

## SPICe Briefing

# Public Services Reform (Scotland) Bill: Healthcare Improvement Scotland

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The Public Services Reform (Scotland) Bill [SP Bill 26] was introduced to the Scottish Parliament on 28 May 2009. It is wide ranging, covering the dissolution of certain public bodies and the establishment of new national bodies, including ones for health and social work and social care scrutiny. This briefing concerns Part five of the Bill on the creation of a new national health scrutiny body Healthcare Improvement Scotland. It begins with a discussion of the current monitoring structures of health services in Scotland, before outlining the background to the proposal itself. It will then utilise views from submissions to the Health and Sport Committee as a basis of discussing the Bill provisions in detail. In addition, the briefing will outline current consideration of the Mental Welfare Commission for Scotland, proposals for which are expected to be lodged as amendments to the Bill at stage 2, should the Bill progress.



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(SB 09/57)

## EXECUTIVE SUMMARY

### Public Services Reform (Scotland) Bill: Healthcare Improvement Scotland

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#### Background

The Public Services Reform (Scotland) Bill [SP Bill 26] was introduced in the Scottish Parliament on 28 May 2009. It is wide ranging, covering the dissolution of certain public bodies and the establishment of new national bodies, including ones for health and social work and social care scrutiny. It seeks to introduce order-making powers to make organisational change easier in specified public bodies and to remove or reduce “burdens” deemed to be holding back “economy, efficiency, productivity or profitability”. It also proposes a duty on improvement and scrutiny bodies in Scotland to cooperate with each other and ensure appropriate “user focus”.

This briefing is one of five SPICe briefings deals with various aspects of the Bill. It is focussed on Part five of the Bill concerning the proposed creation of Healthcare Improvement Scotland (HIS). The Bill would set up HIS as a corporate body in its own right under primary legislation. It would have a national remit with the aims of “improving the quality of healthcare through supporting NHS Boards and independent healthcare providers in improving patient care by bringing together the provisions of advice, and guidance, support for implementation and improvement and assessment, monitoring and reporting” (Policy Memorandum, 2009, para 40). It is proposed HIS will be created by take on all the current functions of NHS Quality Improvement Scotland (QIS) and the functions of the Care Commission in relation to the independent health care services.

The Finance Committee is lead Committee for the Bill. However, the Health and Sport Committee (the Committee) will be one of a number of secondary Committee’s, and it will consider Parts four and five of the Bill. The briefing draws on the 31 responses that the Committee received from a number of sectors.

#### Current monitoring of health services

NHS services are currently monitored by NHS QIS, a Special Health Board set up through regulations under the National Health (Scotland) Act 1978 (as amended). It has a national role across NHS Scotland as a whole. Its primary function is to support area NHS Boards improve patient care by: providing advice, guidance and setting standards; supporting implementation and improvement; assessing, measuring and reporting the performance of NHS Board’s; and, taking a central responsibility for patient safety and clinical governance across NHSScotland. It produces standards, assesses the performance of Boards against these these and reports on its findings. However, it has not enforcement powers itself. Instead, it identifies issues that may then taken up by Scottish Ministers and SGHD officials with the relevant NHS Boards.

Scrutiny of independent health care services is undertaken by the Care Commission under the Regulation of Care (Scotland) Act 2001 (asp 8). The Act (section 2(5)) defines such a service as: an independent hospital; a private psychiatric hospital; an independent clinic; or, an independent medical agency. All care services stipulated under the Act must be registered with the Commission, which is then responsible for their regulation. All services must pay a fee at initial registration and for continued registration. This allows the Care Commission to be self-financing in respect of the regulation of independent healthcare services. The Commission inspects against the 2001 Act and its associated regulations taking account of the relevant National Care Standards published by Scottish Ministers. It carries out inspections at a minimum frequency set by Scottish Ministers. It produces reports after each inspection and any issues it uncovers are tackled through a wide range of escalating enforcement powers, ranging from merely discussing it with the service and monitoring improvement, to issuing enforcement notices to, if necessary, cancelling a service's registration.

## **Background to the HIS proposal**

A key driver for the introduction of the Bill as a whole was the review of by Professor Lorne Crerar, published in September 2007. One of the areas he considered was the system of scrutiny for public services. He concluded there were a number of bodies with different objectives carrying out their work in different ways. This created an over complex, sometimes confusing situation for service users and public services alike. Health scrutiny was one area identified for reform and he recommended the creation of one scrutiny body for all health services. He also recommended one body covering social services and social care. Ultimately he envisaged one public scrutiny body for all public services in Scotland.

Although there was no formal public consultation on the Bill, the Scottish Government has outlined the consultations that Crerar himself undertook, together with its own work in discussing with stakeholders and service users. It published its response to Crerar in November 2008. This included the proposal to create one single scrutiny and improvement body for health (HIS in the Bill) and one for social services and social care (Social Care and Social Work Improvement Scotland (SCSWIS) in the Bill). Originally the health body was to include the functions of the Mental Welfare Commission (MWC). However, concern about this was raised by the Commission itself, stakeholders and service users. Scottish Ministers withdrew the proposals for the Bill as introduced but only so it could reflect further on the matter before lodging amendments at stage 2 should the Bill progress. The Scottish Government has published a consultation on the future of the MWC, which is due to end on 25 September 2009.

## **Provisions in Part five of the Bill**

Most respondents to the Committee's call for evidence made comment on the proposals to establish HIS, though few made comment on whether they supported the proposal per se. Two respondents commented that the level of consultation and pre-legislative scrutiny had been inadequate. A larger number discussed whether or not there should have been a single body for the scrutiny of health and social services. This was evenly split between those in favour and those against, though perceptions were influenced, for some, by their experience of joint scrutiny by different bodies in the past.

Part five of the Bill seeks to insert a number of sections into the National Health Service (Scotland) Act 1978. These sections would establish HIS and stipulates its functions. It would be a corporate body established in its own right. This would make it a similar body in constitution to the Common Services Agency, and not a Special Health Board as NHS QIS currently is. It will have the power to create Committees which it can delegate its functions to. The Bill only states that the Scottish Health Council could be one such Committee. The Bill also stipulates a number of principles for HIS, which prioritise the safety and welfare of persons, and the promotion of good practice.

