The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 15 September 2015

Session 4

Tuesday 15 September 2015

CONTENTS

HEALTH AND SPORT COMMITTEE

24th Meeting 2015, Session 4

CONVENER

Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor David Clark (University of Glasgow)
Beth Hall (Convention of Scottish Local Authorities)
Donald Harley (British Medical Association Scotland)
Councillor Peter Johnston (Convention of Scottish Local Authorities)
Brenda Knox (NHS Ayrshire and Arran)
Norman Provan (Royal College of Nursing Scotland)
Dave Watson (Unison)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 15 September 2015

[The Deputy Convener opened the meeting at 09:15]

Palliative Care

The Deputy Convener (Bob Doris): Good morning and welcome to the Health and Sport Committee's 24th meeting in 2015. I ask everyone in the room to switch off their mobile phones because they can interfere with the sound system. Some MSPs are using tablet devices instead of hard copies of the committee papers.

We have received apologies from Nanette Milne and Duncan McNeil; they cannot make it today.

The first item is a presentation by Professor David Clark on his report "International comparisons in palliative care provision: what can the indicators tell us?". The report was commissioned by the committee and will inform our inquiry into palliative care.

Thank you for coming along this morning, Professor Clark. On behalf of the committee, I record our thanks for the hard work that you have put into the report. It is a substantial piece of work. In a moment, I will invite you to make a presentation to the committee for about 10 minutes. We would find that helpful.

As a small but important aside, I point out that your report got some media coverage this morning. Several members heard you on "Good Morning Scotland" so you had an early start. There is a positive and constructive dynamic about how we acknowledge good work that happens in palliative care, but we have not been afraid to tackle the gaps and drive forward change. We appreciate the work that you have done in pulling some of the statistics together. Thank you very much. I ask you to make your opening presentation.

Professor David Clark (University of Glasgow): Thank you for that welcome and your words of introduction. I am delighted to have the opportunity to present and introduce the report and answer questions on it this morning.

I begin in the same spirit as that in which you have begun, which is to build on some of the significant achievements in Scotland and on Scotland's wider influence in the world of palliative care. I do not want to digress too much into a history lesson, but it is not widely known that the first ever home for the dying in the United Kingdom was established by a woman from Donside in Aberdeenshire, Frances Davidson, who moved to the east end of London and opened a home for the dying there in 1885.

During the 20th century, we have seen developments in hospice services in Scotland and the growth in interest in and influence of some of the major charities, particularly Marie Curie and Macmillan Cancer Support. We have also seen a key role in the formation of what we call the modern hospice movement, which sees hospice care as not just about the delivery of excellent care to people who are in need, but about education, research and wider engagement with society. I pay tribute to Dr Derek Doyle, who was the first medical director of St Columba's Hospice in Edinburgh and who was instrumental in gaining recognition for palliative medicine as a medical specialty in Britain in the 1980s. He went on to be a major advocate for palliative care around the world.

There is quite a lot to celebrate about the contribution that Scotland has made to the field of palliative and hospice care, and about the resources that we have available to deliver care to people in our country. However, the situation in Scotland is quite different from that in the wider global context. Over time, I have tried to analyse the development of palliative care in all the countries of the world. As members will have seen in the report, we estimate that only 20 countries have an advanced level of palliative care development. We refer to things such as the availability of appropriate drugs for pain and symptom management, the provision of services in acute and community settings, the provision of education programmes, the existence of a body of research and, perhaps most important, underpinning policies and strategy on the part of Governments to support the development and delivery of palliative care.

Very few countries in the world are kitted out with those elements. Indeed, the World Health Organization very recently estimated that probably only 14 per cent of the world's population who need palliative care get any access to it.

We live in changing times and we have to continue to review what we are doing, even in countries with well-developed palliative care. The key element of that discussion is that we are moving from hospice and palliative care being seen as the business of specialists of one sort or another—the people who have spearheaded the development of the field—to hospice, palliative and end-of-life care becoming everybody's business. It is becoming more the business of generalists. In a wider context, there is a concern that we should all engage with it as an aspect of civil society and the wider society and communities in which we live.

