of provisions in the bill are subject to the LCM.

The next area relates to changes to the National Institute for Health and Clinical Excellence, which the bill will establish as an NDPB instead of a special health authority and rename the national institute for health and care excellence. Again, this will involve amending section 17A of the 1978 act to include NICE in the list of bodies allowed to enter into NHS contracts and the provision will facilitate arrangements for the supply of products and services that NHS bodies in Scotland can receive from the reconstituted NICE.

Finally—members will be glad to know—the bill makes several non-consequential amendments to the National Health Service (Scotland) Act 1978 and the corresponding legislation in Wales and Northern Ireland to specify in the relevant Scottish, Welsh, Northern Irish or English legislation the Scottish ministers as able to enter into NHS or health and social services contracts. The amendments will also allow for joint dispute determination of contracts to which English, Welsh, Scottish or Northern Irish health bodies are parties. They will rectify devolution anomalies or uncertainties, but they will also alter our executive competence in certain respects and are therefore subject to the LCM. We are also seeking—this has not yet been confirmed—that the bill be amended to include a duty on the UK Government to consult the Scottish Government on any orders making transitional or consequential provision or commencement orders that relate to devolved matters addressed in the LCM.

In conclusion, although the Scottish Parliament would be able to legislate on all those devolved matters, there is no suitable opportunity to do so in the near future. Therefore, it is sensible that the provisions in the bill that I have outlined should be dealt with by the Westminster route on this occasion. I ask the committee to support the draft LCM that has been laid before it, and am happy to do my best to answer any questions on the technical provisions that I have outlined.

The Convener: Thank you very much.

I remind members that this is just an evidence session.

Helen Eadie (Dunfermline East) (Lab): I thank the cabinet secretary very much for her helpful explanation. I am not sure that I followed all of it, but I did my best to concentrate on what she said, and ask her to forgive me if she covered the points that I want to raise.

I have two questions, the first of which is perhaps the more straightforward. It relates to paper 1, which states:

"Scotland currently utilises a number of products and services from NICE, some of which are paid for. In addition, the NHS in Scotland (mainly through NHS QIS and Scottish clinicians; and to a lesser extent the Scottish Medicines Consortium) currently has commentator or observer status in a number of areas of NICE product development."

I refer to the submissions that we have received from NHS Tayside and NHS Greater Glasgow and Clyde. I do not see any financial impact assessment having been carried out by anyone to show precisely what the impact will be on our budgets in Scotland for products and services. I have certainly flagged up that matter to the convener. It is almost as though we are putting our finger up in the wind and hoping that the financial consequences will not be too severe. I ask the cabinet secretary to comment on that, please.

Nicola Sturgeon: Most of the provisions that I have outlined do not in and of themselves give rise to any financial considerations, as many of the services—whether from NICE or the specialised services I talked about that would be commissioned in the future from the commissioning board rather than under the current arrangements—are already paid for by Scotland, and we would continue to pay for them under the new arrangements. However, we must be frank about the fact that, as the newly constituted NICE develops, it may start to charge for a broader range of services, so some services that we currently get without charge might be provided on a commercial charging basis in the future. It is difficult for us to be certain about the impact in Scotland because there is so much uncertainty around how some of the arrangements will proceed in England. However, should that start to happen, we would need to consider whether it still made sense for us to procure those services from NICE or whether we would want to put in place alternative arrangements. I appreciate that members may have concerns about the lack of certainty that exists, but that flows from the lack of certainty about some of the reforms in England.

There are other arrangements. For example, one of the health profession regulation proposals that I outlined is to make self-funding the Council for Healthcare Regulatory Excellence, which is to be renamed; I will not attempt to remember its new acronym. At the moment, we and the other UK Administrations fund it entirely. Over time, there may be a cost saving to us from that change. We need to look at things on a case-by-case basis and make decisions that we consider to be right for us.

10:15

Helen Eadie: I am grateful to you for that answer, cabinet secretary, because you recognised my concern in it. You said that some of the services are paid for in Scotland but covered the point that we may have to review that in future.

My second point comes from the submission from NHS National Services Scotland. You may have covered it, but I want to be sure. NHS National Services Scotland says that it would like

"a modification to paragraph 8 of the LCM to clarify that the Common Services Agency (CSA) (understood to be the legally correct title for NHS National Services Scotland) could, in addition to being able to enter into arrangements with English commissioners, continue to be able to enter into agreements and contracts directly with English Trusts."

However, did I pick you up rightly as saying that the trusts will be abolished?

Nicola Sturgeon: Yes. I will try to outline the position. With a lot of these changes, we are trying, as far as we can and as far as we think right, to preserve the status quo for Scotland. The bill will abolish primary care trusts and strategic health authorities. Their commissioning functions will transfer to the GP commissioning consortia and the NHS commissioning board. Therefore, we have proposed appropriate legislative amendments that will enable the Common Services Agency to enter into arrangements with the appropriate commissioning body, whether that is the board or the GP commissioning consortia.