The briefing considers the proposed functions in detail. However, the Scottish Government notes that the functions proposed are not materially different from those currently held by NHS QIS or the Care Commission in regards to independent health care services. Its functions can be summarised as follows:

- directing and supporting implementation of improvements in quality of healthcare across all sectors
- assessing the performance of the NHS and independent healthcare providers, reporting and publishing findings
- providing independent healthcare providers with a licence to operate and taking enforcement action when necessary standards are not achieved
- inspecting the healthcare environment regime
- providing advice and guidance on effective clinical practice
- facilitating improvements in patient safety and taking responsibility for clinical governance
- supporting, ensuring, monitoring NHS Boards in their duty of encouraging public involvement and promoting equal opportunities

Comments on the proposals were varied, and are dealt with in detail in the briefing. However some key issues raised about HIS were:

- whether being constituted as a health body would give it the necessary independence to carry out its duties
- whether the functions identified would be too diverse for one body and a lack of clarity on whether the focus of HIS would be inspections or the supporting improvement in health services
- a disparity about the powers HIS would have over the independent health sector compared with the NHS and whether or not this would skew its work
- whether or not HIS would have any real enforcement powers over the adoption of its standards by health services, and how these standards linked with the overall targets and priorities of NHS in Scotland and the Scottish Government
- concerns as to whether NHS QIS staff lack the experience in carrying out regulated inspections and using powers of entry

### **Relationship with other bodies**

Many respondents chose to discuss how HIS would work with other scrutinising bodies, particularly SCSWIS. For those that commented, the provisions in Part six of the Bill, providing duties of scrutiny concerning user focus and joint inspections together with the duty of cooperation placed on relevant bodies, were welcomed. However, a number of issues were raised, particularly in relation to joint inspections, where issues surrounding how joint working would take place in practice.

Several respondents were concerned that HIS and SCSWIS would be constituted quite differently under the Bill, with the focus of their work appearing to be different – HIS focussed on service improvement, SCSWIS focussed on scrutiny. Questions were raised about these bodies would work together particularly given the many areas of overlap in the health and social services.

## INTRODUCTION

The proposal to create a new health scrutiny body called Healthcare Improvement Scotland is contained in Part 5 of the [Public Services Reform \(Scotland\) Bill](#) [SP Bill 26] (the Bill), which was introduced to the Scottish Parliament on 28 May 2009. This is a wide ranging Bill concerned with the reform of public services in Scotland. The Bill is accompanied by [Explanatory Notes](#) (2009) and a [Policy Memorandum](#) (2009). The Scottish Government has also published a number of [Regulatory Impact Assessments](#) (RIA) to accompany different Parts of the Bill, including one on Parts 4 and 5 (Scottish Government, 2009a) which is most pertinent to this briefing.

The lead committee for Stage 1 is the Finance Committee. The Health and Sport Committee (the Committee), along with the Education, Lifelong Learning and Culture Committee and the Rural Affairs and Environment Committee, has been designated as a secondary committee. It is considering Parts 4 and 5 of the Bill concerning the proposals to create Social Care and Social Work Improvement Scotland (SCSWIS) and Healthcare Improvement Scotland (HIS).

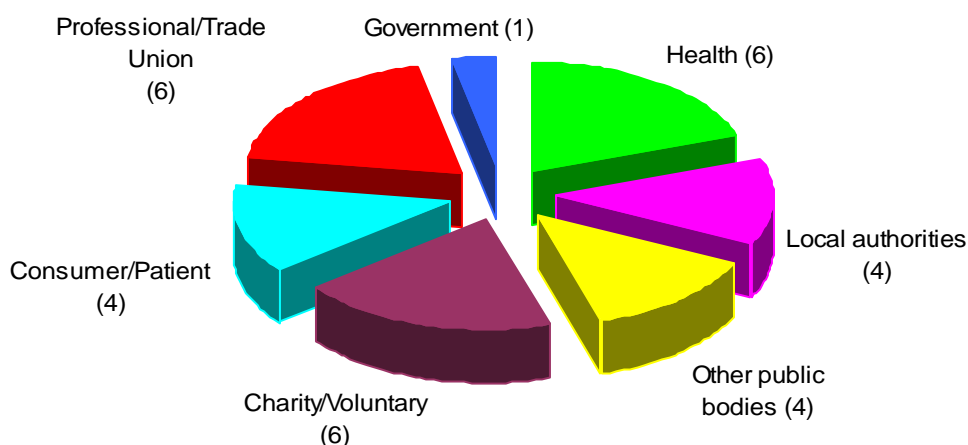
A number of SPICe briefings are being written to accompany the Bill:

- [‘Public Services Reform \(Scotland\) Bill: Finance Committee Scrutiny’](#) (includes a discussion on Parts 1,2 and 6 of the Bill, together with the Financial Memorandum) (Burnside, 2009)
- ‘Public Sector Reform (Scotland) Bill: Rural and Environmental bodies’ (Edwards, 2009)
- ‘Public Services Reform (Scotland) Bill: Creative Scotland’ (Earle, 2009)
- [‘Public Services Reform \(Scotland\) Bill: Social Services’](#) (discusses the creation of SCSWIS in Part 4)(Kidner, 2009)

## HEALTH AND SPORT COMMITTEE CALL FOR EVIDENCE

The Committee issued a call for written evidence on Parts four and five of the Bill on 23 June 2009, which closed on 14 August 2009. At the time of writing 31 submissions had been received, from a range of organisations. A breakdown of submissions by type of body and the Parts of the Bill responded to is contained in Appendix 1. A simple breakdown of types of body that responded is shown in Figure 1, below.

**Figure 1: Breakdown of submissions to the Health and Sport Committee**



As can be seen from Appendix 1, the majority of respondents made reference to both Parts four and five in their submissions. As noted above, a discussion of Part 4 of the Bill is contained in the SPICe briefing on social services (Kidner, 2009). This briefing will use some of the responses relevant to the HIS proposal to provide a synopsis of the arguments being made.

## CURRENT MONITORING OF HEALTH SERVICES

To help achieve the overall purpose of the Bill to simplify and improve a number of public bodies and the scrutiny of public services, it is proposed that a new health body, HIS, be established. HIS would take on both the current functions of NHS Quality Improvement Scotland (NHS QIS) and the regulation of the independent healthcare sector, which is currently undertaken by the Scottish Commission for the Regulation of Care (the Care Commission). However, before considering the proposals in detail it is worth noting current provisions in this area.

## MONITORING OF THE NHS

NHS QIS was established on 1 January 2003 as a Special Health Board under the National Health Service (Scotland) Act 1978 (c 29) (as amended), through the NHS Quality Improvement Scotland Order 2002 (SSI 1002/534). It was the amalgamation of five former non-departmental public bodies tasked with taking forward the quality agenda in NHSScotland - the Health Technology Board for Scotland, the Clinical Standards Board for Scotland, Scottish Health Advisory Service, Clinical Resource and Audit Group and the Nursing and Midwifery Practice Development Unit. . In addition, in 2005, the Scottish Intercollegiate Guidelines Network<sup>1</sup> (SIGN) became part of NHS QIS. As a Special Health Board, NHS QIS has a national role across the NHS as a whole. Its primary function is to support area NHS Boards improve patient care by:

- providing advice, guidance and setting standards
- supporting implementation and improvement
- assessing, measuring and reporting the performance of NHS Boards
- taking a central responsibility for patient safety and clinical governance across NHSScotland

NHS QIS produces standards on services for a range of clinical conditions as well as generic service standards (e.g. for clinical governance and risk management). It operates according to a work programme which it creates, though this is influenced by a number of factors including NHSScotland priority areas, national policy developments and the requirements of Scottish Ministers. It is expected that these standards will be adopted and implemented by all relevant health bodies and practitioners. NHS QIS will then assess performance against these standards through a range of means including self-assessment and peer review visits, publishing its findings. Should NHS QIS find that standards are not being met, then this would be taken up with the relevant NHS Board through the Scottish Government performance management process and its annual review with the Cabinet Secretary for Health and Wellbeing. However, whilst Ministers have powers to intervene over the performance of a NHS Board, NHS QIS itself has no powers of enforcement.