It is time to take stock of where we have got to. There are lots of good things to acknowledge and celebrate, but we need to ask how much palliative care we are delivering and whether we are properly resourced to do that. My report tries to set out how we go about exploring that question and the indicators that we would need in order to provide some answers. Those indicators are to do with the supply of services, the need that those services are oriented to meet, the extent to which we have good access for and complete coverage of all those who need palliative care and, perhaps most critical and difficult of all, what we know about the outcomes of the care that is provided. How good is it? Is it appropriate? Is it well received by those to whom it is delivered? What is its quality?

My conclusion is that Scotland has problems in giving clear answers to such questions—and we are not alone in that—but I have tried to offer some solutions that we might explore in order to be better equipped to address those issues. When questions along the lines of "How good is palliative care in our country?" are quite reasonably put, we need to be better equipped to deliver fairly succinct but robust answers to them.

I recommend a number of things, on which I would be happy to elaborate. First, we need a reasonably robust mapping exercise of the delivery of specialist palliative care in Scotland. As I said in my report, we are unable to model palliative care delivery in Scotland against that in other countries because all the reporting takes place in a context in which Scottish data is buried within data for the United Kingdom as a whole. The time has come to create an atlas entry, if you like, that would allow us to compare palliative care in Scotland with palliative care in countries that have a similar population and are of a similar type.

The second thing worth doing would be to conduct a systematic review of the research on palliative care that has been done in Scotland, assess the research's quality and get more lessons and action points out of it than we currently do. Such an exercise was done in Ireland recently. Good work is going on in our universities, some of which is not very well known. By systematically reviewing that work, we could do a lot more to learn from it and disseminate the results the more widely. It is not uncommon for a person who is involved in research in the field to be somewhat disappointed when they talk to people about work that they have done, which they thought was well known, and find that some of the intended audience is still unaware of it, through no fault of their own. A systematic review and a wide dissemination of the work that has been conducted in recent years would be extremely useful.

We also need more investment in measuring the ways in which we identify people who could benefit from palliative care. In my report I distinguish between the public health question of how many people need palliative care and the clinical question of how we identify those people when we are in front of them and referring them to appropriate services. As I have highlighted, colleagues here at the University of Edinburgh and in the Lothian region are developing a good measure—the supportive and palliative care indicators tool, or SPICT—but it is still at a relatively early stage of development. More work needs to be done on refining such measures to enable clinicians quickly and accurately to identify patients and families who would benefit from palliative care and could be referred to it, whether that is specialist care or care that can be provided by general physicians, general practitioners and the wider health and social care team.

Finally, we need to agree on the appropriate quality indicators that we would like to assess the robustness of palliative care of all stripes as it is delivered in Scotland, and we need to invest in measures that will allow us to gather the data to support those indicators and to disseminate them and learn from them.

The Deputy Convener: Thank you, Professor Clark. I should have given your full title at the start. You are the Wellcome Trust investigator at the school of interdisciplinary studies, University of Glasgow. My apologies for not giving your full title.

Professor Clark: The Dumfries campus, as we always like to say.

The Deputy Convener: That is now on the record. Our first question is from Malcolm Chisholm.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): Thank you for your report. I will start with definitions and numbers, and perhaps definitions have to come first. I suppose that a lot of people think of it as end-of-life care, but obviously palliative care has a different definition. In part, I wonder whether we have an agreed definition. Some people might say that the definition should be stretched to include care for those living with pain and chronic conditions, because people will always try to palliate pain and suffering. Is there a clear definition in the context of what we are talking about? Could it become so stretched that we would not be quite sure what we were talking about?

Professor Clark: I did not want to muddy the waters too much on that, although it is an interest of mine. There are many definitions around—a recent systematic review of definitions of palliative care in English and German came up with 56 variants. I think that we would need some persuading to depart from the definitions of the WHO, which recently produced two definitions. However, there is an awareness that what we mean by palliative care is changing.