Foundation trusts will continue in England. Indeed, it is proposed that all NHS trusts will become foundation trusts, or part of one. The National Health Service Act 2006 provides that

"An NHS foundation trust is a public benefit corporation",

not an NHS trust. Therefore, Scottish NHS bodies cannot currently enter into NHS contracts with

foundation trusts. That will continue to be the case, but it will not prevent health boards or the Common Services Agency from entering into non-NHS contracts with foundation trusts, which is also presently the case.

In their totality, the amendments that we propose will help us to preserve the status quo in relation to the relationships with the relevant bodies in England.

Helen Eadie: That is helpful, thank you.

The Convener: I even understood it.

Mary Scanlon (Highlands and Islands) (Con): My first question also relates to NICE. I found unclear the future relationship between NICE and the Scottish Medicines Consortium or the Scottish intercollegiate guidelines network. Those points are raised in the submission from the Royal College of General Practitioners. It seems to be flagging up some uncertainty about the matter. Will you clarify the future working relationships for those organisations?

Nicola Sturgeon: As I said, our intention behind most of the amendments is, as far as we can, to preserve the status quo of the relationships. Obviously, there is the uncertainty about which I spoke, because we do not have a clear sight ahead of how some of the changes will pan out in England.

I read the RCGP's submission to the committee. It makes some helpful suggestions about future arrangements between Scottish bodies and NICE. I have passed those on to my officials, who are working on the alternative arrangements that we might need to develop within the NHS in Scotland to take account of developments with NICE in England that may no longer suit our circumstances. That is work in progress.

A key area in which Scotland currently takes account of NICE advice is the multiple technology appraisal arrangements for medicines. Those are obviously of particular interest to the SMC. We have our own arrangements in place for medicines approval through the SMC, but NHS Quality Improvement Scotland has commentator status on the NICE multiple technology appraisal process and reviews those recommendations for applicability here. In line with established processes, QIS publishes advice at the same time as NICE does in England. The amendments that are outlined in the LCM will allow those arrangements to continue.

As I said in my reply to Helen Eadie, in the future—perhaps not immediately, but over time—we may, for a variety of reasons, need to consider whether it still suits our purposes to use the services that NICE provides for us at the moment or whether there are better, more cost-effective and suitable ways of doing things. The RCGP's suggestions are helping us to think that through.

Mary Scanlon: It is important to consider the impact, especially on Scottish organisations.

My second question is raised in the written submission from NHS Greater Glasgow and Clyde and is alluded to in one or two of the other submissions. The submission states that

"it is increasingly likely that elements of the GMS contract may begin to be negotiated separately for Scotland."

Has that been part of your discussions? Do you see that happening in the future?

Nicola Sturgeon: It is certainly a possibility. Some may see it as inevitable that UK-wide contracts will no longer suit our purposes, given the divergent paths that the NHS is taking in Scotland and England. It is important that we take time to work through the situation and ensure that we get it right for Scotland. We are continuing our discussions with the Scottish general practitioners committee of the British Medical Association, in which we are considering all of that.

I am going off at a tangent but, looking at the NHS reforms in England, if we see commissioning as putting GPs more in the driving seat of the care that is provided and care pathways, the GP commissioning bit of the bill is probably not the worst part of the reforms. For me, the bigger concerns over the reforms in England are about price competition and subjecting the NHS to competition law—the marketisation of the health service. Members may agree or disagree, but I think that that will probably mean that the NHS in England, as we know it, will cease to exist over the next few years.

We do not want that to happen in Scotland. Equally, however, we have an interest in ensuring that primary and secondary care increasingly work closer together to improve care pathways and ensure that the decisions that GPs make for patients are the right ones, as they have an impact on the rest of the service. We need to find our own route to those improvements in how primary and secondary care work together. Over time, that may necessitate changes to the GP contract, but we must take time to get it right. We should not focus just on the contract. Whether people think that it is too much, not enough or whatever, the money that is spent on the GP contract is a relatively small part of the overall NHS budget. We need increasingly to focus on how the decisions that GPs make influence the bigger bit of the budget.

Those discussions are on-going, and we will continue to have them to ensure that we are making the right decisions for Scotland.

Mary Scanlon: I do not think that it is for us to criticise or praise what is happening in England. There are plenty members of Parliament—

Nicola Sturgeon: No, I was just putting my answer in context.

Mary Scanlon: I am agreeing with you. Given the major changes that are taking place in England, it is important for us to keep an eye on what is happening. The negotiations here could develop into a quite different set of negotiations and we could have a quite different contract in the future.

The Convener: I think that agreement has been reached on that.