As well as the functions outlined above, NHS QIS is the umbrella for a range of bodies which support it in its work:

- [Scottish Health Council](#) - a Committee of NHS QIS with delegated responsibility for monitoring NHS boards to make sure they are involving patients and the public in decisions about services, and taking account of their views
- Healthcare Environment Inspectorate – set up by Scottish Ministers in March 2009 to inspect Scottish hospitals, to ensure the highest standards of infection prevention and cleanliness

Finally it takes a lead role in co-ordinating the work of the [Scottish Patient Safety Programme](#) and provides secretariat support to the [Scottish Medicines Consortium](#) which advises on the clinical effectiveness and cost effectiveness of all newly licensed medicines.

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<sup>1</sup> SIGN aims to promote consistency in clinical practice and clinical outcome. Its guidelines contain recommendations for effective practice based on current evidence

## MONITORING OF INDEPENDENT HEALTH CARE SERVICES

The independent health care sector in Scotland is relatively small, and is largely focussed on elective care through nine hospitals. Key statistics concerning the sector are shown in Figure 2.

**Figure 2: Independent Health Care Services in Scotland – Key statistics**

- 313 acute beds across nine hospitals of which 21 are critical care level 2 beds
- 268 mental health beds across five hospitals
- acute hospitals looked after 45,035 admissions (866 per week), 52% on an inpatient and 48% on a day case basis
- a further 186,396 acute hospital Outpatient appointments (3,585 per week) were attended by patients in 2008-09
- mental health hospitals cared for 725 inpatients and 705 day cases.
- home care services carried out 28,101 patient contact visits (540 per week).

Source: Scottish Independent Hospitals Association (2009)

Scrutiny of independent health care services is undertaken by the Care Commission under the Regulation of Care (Scotland) Act 2001 (asp 8) (the Act). The Act (section 2(5)) defines such a service as: an independent hospital; a private psychiatric hospital; an independent clinic; or, an independent medical agency. All care services stipulated under the Act must be registered with the Commission, which is then responsible for their regulation. All services must pay a fee for initial and continued registration and this allows the Care Commission to be self-financing in respect of the regulation of independent healthcare services.

Services are regulated against the Act and its associated regulations taking account of the relevant National Care Standards, which outline the quality of service that users have a right to expect, and are designed to ensure that all care services are measured against a set of general principles. The Act provides that Scottish Ministers commence the regulation of a particular service through regulations. As regards the independent health sector, the services for which regulation has not been commenced by regulations are “independent clinics” and “independent medical agencies”.

Inspections are based on the Act, regulations and relevant National Care Standards and reporting is according to a grading system, which is designed to give the public more information about the quality of a particular service. Service providers are expected to carry out regular self assessments of how their service is performing against a number of quality themes and standards, and they must provide evidence that these are being met. Each type of service is inspected according to a minimum frequency determined by Scottish Ministers through regulations. Currently, independent health care services that are meeting standards and are considered low risk can expect 2 inspections each 24 months, at least one of which is unannounced, with one of these inspections in each 12 month period. However, the Care Commission may decide to inspect more regularly where there are concerns about the quality of service (Scottish Commission for the Regulation of Care, 2009a).

Where a service is not meeting the standards expected, the Care Commission has a wide range of escalating enforcement powers at its disposal. It describes its approach to enforcement as “graduated”, with the first step being to discuss with the provider its concerns and hopefully securing a resolution. However, if this is unsuccessful, it can consider utilising other sanctions, including a number of enforcement notice powers, and, ultimately, the cancellation of registration (Scottish Commission for the Regulation of Care, 2008). The various steps in enforcement are described in Appendix 2. It is also worth noting that in an emergency situation, where it is judged there is significant risk to the health, welfare or safety of service users, the Care Commission, can seek approval of a Sheriff, to cancel or vary the conditions of registration more or less immediately.

The Care Commission (Scottish Commission for the Regulation of Care, 2009b) has provided some key statistics concerning the regulation of independent health care services, which are shown in Figure 3, below.

### **Figure 3: Regulation of Independent Health Care Services – Key statistics**

- On 31 March 2009 there were 32 registered independent health care service providers (0.2% of all registered services)
- Between 2007-08 and 2008-09 there was no overall change in the number of services. However, within the period there were two registrations and two cancellations.
- In 2008-09 there were four complaints against independent health care services that were completed by the Care Commission, 2 of which were partially upheld
- There were two enforcement notices served on one independent health care service in 2008-09 – one s13 (decision to impose/vary/remove conditions) and one s17 (decision to impose/vary/remove conditions).

## **BACKGROUND TO THE HIS PROPOSAL**

### **THE CRERAR REVIEW**

A key driver for the introduction of the Bill as a whole was the report by Professor Lorne Crerar [‘The Report of the Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland’](#) (Crerar), which was published in September 2007. The Review (2007, p 2-3) found there was “a wide variety of scrutiny methodologies, organisational structures and governance arrangements, and large numbers of different players with the ability and right to both direct and create new scrutiny”. Not only did Crerar believe this lead to an over-complex system but he also considered it resulted in increased scrutiny costs. He developed five principles to govern the application and use of external scrutiny – independence, public focus, proportionality, transparency and accountability – and described what he believed to be the key features of any scrutiny system, which are outlined in Appendix 3.

Ultimately, Crerar envisaged a single national scrutiny body for all public services. However, he proposed, as a first step, a simplification of current scrutiny bodies. As regards health he found that much of the existing scrutiny of the health sector was not external and independent. He recommended that:

“...functions and resources from within NHS QIS and the Scottish Government’s health directorates, as well as resources controlled by the Care Commission in relation to private hospitals and related treatment be redistributed to an external scrutiny organisation.”

The Review was clear that this should take place only after the external scrutiny priorities for health had been identified.

### **FURTHER CONSULTATION**

The Scottish Government (2009a) noted that Crerar sought the contribution from a range of organisations and stakeholders. However, following the publication of the review the Scottish Government set up a Project Implementation Team (PIT) to oversee the development of proposals for improving the scrutiny and complaints systems for public services in Scotland, taking account of Crerar’s recommendations. The Scottish Government (2009a, p 2) stated that as part of this work a stakeholder engagement programme was established in order to continue the discussions with the bodies and stakeholders affected by any proposals. The Scottish Government also makes reference to the Scottish Parliament debate on 8 May 2008 (Scottish Parliament, 2008), which considered many of the issues related to Crerar.

However, there has been no formal public consultation on the eventual provisions contained in the Bill, including those on HIS. The Scottish Government (2009a, p 2) considers that public views had been taken account through a number of initiatives undertaken by Crerar, and more recently through seminars organised by PIT with independent health care service providers and patient representatives and members of the public.