When hospice and palliative care first began to develop, the focus was very much on people with cancer who were at the end stage of their disease, when the trajectory was relatively short and fairly predictable. Hospice and palliative care came in at that point. Over the years, the WHO and many others have advocated for earlier intervention with palliative care and that is raising some complex debates, not least in the United States, where it is tied up with reimbursement issues. There is a strong argument among the palliative care leadership in the United States that we should drop all references to end-of-life care, death, dying or bereavement, and describe palliative care as an extra layer of support that helps people through the inevitable stresses, strains and challenges of their illness at all stages of the illness trajectory.

Here in Scotland and in the rest of the UK, we still see palliative care as closely associated with end-of-life care, and the broad reference point for end-of-life care is people in the last 12 months of their lives. As I have often said, it is often easier to say who those people are with the retrospectoscope than with any prospective approach, and we are challenged to know when people are in the last year of life and how best we can respond to them in that context.

There is no doubt that palliative care has a part to play at earlier stages of disease progression. As we age as a society and as people grow older and live longer, some of us will be challenged by multiple morbidities—not just cancer but other chronic conditions—and it is well accepted that palliative care has a role to play, as Malcolm Chisholm says, in the palliation of some of the problems associated with those conditions.

Malcolm Chisholm: Your report gives estimates of the numbers. Is the main issue that services are not available or is it that people are not being identified? Related to that is the question whether there is a problem with general practitioner registers. Would we deal with the problem through more effective use of GP registers? How do we identify those who are not receiving the palliative and end-of-life care that they might benefit from?

09:30

Professor Clark: The registers are a good start. Their character has been changing. We have had palliative care registers for some time and newer approaches have been introduced more recently. That is still at a fairly early stage. We have not yet done the studies—although some are under way—that would tell us whether those registers are reaching all the people who are in need. They seem to be quite effective at logging people with cancer and less effective for people with non-malignant conditions. In both cases, there is evidence that people are being registered only towards the end of their lives. We would like not only wider coverage but earlier registration.

This is an all-systems issue. We seek to raise awareness across the health and social care sector of the need to be vigilant in identifying people who have palliative care needs and might benefit from such care. As the committee may know, in 2014 I published a paper with colleagues in which we showed that, on any given day in Scotland, 29 per cent of all in-patients in hospital are in their last year of life and 9 per cent of all in-patients will die on that admission.

The point about that study is that it provides a wonderful opportunity for hospitals to think more actively about the identification of patients who are in their care and who unequivocally have end-of-life needs. However, we do not yet have simple measures to enable those people to be more readily identified at scale.

Malcolm Chisholm: Let us say that we successfully identified all those people. What would be the way forward? You suggested in your opening statement that palliative care should be taken on board by a larger number of people, such as generalists. Is there scope for expanding what you might call the specialists—the people who work in hospices or in community teams around hospices? How would the unmet need be addressed?

Professor Clark: I would like to do a proper modelling exercise of the specialist provision that we have, based on the guidelines of the European Association for Palliative Care. That would enable us to assess whether our specialist provision is more or less right. We would then have an evidence-based approach.

Whether or not that is the case, we certainly need to make palliative care more the business of a lot of other people. One difficulty has been that there is still perhaps a perception that palliative care comes in right at the end and involves giving up other things. The idea is that, if I pass my patient to palliative care services, I will lose my involvement with them and the opportunity to actively treat their disease.

As members probably know, that is exactly how hospice care is funded in America, although that is about to change. To go on to a hospice programme there, someone must have a prognosis of less than six months to live and they must give up all active treatment. That is not a desirable position—we would not want to see it here—but the mindset of some clinicians is perhaps still that there is a transition to palliative care that involves giving up certain things in order to access that care. We need to work on that right from the beginning with our medical students and nursing students. We need to promulgate more widely the idea that palliative care has an integrated role in the spectrum of care that we deliver to a person.