Rhoda Grant (Highlands and Islands) (Lab): I want to ask about the specialist services that are provided south of the border. We have received written submissions expressing concern that, following the introduction of the new commissioning service, the cost of accessing those specialist services may increase because there is no competition and the areas concerned are small. Concern has also been expressed that some of the specialist services that are provided in Scotland may find it difficult to continue if the English health commissioning body sets up those services down south, as there may not be enough demand in the UK to support two competing services. How would we deal with the costs going up and our own specialist services being challenged in that way?

Nicola Sturgeon: We need to keep an eye on all of that, including the cost and quality of the specialist services that we currently commission from England. Nevertheless, we cannot be certain about the direction of travel. Specialist services are designated as such under the Health and Social Care Bill, and Monitor, the regulatory body, will have to ensure continuity of provision in the event that a provider fails. We must keep a careful watch over how that impacts on cost, quality and so on.

There are good reasons why we commission specialist services for very rare conditions. As a general comment—it is not meant to apply to any particular service—most people in Scotland would say that, if such services could be provided in Scotland to the right quality, that would be better for patients, who would not have to travel. As I said in relation to NICE, part of the development process might involve considering the balance of services that are provided through specialist commissioning versus services that are provided up here. Cost, value for money and the quality of the service that is provided will be key to that.

Rhoda Grant: The issue that was flagged up was quality. We are talking about conditions that are few in number. We are all aware that a certain throughput of patients is required to maintain quality and a specialism. The concern was that, although we provide some such services, which NHS boards in England and Wales and in Northern Ireland commission from us because we are the leaders in the field, there might be a pull to take on those specialisms south of the border rather than commission them from us. That would put our specialisms in danger, because they would not have the throughput of numbers to keep them at the highest quality, and would also increase the costs of accessing such services.

Nicola Sturgeon: That falls into the category that I flagged up of effects of which we cannot be certain. Our response to the reforms in England needs to help us to preserve our current arrangements. The bill provides for specialist services such as those that we commission in England to be regulated by Monitor, which is supposed to be the quality check. As for services in the other direction, I hope that we will continue to demonstrate quality, excellence and value for money.

To pick up Mary Scanlon's point, I am trying not to pass judgment on the reforms, as that is not my job. However, given that the watchwords of the reforms that are to be introduced are competition and particularly price competition within England as well as in areas with which a relationship exists, the dangers that Rhoda Grant highlights might arise. We must be watchful of that.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have three questions, one of which is on reverse commissioning, which follows from Rhoda Grant's questions. The memorandum contains a lot on how, as far as we can see, we would continue to commission special services in England. Will the bill have the reasonable effect of allowing commissioning by GP groups and the national commissioning board of services that we provide in Scotland?

Nicola Sturgeon: Yes.

Dr Simpson: That is grand—that is helpful.

Paragraph 18 of annex A to our paper 1 says that the

"duty of co-operation between bodies exercising functions in relation to health protection is ... included in the Bill and ... is intended to ensure co-operation between the four ... administrations ... This duty will ... extend to Scottish Ministers and will allow them to recover any costs incurred in providing such co-operation, from the other bodies exercising functions in relation to health protection."

I wonder what that means. Will you give us a little more on that? I am sorry—the issue is technical.

The Convener: Is that in our briefing paper?

Dr Simpson: It is in paper 1.

Nicola Sturgeon: It means that if, as part of those discussions, Scotland performs a health protection function for the Welsh Assembly Government or the Department of Health, we can recover the cost.

Dr Simpson: That is reverse commissioning again?

Nicola Sturgeon: Yes.

Dr Simpson: The acronyms are becoming complicated. I understand that the Council for Healthcare Regulatory Excellence—CHRE—will be replaced by the professional standards authority for health and social care—PSAHSC. That will include social care, but we will remain separate in that respect. Has any consideration been given to the advantage, in terms of cost savings, of merging our Scottish Social Services Council with the new combined body? Appointments to that committee have previously been made by an appointments commission, but I do not quite follow how appointments to the health care professions regulatory bodies will now be made on behalf of the Privy Council and what influence we might have on them.

10:30

Nicola Sturgeon: If I need to, I can supplement my answer in writing to the committee after the meeting. The current appointments arrangements will remain within the new body. At present we have the ability to appoint one member, and that will continue.

Dr Simpson: Right.

Nicola Sturgeon: Please remind me of the first part of your question.

The Convener: I need to be reminded too.

Dr Simpson: I am sorry—it is very difficult. The new PSAHSC combines social care, and we are keeping separate our Scottish Social Services Council. Has any consideration been given, or might it be given in the future, to the cost advantages of simply merging those bodies? There will otherwise be complicated arrangements around temporary registration in England if someone goes to work there, and around whether, if our social workers move to England, their qualifications will be accepted or they will have to undergo a new assessment. That all seems to be quite complex.

Nicola Sturgeon: We have no plans in that direction at the moment, although we would obviously require to look at it in light of developments in England. We have put a great emphasis, as I think everyone would agree, on consistency of regulation across the UK for ease of movement of health care workers and, in this case, social care workers.