## **FINAL SCOTTISH GOVERNMENT CONSIDERATION**

In November 2008, the Cabinet Secretary for Finance and Public Services [announced](#) the outcome of the Scottish Government's consideration (Scottish Government, 2008). As regards health, he announced a new health scrutiny body bringing together the functions of NHS Quality Improvement Scotland and the Mental Welfare Commission for Scotland (MWC), together with the scrutiny of independent healthcare currently undertaken by the Care Commission. Following this announcement there was significant concern about the proposal to include the MWC and what this would mean in practice. As a result of representations to Ministers, the Scottish Government announced a consultation on how best MWC can be included in the new scrutiny system. After reflecting on responses it plans to lodge amendments at Stage 2, should the Bill progress.

The Scottish Government (2009a, p 3) notes that it did consider the option of doing nothing. But it believed a reduction in the number of public bodies was necessary in the aim of creating "a simpler and more easily understood scrutiny landscape". It also noted that whilst there had been models of joint working across scrutiny bodies, it believed these had been limited in effectiveness and there was still a risk that service providers would not see a reduction in scrutiny. Therefore, it elected to proceed with a single scrutiny body for the health sector. It believed this body, as well as SCSWIS, would result in a more consistent and integrated approach for scrutiny of health and social services. This would help to reduce the scrutiny burden on service providers, whilst making it easier to highlight shortcomings in services, encouraging improvement and, ultimately, benefiting service users.

## **PROVISIONS IN PART 5 OF THE BILL**

The following sections will review the provisions in Part five of the Bill concerning the creation of HIS and its functions, utilising views from respondents to the Committee's call for evidence.

## **GENERAL COMMENTS ON THE PROPOSALS**

Of the 31 responses to the Committee's call for evidence 26 made reference to the creation of HIS. Many respondents chose not to make a specific comment about whether or not they supported the proposals per se, but instead reflected on the detail of the proposal, though it is fair to say that a significant number did appear to welcome the Bill in general.

There was little comment on the level of consultation that had taken place concerning the Bill in general or Part five specifically. However, the Association of Directors of Social Work (ADSW) (2009) stated that whilst it had been involved in discussions with the Scottish Government, these were not on the basis of whether the proposed bodies were needed or suitable. Rather discussions were restricted to the working arrangements of the new bodies. MWC (2009) considered the Bill had not been subject to the same pre-legislative scrutiny as other pieces of legislation in which it been involved.

There was some discussion by eight respondents, across sectors, on whether or not there should be a single body for health and social care services scrutiny. Three respondents (NHS Forth Valley (2009), COSLA (2009) and NHS Tayside (2009)) agreed with the proposals to have separate bodies. NHS Tayside (2009) said its experience had been that several scrutiny bodies can work effectively together. However, another three respondents (South Lanarkshire Council

(2009), ADSW (2009) and RCN Scotland (2009)) felt there should have been a move to have one body. Quarriers (2009) certainly felt there should be fewer bodies, adding that its experience of joint working in the past had been poor.

## **THE CREATION AND STATUS OF HIS**

### **The proposal**

Section 90 of the Bill seeks to insert a total of 37 sections (sections 10A to 10Z12) after section 10 of the National Health Service (Scotland) Act 1978 (c 29) (the 1978 Act). These would create HIS and provide for its functions. Schedule 11 of the Bill inserts Schedule 5A into the 1978 Act and this relates to the establishment of HIS.

Section 10 of the 1978 Act created the Common Services Agency, commonly known as NHS National Services Scotland<sup>2</sup> (NSS). Unlike other national NHS bodies, such as NHS Health Scotland or indeed NHS QIS, NSS is not a Special Health Board created through regulations under the 1978 Act. Rather, it is a Non-Departmental Public Body established in primary legislation, which is accountable to the Scottish Government. Inserted section 10A seeks to establish HIS as a health body with a national responsibility, and inserted Schedule 5A proposes it would be a body corporate. The Scottish Government (2009c) has advised this would mean HIS would be similar in constitution to NSS. Inserted Schedule 5A provides for matters such as HIS's membership, terms of appointment, remuneration and procedures. Importantly, it also allows HIS to establish a Committee to undertake any of its functions. The Bill only states that the Scottish Health Council could be set up as a Committee of HIS (see below). However, for any other function, it will be up to HIS to determine the constitution and membership of such Committees.

Inserted section 10B stipulates the principles under which HIS would have to undertake its functions. They prioritise the safety and welfare of persons, and the promotion of good practice.

### **Comments on the proposals**

As noted above, in general, many respondents did not make clear whether or not they supported the proposal to create HIS, and instead made comment on the detail in the proposals. However, several did voice their support. South Lanarkshire Council (2009, p 3) was one of those arguing that HIS should result "in a more efficient and streamlined service and more effective monitoring and evaluation". In addition, NHS QIS (2009a, p 2) considered that the legislation that established it "no longer adequately reflects the approach to our work and [the Bill] presents an opportunity to re-articulate the Scottish approach to quality improvement in healthcare".

There was some comment about the status being proposed for HIS. NHS Forth Valley (2009) and Consumer Focus Scotland (2009) discussed the proposal to establish HIS as a health body by amending health legislation rather than establishing it in the Bill itself. It was felt this could be seen as limiting HIS's ability to be independent. However, NHS QIS (2009a, p 1) felt it should be a health body as it considered that for HIS to fulfil its functions "clinical buy-in" was essential, and it was important to find a balance between "robust and evidenced-based processes and professional expertise and involvement". There appeared to be confusion concerning whether or not HIS would be classed as a NDPB. MWC (2009) was one respondent that noted that unlike the case of SCSWIS this was not expressly noted in the documents accompanying the

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<sup>2</sup> NSS delivers national services deemed critical to frontline patient care and in the support of the efficient and effective operation of NHS Scotland. It encapsulates a number of better known organisations including: Health Protection Scotland, ISD Scotland, the Central Legal Office and Practitioner Services.

Bill.

## FUNCTIONS OF HIS

It should be noted that whilst there are separate provisions concerning the function of HIS in regards to the NHS on the one hand and independent health sector on the other, there are also a number of functions which are relevant to both sectors. However, many respondents to the Health and Sport Committee did not construct their responses around this distinction. Therefore, all the proposals in the Bill will be summarised first, before analysing the responses.