The Deputy Convener: You talked about identifying those who are in receipt of or in need of palliative care. The committee is working on the Carers (Scotland) Bill, which has proposals for young carer statements and adult carer support plans. We are aware from our own family experiences that, as a person makes a transition towards palliative care, their family, friends and loved ones are actively involved in their care.

Legislation is going through Parliament that seeks to capture every individual in that caring process. Might that be an opportunity to identify those in society who are making a transition to palliative care? We will go on to talk about how we support people better. However, we have to identify those who need additional support before we can resource that support and provide it as best we can. Does that bill provide an opportunity to do that?

Professor Clark: It definitely does. I have used rather medical language in talking about patients and their needs, but the key thing about palliative care is that it supports carers, families and others who are directly affected by the illness and impending death of a person and it seeks to assess their needs in delivering care.

The example that you just gave affords us an opportunity to seed thinking, language, ideas, information and evidence about palliative care across a spectrum of policy instruments, guidelines and statements from the Government. That is what we badly need.

Around the world, palliative care is still very much in an early advocacy stage, with people drawing attention to what it is and helping people to better understand it. The next step is to integrate those ideas more widely across health and social care systems. That means seeing such language in the documents that Governments issue.

Dennis Robertson (Aberdeenshire West) (SNP): The deputy convener went down the line that I was going to pursue. Before I continue on that line, I will address another issue.

Around 6.40 this morning, on “Good Morning Scotland”, you mentioned specialists and talked about a generalist approach. I would like to tease out a wee bit more about that approach, which includes the allied health professionals and, as the convener said, friends and family. When we took evidence on the Assisted Suicide (Scotland) Bill, it came out clearly that, culturally, we in Scotland do not face death well—we do not talk about dying or make provision for it. Is that a barrier?

Professor Clark: That is an important issue, which the palliative care community in Scotland is doing excellent work to address. We have seen a number of examples of that in the past few years, such as the death on the fringe project; the good life, good death, good grief initiative; and the to absent friends festival. Those are all organised by the Scottish Partnership for Palliative Care.

That organisation and others, me included—I write regularly on a blog, and we run death cafes and the like—are trying to create a wider conversation across society about mortality and death. My experience of the death cafe phenomenon shows that it is remarkably easy to get people to talk about death, once we have brought them together and given them the opportunity. The notion that it is a taboo is quickly undone when we sit people down with a cup of coffee and an opportunity to talk about these things.

A great deal of work could be done on that. I would like a wider conversation to take place and our major institutions to take the issues more seriously. Universities, the business world and faith groups all have a significant part to play in a wider conversation about care at the end of life. They could also contribute to a discussion about the limits of medicine: what can we expect from our healthcare system and at what point do we acknowledge that the focus should be on palliation, comfort and dignity at the end of life? Those things are relatively intangible and somewhat difficult to measure, but they are not necessarily costly to deliver.

Dennis Robertson: There is a pathway or journey towards palliative care across all ages. People move from requiring some care to requiring nursing care and then palliative care. In that transition, how do the families, the medical professionals and the allied health professionals identify when the patient requires palliative care?

Professor Clark: A number of triggers can be identified, but they need to be put together and a conclusion needs to be reached. There are factors such as repeat admission to hospital; prolonged and unrelieved symptom difficulties or pain, even when the concurrent care for the condition appears to be optimal; and dwindling mood and a depressed affect. We can do many things, but the difficulty, particularly for families, is that these things can creep up on us slowly and are difficult to identify day by day. Nevertheless, the clinician’s role is to put such things together in a bundle and say, “Look, there’s a light flashing here. We need to think differently and have a conversation.”

Dennis Robertson: You are absolutely right. Because they live with the situation 24/7, families tend to adjust and perhaps do not recognise the signs. Are you saying that it is down to clinicians to identify that the condition has moved forward on the journey towards the need for palliative care?

Professor Clark: Clinicians are certainly key. In America, a lot of work is being carried out on an interesting model in which service users are being encouraged to self-monitor and then ask for palliative care.