Although we think that it is right that we do things in a way that suits us, we do not want to put barriers in the way of people who move to different parts of the UK. We will certainly be very mindful of how those changes impact on our arrangements here.

Dr Simpson: I am very conscious that there are significant barriers for teachers between the General Teaching Council for Scotland and the English set-up, which can cause difficulties for suitably qualified people who want to move. I would not like that to happen in this case.

I will move on to the section in which we are going to save money. We currently contribute money—£223,000—to what was the CHRE and is now the PSAHSC, and that will now be paid for on a self-funding basis by the individuals who register.

You say that the costs should be low because the number of registrants is high, and I accept the logic of your argument and that we may just have to live with the uncertainty, but General Medical Council fees have gone up from £270 only three or four years ago to £410 at present, which is an increase of around 30 per cent. That is not by any means a low increase, and it has come about through the changes in structures that have been taking place in the medical profession. Have you made any estimate of the potential costs to individual registrants with the new body?

Nicola Sturgeon: Fees for bodies such as the GMC are entirely reserved, because the profession was regulated prior to the Scotland Act 1998. As you know, only professions that have been newly regulated since this Parliament was set up are devolved, so it is fair to say that we have limited influence around many of those decisions, although we try to maximise that influence.

Dr Simpson: I understand that.

Nicola Sturgeon: I do not think that we have made any assessment in that direction, because we do not have the necessary level of detail on what those fees are likely to be. Again, it is another area in which we need to ensure that we watch our interests carefully.

Dr Simpson: Fine. Thank you very much.

Ian McKee (Lothians) (SNP): Good morning, cabinet secretary. I am relieved, as I am sure most of us here are, that you have stated quite clearly that you intend to preserve the characteristics of the Scottish health service and not to go along the lines of the changes that are taking place in England. I accept completely your argument that because things are still moving in England we

cannot make any firm financial plans with regard to how the changes will affect us in Scotland.

I see that there is a possibility of paying more money for advice from NICE, or whatever the acronym will be in the future. Some of that advice is to do with the quality and outcomes framework for primary care.

I appreciate that the amount that general practitioners get paid for the contract, the QOF and so on is probably a matter for negotiation with the British Medical Association, as the union of the medical profession, but have you considered taking advantage of the changing situation by entering into discussions with the RCGP about devising clinical priorities that are perhaps more suitable for Scotland than those that have been set for the whole United Kingdom?

Nicola Sturgeon: That is something that we may well look at. Perhaps there are issues particularly around the NICE changes, because some of the things that we currently get without charge may be charged commercially in the future. We will therefore want to see whether we can do things differently or better. I do not rule that out.

I would not characterise the current arrangement as our simply accepting clinical priorities from England. That is not quite how the system works; we seek to influence it and take from it what we think suits our circumstances. However, as I said to Mary Scanlon, there may be—not particularly because of anything we do but just through how things are developing in England—an inevitability about our looking to do things differently in future. As you would expect, we work closely with the RCGP in a number of areas; this may be one in which we would work even more closely with it in the future.

Michael Matheson (Falkirk West) (SNP): Richard Simpson asked about the decision to abolish the General Social Care Council in England, which regulates social workers in England, and the decision to retain the SSSC, which regulates social workers in Scotland. If we sought at some point in the future to move the SSSC into the successor body to the Health Professions Council—the health and social care professions council—would we require legislation at Westminster to allow that to happen? The constitution of the HPC and HSCPC will still be a reserved matter.

Nicola Sturgeon: I think that the answer to that question is yes, but with your permission, convener, we will double-check that. Although the regulation of social care is devolved, the regulation of the HPC and its successor body is reserved. Bringing something within the purview of that would, I am pretty sure, require Westminster legislation.

Michael Matheson: Would there be scope in the bill to create the opportunity for that change to be made in the future without requiring legislation at Westminster? Ministers could just move an order, which could prevent a potential difficulty in finding time for legislation in future.

Nicola Sturgeon: We can look at that and come back quickly to the committee on it to give you a factual answer as to whether it would be possible.

Michael Matheson: Okay. Thank you.

Helen Eadie: I do not know whether you have seen the submission from Unison, but it is clear that it has serious concerns about the potential impact on social workers of the new social work regulation. It states:

> "This means that the right of appeal will be to the High Court rather than the current Care Standards Tribunal. This is causing great disquiet among social workers because permissible grounds for appeal are much narrower and less responsive to the complexities of social work cases. Pursuing an appeal will become more expensive and risky. UNISON is very concerned that the new system will reduce access to justice as parties have to instruct barristers or solicitors with higher rights and social workers pursuing appeals run the risk of having costs awarded against them. The current Care Standards Tribunal system has proved itself to be accessible, efficient and cost effective in ensuring fair outcomes for social workers ... UNISON will therefore be seeking to amend Clause 200 and calling for the current appeal arrangements to be retained."

I just hope that you keep that in mind as well in your deliberations.