### The proposals

#### *Functions connected with the NHS (inserted sections 10C and 10D)*

The Scottish Government (2009c) has advised that these functions are not materially different to those of NHS QIS. Inserted section 10C provides for a number of functions, including:

- requiring HIS to exercise the functions of supporting, ensuring and monitoring the quality of health care provided by the NHS in Scotland (including quality assurance, and accreditation) eg advice to the NHS on the effectiveness of medicines<sup>3</sup> or the monitoring of the healthcare environment
- ensuring the promotion of user involvement and equal opportunities in the planning and development of health services by NHS Boards, Special Health Boards and NHS NSS
- conferring certain functions exercisable by Scottish Ministers under the 1978 Act eg to assist, financially or otherwise, voluntary organisations that undertake services similar or related to those of HIS, which is currently not a function of NHS QIS (NHS QIS, 2009b)
- making available to the public information on the availability and quality of health service eg details about the location and types of services available and the results of any inspections of services requiring the provision of advice to Scottish Ministers whether or not requested

Inserted section 10D would allow Scottish Ministers to delegate, through regulations, any of their functions in relation to the NHS to HIS, eg conducting an inquiry into failure in NHS care. In addition, HIS would be required to undertake tasks for bodies associated with the NHS as long as those bodies and Scottish Ministers agree.

#### *Functions connected with independent health care (inserted sections 10E to 10G)*

Inserted section 10E includes proposals for a number of functions to be undertaken by HIS concerning information on the availability and quality of independent health care services, which would be similar to those for NHS services described outlined above. In addition, (through inserted sections 10E to 10Z) it proposes HIS undertake the functions of registration, regulation and inspection of independent healthcare services, which are currently held by the Care Commission.

Inserted section 10F defines what an independent health care service would be under the legislation, which is the same as that currently in the Regulation of Care (Scotland) Act 2001 (asp 8), discussed above. Inserted section 10G provides powers for Scottish Ministers to introduce regulations (after appropriate consultation) to modify the functions of HIS in relation to independent health care service and/or the definition of those services.

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<sup>3</sup> It should be noted that, currently, a large part of this function is undertaken by the Scottish Medicines Consortium (SMC), which is not technically part of NHS QIS, though NHS QIS provides secretariat support. However, NHS QIS is responsible for deciding whether NICE guidance on a medicine is suitable for the NHS in Scotland. Should that guidance be different from that produced by the SMC, then this NICE/NHS QIS guidance takes precedence.

### *Standards and outcomes (inserted section 10H)*

This would provide Scottish Ministers with a power to prepare and publish standards and outcomes concerning the NHS and independent health services, and to keep these under review. Scottish Ministers would also be required to undertake consultation prior to publication and review. These standards should then be taken into account by HIS when it makes decisions related to the registration, inspection and enforcement of services provided under the NHS and independent health services. Ministers would be able to delegate this power to HIS.

### *Inspections (inserted sections 10I to 10N)*

These sections make a distinction between the inspection of NHS services and independent health services. Inserted section 10I would allow HIS to undertake an inspection of any NHS service under its duty of improvement and quality. These would be subject to a timetable approved by Scottish Ministers. Inserted section 10J would allow HIS to undertake an inspection of any independent health service, though this provision is more detailed on the face of the Bill given that these are private services, for example it stipulates:

- the purposes of an inspection would be to review and evaluate their effectiveness, to investigate particular aspects of a service and to encourage continuous improvement in the provision of those services
- that any service or combination of services nationally or in a part of a country could be inspected eg to allow a themed inspection of services provided to older people
- that HIS may require a person who provides a relevant service to supply it with any information necessary for HIS to undertake its functions
- that HIS would be able to decide the form which any inspection will take, subject to any regulations made under inserted section 10N (see below)

In addition, inserted section 10K, stipulates that that any inspection of independent health services must be carried out by a person authorised by HIS. It goes on to provide powers for this individual to enter and inspect any premises being used to provide such services, but also makes it clear that any confidential information they obtain during the inspection must not be used or disclosed by that person other than: a) for the purposes of the inspection; b) if required under law or a court order; and, c) for the purpose of protecting the welfare of a child or adult at risk or the prevention or detection of crime or prosecution of offenders.

The remaining inserted sections in this group then apply to both NHS and independent health services. Inserted section 10L proposes that Scottish Ministers can instruct HIS to undertake an inspection of any NHS or independent health service eg an inspection of the services provided to people with mental illness across both NHS and private providers. This provides for systems already in place, as it has been agreed that NHS QIS clinical standards will apply in the independent hospital sector (Scottish Government, 2009c). In addition, the NHS QIS review of anaesthetic services, published in June 2007, looked at both NHS and independent hospitals. Inserted section 10M would require HIS to prepare a report after carrying out an inspection of any service. It then sets out that reports should be sent to the relevant provider for comment and that it be made available to the public. It would also allow Scottish Ministers powers to introduce regulations that provide further detail on what would be required. Finally, inserted section 10N provides that Scottish Ministers be able to introduce regulations that make further provision on the detail of inspections and on the different types of inspection to be carried out, including: the frequency of inspections; authorised persons; interviews and examinations which might be carried out in relation to inspections; and, the creation of offences.

### *Regulation of independent health care services (inserted sections 10O to 10Z6)*

The Scottish Government (2009c) has advised there is nothing materially different in these sections that are not already in place in terms of the regulation of the independent health care

services by the Care Commission. These were outlined in the [‘Monitoring of independent health care services’](#), above. Therefore, the provisions cover registration, improvement notices, conditions, appeals, fees, complaints about services and offences related to the provisions.

#### *Inquiries (inserted section 10Z7)*

This would allow HIS to investigate a matter of serious concern on: the exercise of its functions; the provision of an independent health service; or, a service provided under the health service. Other provisions concerning an inquiry include:

- that such an inquiry be held in private, where necessary, for example in order to protect a victim of child abuse
- that the person holding the inquiry could issue a summons requiring an individual to give evidence or produce any documents in their possession or under their control
- allowing HIS to determine who should pay their expenses in relation to an inquiry

#### *Establishment of the Scottish Health Council (inserted section 10Z10)*

The Scottish Health Council (SHC) is currently set up as part of NHS QIS, to which NHS QIS delegates the function of supporting, ensuring and monitoring public involvement in the NHS. The SHC oversees consultations on major service changes and feeds into the boards’ annual reviews, reporting on how well they are delivering their public involvement responsibilities.

The Scottish Government wishes to ensure the SHC continues in this role. Whilst the Bill does not stipulate that it must exist as a Committee of HIS, the Bill allows it to be so. The Scottish Government (2009c) has advised that SHC was recently subject to review and while Ministers intend it to have a distinct identity within HIS, the precise nature of that has still to be determined. However, it is to have the responsibility of supporting, ensuring and monitoring the duties of NHS Boards, Special Health Boards and the Commons Services Agency to encourage public involvement in the health services for which they are responsible and equal opportunities in the delivery of all their functions.

#### *Transfer of staff (inserted section 10Z11)*

This provides that the existing staff of NHS Quality Improvement Scotland will transfer to HIS on the date on which it is established as a new body.

### **Comments on the proposals**

As indicated above, there was significant comment on the functions proposed for HIS. The key points raised will be outlined in the various sub-sections below.

#### *Functions – General*

Several respondents wanted greater clarity and detail on how HIS would operate and undertake its functions in practice, including Scottish Borders Council (2009) and UNISON (2009), the latter adding that this made it difficult to comment on any expected improvements. Others, for instance NHS Forth Valley (2009) and South Lanarkshire Council (2009) considered that for HIS to deliver the improvements envisaged by the Scottish Government there would need to be significant thought put into how HIS will bring together the functions and practices of its composite parts. NHS Forth Valley (2009) noted the very different cultures that exist in the Care Commission and NHS QIS.