Having mentioned aspects that we can attend to, I have to say that I was impressed with last year’s Reith lecturer, Atul Gawande, when he gave the key lecture at the Royal College of Physicians in Edinburgh last November. He talked about the simple questions that people should think about asking in this context, which include: what do you understand by your condition at the moment? What are the limits on the things that are acceptable to you? What would you most like to happen and what do you not want to happen? If those basic questions are put to someone, they will often result in good information. However, they are not routinely asked, and one notion is that such questions should be built into systems and asked as routinely as, say, the question whether a person is allergic to penicillin. The analogy that we should be thinking of those questions as routinely as we think about allergies is interesting.

The Deputy Convener: Perhaps, Mr Robertson, you can ask one more follow-up question and then let other colleagues in.

Dennis Robertson: Indeed, convener.

How important is such awareness for the health and social care agenda that we are moving into? In 2014, the World Health Assembly talked about the requirement for this to be an integral part of the services that all health boards provide.

Professor Clark: Earlier you referred to the social dimensions. For most people, dying is not a medical but a social and personal event. However, although personal and social services are critical, they have tended not to be prominent in the dialogue about how we deliver end-of-life care.

The integration of health and social care provides a wonderful opportunity to address that more actively, to reduce inequalities, to promote equality and to build on the assets that exist in communities. I began by mentioning our assets in specialist palliative care, but we also have huge assets in our families and communities that we can build on if we properly support those who can give help.

09:45

Mike MacKenzie (Highlands and Islands) (SNP): I was interested in—and, in fact, disappointed by—your comment that we do not have the necessary data to fully understand the palliative care situation in Scotland. I am not sure whether that is because of an overall lack of data or an inability to disaggregate the data at Scottish level from the data at United Kingdom level.

You note in your report that you could not detect any significant correlation between the availability and quality of palliative care and inequality. There appears to be no difference between the availability of palliative care to those who are better off and its availability to those who are worse off in society, but have you noted any regional variation? A larger proportion of the Scottish population than of the UK population lives in rural areas, and I wonder whether there are particular problems in delivering palliative care in rural and remote rural areas. Do we have the data to know that?

Professor Clark: This is a fairly weak answer, but we do not have the information. That is not because data cannot be got; it is because we have not committed to getting it, analysing it systematically and sifting it over time. That would not be too difficult a job to do, but we would need a commitment to do it and the resources to support that. I would like us to do that in order to build up a clearer picture of the quantity of palliative care—at the very least, of specialist palliative care—that is being delivered across the country as well as of the issues, if there are any, that arise in relation to access not only by where people live but according to their age, ethnicity and diagnosis. We need more robust data on all those areas if we are to properly understand how palliative care functions in Scotland.

Mike MacKenzie: Thank you very much. You have answered my questions.

Rhoda Grant (Highlands and Islands) (Lab): I have a quick question on the data and information. It seems that the Scottish data is all wrapped up in the UK data and is hard to extrapolate. Why is that the case, given that we have had different health services since before the Scottish Parliament was created?

Professor Clark: I do not know why that is the case. Some academics in Scotland are interested in the issue, but we do not have a Scottish network or a centre for palliative and end-of-life studies where those people could work together in a co-ordinated way and be resourced appropriately. We do not have an end-of-life observatory that routinely collates such information; we have a relatively small group of people who are doing studies. Many of those studies, important though they are, are based on small samples of local populations.

I have been arguing for a while that we need more population-based data on the need for palliative care in Scotland. I now have a role in assisting the Scottish Government to prepare its palliative and end-of-life care strategic framework for action, and the Government has identified measurement and data as a key issue for that framework to address.

Rhoda Grant: There have been studies on the availability of palliative care for different conditions. Marie Curie published a report that said that people with cancer are much more likely to access palliative care than people with other conditions are towards the end of life. How can we make the system fairer, so that people with all conditions can access palliative care?

Professor Clark: In my report, I hinted that the cancer and non-cancer distinction is becoming more blurred. Ten or 15 years ago, the contrast was quite stark, and most specialist palliative care services—then as now—dealt predominantly with people who had a cancer diagnosis.