Nicola Sturgeon: Yes, I certainly will. I know that Helen Eadie is aware of this, but I just want to put it on record that most of the Unison submission, as it itself acknowledges, is about the English reforms—its comment about social work regulation is about what is happening in England, not about what is happening in Scotland—but Helen Eadie is right that, should we go down that line, such concerns would obviously require to be considered.

The Convener: The word "barristers" was the clue there. Thank you very much, cabinet secretary. This particular agenda item is ended. I suspend the meeting for five minutes, or three minutes—do not take longer than five minutes.

10:39

Meeting suspended.

10:45

On resuming—

Subordinate Legislation

Public Services Reform (Social Services Inspections) (Scotland) Regulations 2011 (Draft)

Public Services Reform (Joint Inspections) (Scotland) Regulations 2011 (Draft)

Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 (Draft)

Healthcare Improvement Scotland (Inspections) Regulations 2011 (Draft)

Public Services Reform (Scotland) Act 2010 (Consequential Modifications) Order 2011 (Draft)

Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (Draft)

The Convener: Item 2 is an oral evidence-taking session with the Minister for Public Health and Sport and Government officials on six affirmative instruments, all of which relate to the upcoming establishment of healthcare improvement Scotland and social care and social work improvement Scotland.

Members will recall that we considered parts 4 and 5 of the Public Services Reform (Scotland) Bill in the autumn of 2009, which dealt with the establishment of those two new organisations. At that time, we reported our conclusions and recommendations on the bill to the Finance Committee, which was the lead committee on the bill.

We have a cover note setting out the instruments and the Subordinate Legislation Committee's comments. We also have a letter from the minister setting out the purpose of each instrument.

Once the evidence session is over, we will consider motions to approve four of the six instruments. The motions to approve the remaining two instruments will be considered as soon as the Subordinate Legislation Committee has formally commented on them. The Subordinate Legislation Committee considered the two instruments yesterday, so we should have its comments in time for our next meeting on 2 March.

I draw to members' attention the seven negative instruments that we will consider under agenda item 7, which also deal with HIS and SCSWIS. If members have any questions on those instruments, it would be useful to put them to the minister while we have her here, so that we can consider the subject matter of all the instruments together.

I welcome the witnesses from the Scottish Government: Shona Robison MSP, Minister for Public Health and Sport; Anne Aitken, head of health quality branch, quality division; Adam Rennie, deputy director of community care; and Kirsty McGrath, solicitor in the food, health and community care division. I invite the minister to make brief opening remarks.

The Minister for Public Health and Sport (Shona Robison): Thank you for the opportunity to speak in support of the instruments. Adam Ingram and I wrote to the committee last week setting out the background to and purpose of the instruments, which I hope was helpful to the committee.

Today, I intend to give a very brief introduction to the instruments. I will be happy to answer any questions. The instruments are required to complete the legislation in respect of the creation of the two new scrutiny bodies SCSWIS and HIS, which are being established as part of the Scottish Government's drive for greater efficiency in public services, in particular in the bodies that scrutinise health and social services.

The instruments put in place a framework that enables the new bodies to regulate social care, social work and independent health care services by registering, where appropriate, and inspecting those services. Care services will be inspected against the current standards—the national care standards—which will ensure continuity for both providers and service users.

One issue that my letter did not mention is that we have now laid for the Parliament's consideration a transitional and saving order, which will ensure that services that currently are registered will continue to be registered under the new legislation. Any condition notices, improvement notices and so on that are still in force at the end of March 2011 will also be carried forward.

Under the new inspection regime, ministers will approve the overall inspection plans for each body and any future changes that are proposed to those plans. The inspection regulations do not provide for a minimum frequency of inspections. That change will enable SCSWIS and HIS to develop proportionate and risk-based inspection regimes to ensure that scrutiny is focused on the areas of greatest risk.

I am happy to answer any questions that members have on the instruments.

The Convener: Thank you very much. Richard, do you have a question?

Dr Simpson: Yes.

The Convener: I am going to try to get other people in first this time, so if you do not want Helen Eadie and Mary Scanlon always to get in first—there is no harm in that—get your hand up fast.

Dr Simpson: I did not put my hand up for that reason. I am very happy to follow my colleagues.

The Convener: I was fishing over at the other side of the table. Richard, you can start.

Dr Simpson: I have two questions for the minister and her team. One is about the Scottish health council. I am trying to remember what we finally decided in the Public Services Reform (Scotland) Act 2010. If I remember correctly, the council is to be subsidiary to HIS. You have announced that you are appointing a chair for the council, but we said that HIS had to reconstitute it. It was going to be abolished, but it has been retained. Will you clarify the situation?

Shona Robison: The Scottish health council will continue and will have its own chair. The appointment process for the appointments that I have just approved, which will be made public shortly, included the identification of a chair for the council. The membership of the board will include a chair.