NHS Tayside (2009, p 2) considered there was “a genuine concern that the functions identified in the Bill are too diverse that it is not clear whether HIS is an improvement agency or inspection agency”, adding that undertaking such different functions would be a difficulty for any single

agency. RCN Scotland (2009) reflected on the joint roles of scrutiny and improvement that would be awarded to HIS. It warned that public interest in scrutiny could skew the emphasis of HIS and its resources towards that area at the expense of quality improvement. Finally, NHS Greater Glasgow and Clyde (2009) questioned what would happen in the situation where HIS and another body have an overlap in functions eg the work of Health Protection Scotland (part of NSS) in connection with healthcare associated infection.

### *Independent Health Care Services*

A number of bodies, including NHS Greater Glasgow and Clyde (2009), BMA Scotland (2009) and the Scottish Independent Hospitals Association (SIHA) (2009), considered that the proposal to include the regulation of the independent health sector within the functions of HIS was appropriate. SIHA (2009) considered that it was an opportunity to review procedures for the regulation and registration of independent services. However, it was also considered by some that HIS was being given different powers over the scrutiny of the independent sector to those over the NHS. For example Scottish Borders Council (2009) called for more parity in the standards expected of the two services. NHS QIS (2009a) believed the lack of equivalence could present a significant challenge to developing a common approach.

There was some comment on the definition of independent health services in the Bill. NHS QIS (2009a) sought clarification of what was meant by an “independent medical agency” and how this was distinguished from an “independent clinic”. It also urged further reflection on “independent hospital” as it was unclear how situations where the NHS and independent sector work closely together in co-locating sites would be dealt with. Which? (2009) wanted the definition amended so that it would include cosmetic services such as laser surgery. This was echoed by RCN Scotland (2009) noted that the definition of a registered clinic was one where services are provided by a medical practitioner. It was concerned invasive cosmetic procedures could be set up by another type of health professional and would not be covered by the Bill. It was similarly concerned about alternative health treatments.

The Social Work Inspection Agency (2009) noting how all independent health services are being regulated (discussed above), felt that extending scrutiny across all defined services would be of benefit. However, NHS QIS (2009a), whilst welcoming the inclusion of such services within the remit of HIS, noted that there was a risk that the sector could distort or even dominate the balance of HIS’s improvement activities. It felt such a risk could be exacerbated if regulation extended to all independent services within the definition, noting that any extension would include dentists and other clinics. This was picked up by the British Dental Association (BDA) Scotland (2009), which raised the issue of dentists who provide both private and NHS treatment. It wanted clarification on how such dentists would be dealt with under the proposals.

NHS QIS (2009a) also considered the regulatory powers for HIS over the sector, pointing out that it does not currently register any services, and arguing that this would have a significant resource implication for HIS.

### *Standards and outcomes*

It was noted by several respondents that the approach proposed was a continuation of the approach of NHS QIS, and this was welcomed (eg NHS Greater Glasgow and Clyde (2009) and NHS QIS (2009)). NHS QIS (2009a) added that co-ordination and consultation on any standards published by Ministers was important to ensure consistency of approach. BMA Scotland (2009) reiterated the need to ensure clinicians were properly consulted when considering standards. NHS Greater Glasgow and Clyde (2009) felt it was important to distinguish between different types of standards and recommendations and the evidence base for these. For example, clinical guidelines may be based on significant and agreed evidence, whilst service standards may be more subjectively based on opinion and practice from elsewhere.

In terms of standards for the independent health sector, NHS QIS (2009a) noted that, at present, any independent provider delivering services on behalf of the NHS is required to comply with its standards. It welcomed a more integrated approach to standard setting across both sectors. NHS Forth Valley (2009) considered that the provisions would be of significant benefit to the independent sector.

Finally, several respondents discussed the relationship between any standards of HIS and overarching health targets and priorities. NHS Greater Glasgow and Clyde (2009) argued that, at present, the status of NHS QIS recommendations were not clear in relation to the priorities and performance targets of the Scottish Government. It wanted to see HIS have a clearly defined work programme that was aligned to wider NHS objectives and targets (eg HEAT targets), particularly in respects of the Healthcare Quality Strategy being developed by the Scottish Government. Similar points were raised by RCN Scotland (2009). COSLA (2009) also raised the issue in connection with Single Outcome Agreements with local authorities.

### *Inspections and reports*

Several bodies addressed this area in their submissions. NHS QIS (2009a, p 4) welcomed the provisions, but stated that whilst the inspection process will be transparent and accountable to the public and Scottish Ministers it “does not guarantee that the findings and recommendations of reports will be able to secure an adequate response by government and other relevant bodies...”. The MWC (2009, p 2-3) noted the separate provisions in the provisions for NHS and independent sector services. It considered that the outcomes specified for inspections of the independent sector by HIS were not replicated for the NHS, and said it was unclear about the Scottish Government’s “intentions and expectations about standards-based inspection in the NHS”. It also wished the Bill to be explicit about how and under what circumstances HIS could recommend improvements to the NHS, particularly given this was clear for the independent sector and that SCSWIS would have such powers over care services.

NHS Forth Valley (2009) also considered the impact of a HIS recommendation, and called for greater clarity concerning what enforcement powers it would have. It believed that NHS QIS had resisted seeing itself as an inspectorate in the past and that it was less skilled in scrutiny. It suggested that the skills and competencies of those authorised to undertake inspections and reviews be considered in the light of the very different regimes in NHS QIS and the Care Commission (which currently regulated the independent health sector).

NHS QIS (2009a) also made comment on the proposal that Ministers be able to introduce regulations concerning the provision of information during inspections. It noted that these are not approaches currently employed by NHS QIS and it strongly recommended that these provisions be underpinned by a Code of Practice, particularly in relation to the need for consent. The Information Commissioner’s Office (2009) raised concerns over what it considered to be wide ranging powers over what information could be demanded, and called for this to be limited only to information necessary for the inspection.

Finally, BDA Scotland (2009) raised several points concerning the proposals from the perspective of dentists should they become subject to the provisions. It noted the inspection of dental premises currently undertaken by NHS Boards and NHS Education for Scotland. It queried whether these inspections could be amalgamated with the regime to be undertaken by HIS. It also had some concerns as to how the proposal to give authorised persons powers to enter and inspect premises at any time, which it felt would cause disruption to practices and patients. It was concerned too that “authorised persons” be defined and that it be clear what persons would be included for dental services. The wider point made here was echoed to an extent by the Care Commission (Scottish Commission for the Regulation of Care, 2009) which suggested that authorised persons hold a regulatory qualification which is currently required for its officers. The final point raised by BMD Scotland (2009) was a more general point concerning

the publication of reports, and whether or not a provider would be able to appeal against a recommendation of HIS made in a report.