For a time, people said that a cancer diagnosis was the passport to getting world-class palliative care and that those without it were excluded. However, cancer is changing—it is becoming a chronic illness. Someone might have cancer more than once in their life, and they might have other conditions as well. We should focus on the basket of conditions rather than on the cancer and non-cancer distinction. Particularly among older people, we have to link palliative care to issues of frailty as people live to advanced age.

It is generally accepted that some barriers to accessing palliative care still exist. The barriers also relate to age. Historically, palliative care has been better at responding to the needs of people with cancer in the slightly younger age groups. It has not been so effective at delivering care to people in advanced old age who might have had cancer but who might also have other problems, such as stroke, heart failure or orthopaedic problems.

There are lots of opportunities for geriatricians, orthopaedic surgeons and other services to be brought into the dialogue about their role in palliative care. In some of our hospitals, good work is going on where people are collaborating across specialties. We need to get a range and breadth of palliative care, rather than have a narrow focus of intervention.

Rhoda Grant: Is the issue to do with patients being able to speak up for themselves? People with cancer who have a terminal diagnosis that is quite rapid can be in reasonably good health when they are discussing palliative care and can be demanding of those services. Elderly people, who might have had a much slower decline, and other people with illnesses in which the decline is much slower might be less able to ask for intervention when they need it and should have asked for it earlier.

Professor Clark: That is right. Advocacy is an issue, which is why I have used the study that we did in Scotland’s hospitals as a platform for advocating for older people. We found in the study that not only do 28 to 29 per cent of all hospital in-patients die within a year but that figure rises steeply with age, particularly for men. More than 50 per cent of older men in hospital will die within a year, but they are not necessarily being advocated for or signposted for palliative care. That is where the involvement of other specialties becomes important, as well as the advocacy of the GP, the social worker and the nursing team.

Colin Keir (Edinburgh Western) (SNP): Before I ask a question, I will say that I totally agree with Professor Clark’s comments about Dr Derek Doyle, who did remarkable work. I say that not just because I know of his work in St Columba’s Hospice and his work after that but because, prior to moving on, he was my GP. I am delighted that he is getting recognition here. He deserves it after his lifelong work in this field.

In replying to Rhoda Grant’s and Mike MacKenzie’s questions, you have talked about a lot of what I wanted to ask about. I will go back a bit. Cancer care is the most common and the most well-known form of palliative care; members of the public are aware of it. Slow degenerative illnesses seem to present a problem because of difficulties in going from ordinary care to palliative care—that depends on the speed of the individual’s decline—and because of the specialisms that are required to look after someone with, for example, Huntington’s disease or Parkinson’s disease. Is there a general way in which we look after people in palliative care, or are there differences that cause difficulties in providing the service throughout the country?

Professor Clark: Some underlying principles are common across all conditions: good pain and symptom management, good assessment, regular and continuous review, multidisciplinary approaches that involve other colleagues and attention not just to the patient but to the family and the wider social context. All those general principles play out in any context. There are also condition-specific implications of the kind that you highlighted. One condition that you did not mention is dementia.

Although we were delighted that palliative medicine was recognised as a specialty in our country in 1987, perhaps it was a mistake to create a specialty with a full four-year training programme of its own. In other countries—most notably the USA—palliative medicine has become a sub-specialty of other medical specialisations.

When palliative medicine was recognised rather late in America as a specialty, it became a sub-specialty of about a dozen other fields. The idea was that someone first trained in paediatrics, geriatrics, orthopaedics, oncology or neurological conditions and then sub-specialised for a shorter period in the palliative care of people with those conditions. As a result, a body of knowledge and expertise is building up about the specific palliative care needs—as you indicated, they are sometimes complex and demanding—of those with particular diagnoses. Those specific care needs must be attended to by people who care for those patients in a specialist context and who practise the broader principles of palliative care.