Dr Simpson: Are there only interim chief executives for the other bodies?

Shona Robison: Yes. I can go into the reasons for that. However, to cut a long story short, following an open competition, the appointment panel did not recommend anyone for appointment by ministers as a substantive chief executive of SCSWIS. We were concerned about the delay that readvertising and so on would involve, therefore interim chief executives have been appointed for both bodies until the end of December. The good side of the arrangement is that the new boards will each be able to appoint their own person beyond that date. The two interim chief executives are people who know the score and will be able to offer continuity. At the end of December, the boards will each be able to appoint their own person going forward.

Dr Simpson: That is a helpful answer.

When we were debating these issues, we heard that care homes think that they are overinspected. I welcome your opening remarks about the reduced frequency of inspection, which will now be proportionate to the perceived quality of care homes, so that they do not have to be reinspected if they are meeting high quality standards.

However, we also heard the complaint that local authorities, which commission much care in care homes, also carry out a form of inspection; certainly, care homes are required to fill in extensive duplicated paperwork. As we move forward, what steps has the Government taken to try to eliminate that wasteful, time-consuming bureaucracy? I understand that local authorities say that they have a duty to ensure that the terms of the contracts for which they are contracting and commissioning are fulfilled. However, as part of the proportionate approach that I welcome from the Government, we must drive inefficiencies and duplication out of the system. I invite you to comment on that point.

Shona Robison: I will ask Adam Rennie to say a little more about it. You are right—local authorities say that they are required to carry out their own inspections to ensure contract compliance. However, I agree with you that we need to reduce that burden, for lack of a better word. The costs to local authorities of their contract compliance systems are an issue for them. I think that we can find a more efficient, effective way of proceeding that can preserve the legal requirements for contract compliance and monitoring but which does not require significant investment by local authorities or place a burden on the providers who must meet those requirements.

Adam Rennie (Scottish Government Directorate for Health and Social Care Integration): I have little to add to what the minister has said, except to recall that, during the passage of what is now the Public Services Reform (Scotland) Act 2010, a provision was added that required local authorities, in effect, to acquaint themselves with the reports that the regulators have made on the services that local authorities are considering commissioning. That is a further linkage between the formal inspection system and local authorities' commissioning system.

Dr Simpson: Much play has been made of the joint nature of such work. We decided not to go for a single unit at the moment but to have things really work together. You have added in two further bodies to the arrangement, which I welcome, but I wonder whether we should not go further in that respect. Instead of saying merely that local authorities should have regard to reports, we might say that, when some form of inspection is being carried out, local authorities should be informed of that and, perhaps, second an individual to be there, so that the processes are completed at exactly the same time and the paperwork is dovetailed.

Shona Robison: We will have to look at all those things as we drive further efficiency in the

system. Certainly, local authorities will want to consider more effective ways in which to carry out what they are required to do. I am sure that we can have dialogue on that.

Mary Scanlon: The letter from the minister and Adam Ingram is helpful, but the language concerns me. The second paragraph states:

"The 2010 Act ... places a duty on ... local authorities and health boards when providing care ... services ... to consider reports and other information".

On the second page, it continues:

"SCSWIS and HIS will analyse evidence and other information ... From this analysis they will report on the quality of services, how risks can be minimised and problems addressed."

I appreciate Richard Simpson's points about reducing inspections, but I am concerned about increasing self-evaluation. I am on record as saying—I make no apology for it—that the existing regulation, monitoring and inspection of care homes and nurseries by the Scottish Commission for the Regulation of Care is not good enough; it makes recommendations and does not follow them up. Many people save all their lives and can pay up to £1,000 a week in a care home and we have the most expensive nursery education in Europe. What reassurance can the minister give people who cannot work because they cannot afford child care or who do not work because they are concerned about putting their children into child care because of the standards?

We appear to be moving towards a softer-touch approach with fewer inspections and more self-evaluation. How can you reassure people whose parents are in a care home or parents whose children are at a vulnerable age and are in nursery education that we are moving to something that is better than the current arrangements, which I do not consider to be good enough?

Shona Robison: I dispute strongly that the new arrangements will be a softer touch. The whole purpose and thrust of the new regime is that it should be more proportionate and risk based. Therefore, the poorly performing care homes and nurseries to which the member refers can expect more attention under the new regime, because it will be an intelligence-based system. The purpose of self-evaluation is to ensure that good providers that constantly receive good reports, are valued by clients, are well thought of and that score highly maintain that quality and are covered by a proportionate inspection regime, so that far more time can be spent on services that do not come up to scratch. Standards can be driven up by spending more time with providers in which the quality is not as good as it should be. In fact, the new system will begin to address far more effectively some of the issues that the member raises.

Mary Scanlon: The argument is probably for another day, but I will certainly take what you say at face value. I have found from personal experience and from constituents that many recommendations from three, four or five inspections have been ignored and the care commission has done nothing. I hope that you are right, but I will certainly continue my individual scrutiny. I am almost more concerned about nurseries than about care homes, given what I have seen and been told.