### *Scottish Health Council*

There was not a great deal of comment about the possibility of creating the Scottish Health Council as a Committee of HIS. The Scottish Health Council (2009) was satisfied with this as it allowed the Council to continue on a similar basis as currently exists. NHS QIS (2009a) also welcomed the possibility, which it considered would help to fully integrate user involvement in HIS. However, should this be taken forward, it suggested that if Scottish Ministers appoint a chair of the Council then this individual should be from core membership of HIS with the same lines of accountability as other members and not, as is currently the case, independently accountable to Ministers.

## **RELATIONSHIP WITH OTHER BODIES**

### **The proposal**

A key issue for the Bill is the manner and extent the new scrutiny bodies work together. Provisions for this are contained in Part six of the Bill and are discussed by Burnside (2009). However, joint working and the relationship between HIS and other bodies was raised by many respondents. Therefore, it is appropriate to briefly outline what the Bill proposes in Part six as a basis for discussing the views of respondents.

The Bill identifies a number of listed scrutiny authorities. These bodies, which include HIS, SCSWIS and MWC, would have a number of duties placed upon them:

- scrutiny: user focus – would require the scrutiny bodies to ensure users of public services are better involved in the development of governance arrangements and services, and in the delivery of those services
- scrutiny: duty of co-operation – would require the scrutiny authorities to co-operate and co-ordinate activities in the regulation, audit or inspection of local authority, social service and health services. Activities would also require to be co-ordinated with Scottish Government activities.
- joint inspection – would enable Scottish Ministers to request two or more scrutiny bodies to work together with other scrutiny bodies on joint inspections for children and other relevant services. It would also require joint inspection teams to work in an integrated way.

### **Comments on the proposal**

Several respondents discussed the proposals in Part six specifically, or their comments on such relationships related to the duties in this Part. Therefore, these shall be addressed first, before considering other issues raised in connection with the relationship between HIS and SCSWIS.

#### *User focus*

This duty was particularly welcomed by the Scottish Health Council (2009). NHS Forth Valley (2009) also welcomed the proposal noting that it would build on the good work already being undertaken. However, it considered that the preparation required for involving both staff and the public was significant, involving training as well as capacity building ensuring the public and staff were able to work effectively together. In terms of governance arrangements it also noted the specific skill set and understanding of requirements that were required by service users involved. NHS Greater Glasgow and Clyde (2009) noted the benefits to scrutiny and the identification of priorities that user involvement could bring but stated that it was important that the level of user involvement be appropriate to the scrutiny objectives identified. It added that

user involvement in the scrutiny process should not be confused with the scrutiny of organisations in engaging with the public, which was a matter for the Scottish Health Council. Finally, Which? (2009) called for an explicit provision in the Bill to ensure HIS itself undertook proper public involvement.

### *Co-operation*

Implicit in responses was the need for scrutiny bodies to co-operate well together. Therefore, there was not much detailed comment. NHS QIS (2009a) thought that the provisions would present HIS and SCSWIS with the opportunity to strengthen and develop working practices, for example in terms of a more consistent approach to risk assessments and improved sharing of information.

Amongst voluntary organisations, in particular, there was a call for local authorities to be subject to the duty to co-operate (eg Children 1<sup>st</sup> (2009)). However, it is difficult to see how this would be achieved in the Bill in its current form given part of the duty extends to scrutiny bodies cooperating on scrutiny of local authorities and their services. Scottish Care (2009) accepts this point. However, it felt there was confusion and duplication of scrutiny for care providers because of the demands of regulation on the one hand, and the demands of local authority commissioning and contracts compliance on the other. Therefore, it was something that needed further consideration. This point was reiterated by Community Care Providers Scotland (2009).

### *Joint inspections*

Again, this measure was widely welcomed. NHS Forth Valley (2009) identified a number of points for consideration, which also mirror some of the thoughts of other respondents including the Care Commission (2009) and COSLA (2009):

- it is important to ensure that individual scrutiny bodies merge their approaches to add value and not merely bolt on to each other
- joint inspection should reflect the fact that services are delivered along the patient journey of care
- there needs to be clarity of roles and purpose of the organisations taking part in the inspection
- there needs to be the development of joint standards to promote joint inspection
- there needs to be clarity of the information and/or evidence required dependent on the function of the inspection
- there should be ongoing evaluation of processes to ensure improvement and that they add value

The Care Commission (2009) also considered that scrutiny bodies themselves should be able to initiate a joint inspection, and not only because Scottish Ministers require it as is proposed.

### *Comparison between HIS and SCSWIS*

As noted above, some respondents would have preferred to have had a single scrutiny body for health and social services, and this led some to compare what is proposed for HIS and SCSWIS.

As the discussion on joint inspections and co-operation, above, show, it was considered that such duties were essential and would only benefit scrutiny of services across sectors. Respondents discussing this issue noted the Scottish Government's intention of there being a close relationship between HIS and SCSWIS, particularly given the overlap between health and social services in a number of areas. However, several considered that there were significant

differences which could present problems with that aim. These are briefly summarised below:

- the principles of the two bodies are different, with those of HIS appearing to focus more on quality improvement and advice and SCSWIS having a stronger focus on regulation (eg NHS Forth Valley (2009))
- whilst there is potential to reflect more accurately the integrated way health and social care is delivered, structural solutions alone will not be sufficient, and much will depend on how the bodies operate in practice (eg NHS Tayside (2009) and Children 1<sup>st</sup> (2009))
- further clarity is needed about the relationship of the two bodies, particularly in terms of the development of joint working practices and processes (eg NHS Greater Glasgow and Clyde (2009)) and for those providers who deliver services that span both remits (eg Scottish Care (2009))
- it is unclear how the Bill will improve the current situation of discrepancies in standards across the care spectrum – people should be able to expect the same minimum standards regardless of the setting (eg MWC, 2009)

## PROPOSALS FOR THE MENTAL WELFARE COMMISSION

The Mental Welfare Commission (MWC) was first established under the Mental Health (Scotland) Act 1960 (c 61). It is an independent organisation in its own right, with its constitution currently set out in the Mental Health (Care & Treatment - Scotland) Act 2003 (asp 13) (the 2003 Act), with a number of other duties set out in the Adults with Incapacity (Scotland) Act 2000 (asp 4). Its principle role is to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. The 2003 Act was implemented in October 2005. It enhanced the role of the MWC to involve monitoring and promoting of the Act and promoting best practice, in addition to the Commission's existing visiting role. Thus it has a significant role in scrutiny and promoting improvement amongst mental health services.

As discussed above, the Scottish Government's original intention was to include the functions of MWC within Healthcare Improvement Scotland. However, following publication of this proposal concerns were raised by many stakeholders and service users. As a result of representations to Ministers, the Scottish Government elected not to proceed with including the MWC in the Bill as introduced. However, Ministers said they would reflect further on how best to include MWC in their plans for the scrutiny of health services, and lodge amendments at stage 2, should the Bill progress.