The difficulty is that, over a long period, most of the focus has been on patients in the oncology setting with a diagnosis of cancer. We now have palliative medicine services that sub-specialise to a degree in looking after the groups that you described, but that is not the solution to meeting their needs. That solution comes from the specialist services that are already looking after them, which need to be more attuned to the palliative care approach.

The Deputy Convener: I have one final question, which brings us back to where we started when we discussed the definition of palliative care and whether such care is part of the care specialist’s role or whether we all have a responsibility to offer a degree of palliative care, whether we are family or friends; care staff who come into the home to support someone’s social care needs; under-pressure care staff in a residential care setting who have to meet the variety of needs of frail elderly people, who might have additional multimorbidities; or staff in a nursing home.

I am trying to tease out whether, as the Scottish Government develops its palliative care strategy—you are assisting with that and the committee is conducting an inquiry into palliative care—you would encourage us to look at the full range of social care supports. If someone has trouble swallowing, a bit of help in eating might look like a social care support, but the chances are that the person could be in their last year of life, so it could be part of palliative care support. Would you urge us to broaden our inquiry or to focus on specialisms?

Professor Clark: Definitely the latter. I have written about this elsewhere, although not in my report for the committee. There are two facets to palliative care. We have tended to dwell on one of them this morning—the view that it is a specialist medical service—but there is also the notion that it is everybody’s business as an issue in the wider sense of public health, as part of health promotion, community assets and community engagement.

We have a wonderful opportunity in Scottish society to promote more discussion and involvement in that. The questions could be addressed in the curriculum for excellence in our schools. We could engage on some of the issues with our young people and raise more awareness of end-of-life and palliative care needs across many of the subject areas that we teach in university. Employers could become more sensitised. Trade union members, faith groups and all kinds of community organisations also have a part to play.

There is a will on the part of some activists in palliative care in Scotland for there to be more engagement and for it to be recognised that, as the Scottish population age and grow, the solution to the issues will not be found simply in the formal healthcare system, because the issue is for the whole of society.

The Deputy Convener: We are out of time but, given the nature of the discussion, I want to check that none of my MSP colleagues wants to ask a final question.

Dennis Robertson: I will keep it brief, Professor Clark. You mentioned at the beginning work that is going on at the University of Edinburgh. Is that work being done on a tool that can be used to assess the need for palliative care?

10:00

Professor Clark: That is exactly what it is. It is a relatively simple tool that can be used in a lot of contexts to identify people who might not necessarily benefit from specialist palliative care but who need greater attention to be given to their palliative care needs by those who are caring for them.

Dennis Robertson: Will that tool be able to be used by all professionals, including medical professionals, allied health professionals and carers?

Professor Clark: It could be developed in that way. However, I should point out the slight note of caution in my report. A tool called the Liverpool care pathway was developed and rolled out in England and many other countries but, because it was not well validated or robustly tested, it ran into major problems. We are eager for simple tools that can be widely adopted, but we need to invest time and energy in ensuring that they are robust, usable and reliable.

Dennis Robertson: Was a tool used at NHS Grampian’s Roxburghe house by the consultant at the time, David Carroll, to measure more or less daily the patients who were in the hospice?

Professor Clark: That tool would have been used with patients in a specialist setting. The interesting feature of the SPICT tool is that it identifies people wherever they are in the system.

The Deputy Convener: Your report, presentation and answers to our questions will certainly help the committee with its on-going palliative care inquiry. Thank you for that and the work that you have carried out so far for the committee. I have no doubt that we will keep the dialogue and communication going.

I briefly suspend the meeting to allow us to set up for agenda item 2, which is a round-table evidence-taking session.

10:01

Meeting suspended.

10:05

On resuming—

Health (Tobacco, Nicotine etc and Care) (Scotland) Bill: Stage 1

The Deputy Convener: Welcome back, everyone. Item 2 is our third evidence session on the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill.

In a round-table discussion, we have a round of introductions rather than my welcoming everyone to the committee. I will start. I am Bob Doris. I am a Glasgow MSP and the deputy convener of the committee.

Norman Provan (Royal College of Nursing Scotland): I am associate director of the Royal College of Nursing Scotland.