Shona Robison: I hope that I can reassure you on that. One point is that there is a direct correlation between the system of grading care homes and the resource that they receive. In effect, investment, good management and good service in a care home are rewarded directly through the grading it gets and consequently the resource it receives.

There have been improvements, but is everything perfect? No, it is not, but I believe strongly that this system will allow the inspectors to do what they want to do, which is to spend far more time with the services that need to have time spent on them.

11:00

Mary Scanlon: I have a final point, convener. I was recently talking to a young mum who was shocked that the nursery that her son was in had the lowest possible rating. We have to be better at communicating with those who are paying for such services to let them know about the ratings, because parents and other individuals will drive up standards. Parents will not want to put their children into the worst-rated nursery—often at the highest price—but that is an issue for another day.

The Convener: That was not really a question, was it?

Mary Scanlon: No, but my point is that there is no point in giving ratings if people do not know what the ratings are.

Shona Robison: Communication is important. The whole point of having a grading system is to ensure that there is consumer choice and that the information is produced in a simple form so that people do not have to read through all the reports, which is obviously difficult for many people to do. The grading system is a way of making the information visible. There are sometimes nuances—within the higher gradings, the difference between a couple of gradings can be down to something on the day of the inspection—but the process certainly sorts out the ones that are at the top of the grading system from those in which big improvements require to be made.

Michael Matheson: I want to be clear about how the reforms will impact on the current care service architecture. The issue that comes to mind is how the new regime will apply to what are often specialist joint health and social work teams—the team is largely health-based but a number of social work professionals work within it. Such teams operate in, for example, mental health.

How will the regime apply to the inspection and regulation of such teams? Which of the two bodies that are responsible for such teams—the health service and the local authority—will be responsible for considering and therefore responding to any findings from a report?

Shona Robison: I will pass the question on to Adam Rennie, but I will first try to answer it as broadly as I can.

It may be appropriate to have a joint inspection by the two bodies if there is a large component of both health and social care. I am trying to think of such a service but I cannot off the top of my head. Perhaps a joint inspection may be appropriate in the circumstances that you describe.

If issues arise that impact on both health and social care, I would have thought that it would be for both bodies to ensure follow-up and compliance with any requirements that are made. Does Adam Rennie want to add anything?

Adam Rennie: Yes. Thank you, minister.

I would see a distinction between the individual service-level provision that might be being commissioned as a result of such joint working, when the inspection regime would depend on the particular service that was being commissioned—in most cases SCSWIS would be the scrutiny body—and the higher level areas to which the minister referred when two statutory agencies, the health board and the local authority, are working together. In the latter case, joint inspection arrangements may be appropriate—or it may be appropriate to have, at a less formal level, a multi-agency inspection in which the various agencies work together on an inspection. That does not have the status of a joint inspection, but it involves the bodies coming together in their own right to carry out the work.

Who would have to consider the findings would depend to some extent on what the findings were but, by and large, one would expect that they would need to be addressed jointly, if it was a joint exercise.

Michael Matheson: There are teams in some health board areas in Scotland that are largely health-led but have a social work component, and the standards that apply to the team are set by the health board. When it comes to inspection of that type of team under the current regime, how can a local authority be held to account for a health board standard that might not be being met but is found in the inspection report?

Shona Robison: That is a good question and we might need to consider it further. I suppose that that situation could be captured in some kind of operational guidance about what should be done when the integration of the team is such that it would be hard to not apply the health requirements. It might be a bit silly if they were not applied to the whole team. We need to look at having some sort of operational guidance for such circumstances. We have not given any particular thought to that. Perhaps we should consider what we are asking the two bodies to do. We would not want to fragment an integrated team when it came to any action points for follow-up, for example. We need to think about that.

Adam Rennie: I agree with the minister. The integrated team from the two statutory bodies working together would mean a different form of scrutiny or regulation from the individual service, which might well be what was emerging from the workings of the team—

Michael Matheson: No. I am entirely with you, but what you are saying is going in the wrong direction. I am talking about a health-led joint team that has embedded local authority staff and which is managed by the health service, but the local authority staff's contracts and management line technically go through social work. I am not talking about service provision but about the standards that should be applied to that team. If the health standards are applied to the social work staff, who have a direct line of management to health board members in the team, but whose professional responsibilities are to social work, which standards are to be applied? Who is held to account for those standards being met? Who is responsible for conflict resolution? The local authority might not agree with the standards that the health service might want to impose on the team. There could also be personnel issues for the local authority.

Shona Robison: Such issues might already exist to some degree in integrated teams. Where do they sit and what standards apply, given that their line management accountability is different from where they sit in employment terms?