On 1 August 2009, the Scottish Government (2009d) published a [consultation](#) that sought views on two key matters:

1. the future structure of the MWCS in terms of its functions and how it sits within the broader scrutiny and improvement landscape
2. the future governance of the MWCS assuming it remains an independent entity

It asks seven specific questions based on these two themes, and the consultation is due to end on 25 September 2009.

A number of respondents to the Health and Sport Committee made reference to the situation concerning MWC. NHS Forth Valley (2009) felt the decision to remove MWC from the Bill as introduced was appropriate. It believes there is merit in MWC retaining its specialist functions given the strong tradition of it has of protecting potentially vulnerable people, as well as providing advice for professionals and patients and their families. However, it did think its relationship with HIS was important. NHS Tayside (2009) agreed with this sentiment. The Social Work Inspection Agency (2009) felt that the uncertain situation was unhelpful, and stressed the importance of resolving the matter.

MWC (2009, p 4) noted the situation in its submission but considered the proposals in Parts 4

and 5 in terms of any future relationship it may have with SCSWIS and HIS. It stated:

“A major issue for us is the decision to split scrutiny and improvement functions between Health and Social Care. We exist primarily as a safeguard for the individual person with mental illness, learning disability or other mental disorder. We conduct this function across the spectrum of services, including not just health and social care but also others, including criminal justice. A key issue for us, especially in our investigations, is where failure to act collaboratively across the care spectrum results in deficiency of care or treatment for an individual. We have some concerns that this split in functions might not help address some of the joint working issues that we identify.”

It considered that without greater clarity on the form and function of the new organisations, it is difficult for us to determine how best to work with them

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Which?. (2009) *Public Services Reform (Scotland) Bill: Response to the Health and Sport Committee Call for Evidence*. Available at: <http://www.scottish.parliament.uk/s3/committees/hs/PSRBill/documents/PSR29Which.pdf>

## APPENDIX 1: RESPONDENTS TO THE HEALTH AND SPORT COMMITTEE; PARTS OF BILL RESPONDED TO

Sector	Name	Part 4	Part 5	Both
Health	NHS Forth Valley		.	✓
	NHS Greater Glasgow & Clyde			✓
	NHS QIS		✓	
	Scottish Health Council		✓	
	Scottish Independent Hospitals Association		✓	
	NHS Tayside			✓
Local authorities	Falkirk Council	✓		
	COSLA			✓
	South Lanarkshire Council			✓
	Scottish Borders Council			✓
Other public bodies	Information Commissioner's Office			✓
	Social Work Inspection Agency			✓
	Mental Welfare Commission for Scotland			✓
	Care Commission			✓
Charity/Voluntary	Children 1st			✓
	SAMH			✓
	Age Concern/Help the Aged			✓
	Community Care Providers Scotland	✓		
	Quarriers			✓
	Scottish Care	✓		
Consumer/Patient	Involving People Group	✓		
	Scottish Patients Association			✓
	Which?		✓	
	Consumer Focus Scotland			✓
Professional/Trade Union	BMA Scotland			✓
	ADSW	✓		
	BDA Scotland		✓	
	Unison Scotland			✓
	RCN Scotland			✓
	RCGP			✓
Government	Scottish Government			✓

## **APPENDIX 2: CARE COMMISSION ENFORCEMENT REGIME**

### **Step 1: Making a recommendation**

Recommendations will usually be noted in inspection reports and complaints resolution letters following discussion with the service provider. Where Regulations attaching to the Act or other relevant Regulations are breached, Care Commission staff will proceed to Step 2.

### **Step 2: Making a requirement**

If a Regulation is being breached, then a requirement should always be made and the service provider informed of this. National Care Standards may be the basis of a requirement where they link to Regulations. Requirements will usually be written in an inspection report or in a complaints resolution letter following discussion with the service provider and will have a timescale for implementation attached. The service provider will be asked to provide an action plan detailing how they will meet the requirements within the timescales, and this will be taken into account by the Care Commission in deciding the level and timing of regulatory monitoring activity. Care Commission staff will review whether the necessary action has been taken by the service provider. Care Commission staff will ensure that the service provider's response to requirements is monitored and recorded. Requirements are enforceable at the discretion of the Care Commission.

### **Step 3a: Formal enforcement – Section 13 condition notice.**

Where Step 2 has not succeeded in bringing about improvement or where the circumstances suggest that formal enforcement is a necessary first step, the service provider may be served with a section 13 notice of intention to impose an additional condition or vary an existing condition of registration. The service provider has a right to make representations against the imposition of the condition.

### **Step 3b: Formal enforcement – Section 10 improvement notice**

Where the evidence of breach of the Regulations is such as to justify cancellation of registration the service provider may be served with an improvement notice, under section 10 of the Act, which will detail the nature of the improvement required, the legal basis for this action, and the timescale for implementation. Step 3b may follow Step 3a, where the imposition of a condition has not succeeded in bringing about improvement, but may also be justified without a condition having been imposed. Conditions may be imposed at the same time as improvement notices.

### **Step 4: Formal enforcement – Section 12 cancellation notice**

Where the timescale for meeting the terms of the section 10 improvement notice has expired without compliance, the Care Commission may move to giving notice of intention to cancel registration under section 12 of the Act. The service provider will be advised of the legal basis of this action. The service provider has the right to make written representations against cancellation.

Source: Scottish Commission for the Regulation of Care (2008, p 4-5)

## APPENDIX 3: CRERAR REVIEW – KEY FEATURES OF A SYSTEM OF SCRUTINY

- Strategic priorities agreed by Ministers and Parliament, and focusing on areas where assurance about public services are most important. We recommend that financial audit should be one of the priorities.
- Core risk criteria agreed by Ministers, and considered by the Parliament, to assess the need for current and future external scrutiny.
- Self-assessment by providers as the main source of information about performance. Performance management frameworks are still being developed, so reliance on self-assessment is a longer term goal.
- Two stages in considering the application of scrutiny. First, there must be an assessment of risk against the core criteria agreed by Ministers. Second there must be an assessment of the appropriate external scrutiny required.
- Where scrutiny is needed, if there is more than one existing organisation, only one should be asked to do the work and to be responsible and fully accountable. Creating a new external scrutiny organisation to attend to the issue should not be an option.
- A timeframe with a preset 'sunset'; clause for each external scrutiny initiative or programme.
- Cyclical inspection, audit and regulatory programmes happening only where all other options have been considered and ruled out.
- Existing scrutiny being removed or scaled back when new scrutiny is introduced

Source: Crerar (2007, p 3)

## RELATED BRIEFINGS

- Burnside R. (2009) [\*Public Services Reform \(Scotland\) Bill: Finance Committee scrutiny.\*](#)
- Earle, M. (2009) *Public Services Reform (Scotland) Bill: Creative Scotland.*
- Edwards, T. (2009) *Public Sector Reform (Scotland) Bill: Rural and Environmental bodies.*
- Kidner, C. (2009) [\*Public Services Reform \(Scotland\) Bill: Social Services.\*](#)

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