The move towards more integrated teams probably means that we will have to consider that issue in more depth. While we move towards a more fully integrated system across the board, an interim solution might be one that takes the operational nature of the team into account—what is important for the outcomes for service users in that situation and what applies to the team. We do not want to not apply something that is important to the outcomes for service users and which could

improve the service because some of the team is technically employed by the council, albeit that they are managed by an NHS manager.

The interim solution that we will have to consider will involve an examination of what it makes sense to do in operational terms in order to drive up standards to deliver better outcomes for service users, if standards are found to be lacking. It is a good point, and certainly one that we will take away. We might write to the committee once we have had a think about what we could put in place to capture some of that.

Ross Finnie (West of Scotland) (LD): Does the point that Michael Matheson has raised also apply to those arrangements that would cover the regulation covering community health partnerships and community health and care partnerships, which would result in exactly the same position as Michael Matheson was positing, whereby a local authority person would collaborate with health employees under regulations governing CHPs and CHCPs that are driven by the national health service regulations?

Shona Robison: The CHCPs operate under the governance arrangements of the health board. They have no legal status of their own at the moment. In some ways, the same issue may apply—

Ross Finnie: It would be helpful if you brought the issue into the round.

Shona Robison: The issue is to do with separating the governance and management arrangements with regard to who leads the team from the requirements in terms of professional standards, for example. Further, who someone is legally employed by might be a different matter from the operational nature of their day-to-day job as part of an integrated team under an NHS manager. We have not explored that very far, but we want to take it away.

Kirsty McGrath (Scottish Government Legal Directorate): A number of issues have been raised in the on-going consultation on the self-directed support bill so that we can gather the public's views on the integration of health and local authority services, and on how standards in health can be applied to local authorities and vice versa.

Ross Finnie: I accept that that is a matter of fact, but it does not answer either Michael Matheson's question or mine. If what I have just posited comes within the ambit of all of that, it would be helpful if the minister were able to bring all of that together.

Shona Robison: We can find some kind of interim solution that captures that scenario while discussions go on elsewhere about the integrated nature of the future of those services.

The Convener: I see you indicating, Rhoda. Do not fret; you are on my list. I am alive and I am looking at you.

Ross Finnie: We could have a debate about that.

The Convener: We will not have a debate about whether I am alive or not.

Michael Matheson: You are looking well, convener.

Rhoda Grant: Is the issue not to do with the standards rather than the body that is reviewing them? In the Highlands and Islands, care homes and small community hospitals share services such as laundry and catering and the situation can become difficult for them, because care homes and hospitals have different standards of service. That is almost a barrier to integrating services, even though, in small communities, it is much easier to have those services based together.

It should not be beyond the wit of man to say that, within a hospital, because people are quite vulnerable, we need a certain standard of heat, food and laundry and that, therefore—if the services are integrated—the standards in the care home must be the same. However, I think that some of the regulations that are in place around water temperature and so on in care homes prevent that. It might be that someone needs to sit down and come up with a sensible approach to shared services that can cope with both circumstances.

Shona Robison: It might be possible for work to be done on coming up with common standards. I hope that the requirement for HIS and SCSWIS to work together and look at such issues will result in some simplifications of the situation and, perhaps, the adoption of a shared approach that might involve a common set of standards in the scenario that you are talking about. We can certainly flag that up with the new bodies as being something that we would like them to have an early look at.

11:15

The Convener: That concludes our evidence-taking session. Item 3 on the agenda is a debate on the motions to approve the instruments before us. As no member wishes to speak in the debate, we will move straight to the questions.

Motions moved,

That the Health and Sport Committee recommends that the Public Services Reform (Social Services Inspections) (Scotland) Regulations 2011 be approved.

That the Health and Sport Committee recommends that the Public Services Reform (Joint Inspections) (Scotland) Regulations 2011 be approved.

That the Parliament recommends that the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 be approved.

That the Health and Sport Committee recommends that the Healthcare Improvement Scotland (Inspections) Regulations 2011 be approved.

Motions agreed to.

Social Care and Social Work Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI 2011/26)

Social Care and Social Work Improvement Scotland (Fees) Order 2011 (SSI 2011/27)

Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 (SSI 2011/28)

Social Care and Social Work Improvement Scotland (Applications) Order 2011 (SSI 2011/29)

Healthcare Improvement Scotland (Fees) Regulations 2011 (SSI 2011/33)

Healthcare Improvement Scotland (Requirements for Reports) Regulations 2011 (SSI 2011/34)

Healthcare Improvement Scotland (Applications and Registration) Regulations 2011 (SSI 2011/35)

The Convener: The next agenda item concerns the consideration of seven negative instruments associated with the establishment of healthcare improvement Scotland and social care and social work improvement Scotland. Members have a copy of each of the instruments and a note from the clerk.

Do members have any comments?

Members: No.

The Convener: Are members content not to make any recommendation to the Parliament on the instruments?

Members *indicated agreement.*

The Convener: I thank the minister and her officials for their attendance.

11:17

Meeting continued in private until 12:01.

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