Mike MacKenzie: I am an MSP for the Highlands and Islands region.

Dave Watson (Unison): I am the head of campaigns at Unison Scotland.

Dennis Robertson: Good morning. I am the MSP for Aberdeenshire West.

Malcolm Chisholm: I am the MSP for Edinburgh Northern and Leith.

Brenda Knox (NHS Ayrshire and Arran): I am health improvement lead at NHS Ayrshire and Arran.

Colin Keir: Good morning. I am the MSP for Edinburgh Western.

Councillor Peter Johnston (Convention of Scottish Local Authorities): Good morning. I am a West Lothian councillor, but I am here in my capacity as the Convention of Scottish Local Authorities health and wellbeing spokesperson.

Beth Hall (Convention of Scottish Local Authorities): Good morning. I am an officer with COSLA.

Richard Lyle (Central Scotland) (SNP): Good morning. I am an MSP for Central Scotland.

Donald Harley (British Medical Association Scotland): Good morning. I am deputy secretary of the British Medical Association Scotland.

Rhoda Grant: I am an MSP for the Highlands and Islands.

The Deputy Convener: I thank everyone. You are all most welcome.

In a moment, I will ask COSLA and the RCN to give two-minute statements, which they requested to do.

There are two main parts of the bill. We have yet to hear evidence on the duty of candour and on wilful neglect. What the witnesses decide to give their statements on is, of course, in their hands, but when we start our questioning, we will concentrate on those parts of the bill first. We will, of course, go on to the other parts of the bill.

MSP colleagues, we do not have anyone who has agreed to ask the opening questions, so you should feel free to catch my eye once you have been inspired by the statements.

I ask a COSLA representative to go first. Who will make the opening statement?

Councillor Johnston: I have drawn the short straw. Thank you for the opportunity to speak to the committee.

As a significant partner in the on-going campaign to reduce the number of people who smoke in Scotland, COSLA signed up to the existing tobacco control strategy in early 2013. We believe that most of the proposals in the bill provide the support that is needed to keep us aimed firmly at the national targets.

We believe that the next period will be particularly challenging in light of the increasing popularity of e-cigarettes, which many people see as a means to help them to quit smoking. We recognise the risk that that popularity has the potential to undermine our efforts to denormalise smoking.

We support the proposal to allow point-of-sale advertising of e-cigarettes. Our view is that smokers who wish to use e-cigarettes to help them to quit smoking might benefit from point-of-sale advertising.

We are concerned about the proposal to introduce legislation to ban smoking in hospital grounds. The national health service only recently—in April 2015—extended its smoke-free areas to outdoor areas. Local authorities are in the process of doing the same by the end of this year. We believe that there has not been sufficient time to look at the evidence base that comes from where we currently are before moving to legislation.

I want to comment on the duty of candour and go on to wilful neglect.

In relation to the other parts of the bill, which deal with care, it goes without saying that we fully support continuous improvement in quality and safety across health and social care and that we recognise the need for disclosure and remedy of harm. However, we are uncertain as to whether more legislation is absolutely necessary to meet those objectives, especially in the case of the proposed duty of candour. The social care profession has a long history of operating in a culture of openness that supports frank discussion of potential harm and the management of risk within that context. It is not clear to us that placing a new duty of candour on providers of health or social care is the best or only way of securing a culture of openness and transparency across the newly integrated health and social care systems.

Careful consideration of all other avenues for achieving that policy intention is required and it might be that securing the desired culture change should be a matter for guidance, training and bespoke improvement support rather than legislation.

With regard to the part of the bill that deals with wilful neglect, we make it clear that COSLA is committed to the principle that the state should take strong action against ill treatment or wilful neglect, and that people who receive health and social care services should expect to be safe from harm and be supported in an environment that respects their dignity. If we are to realise that policy intent, careful consideration of the evidence of the most effective means of achieving those aims is required. Should the case be made that the new legislation will aid prosecution, enhance deterrence and avoid criminalisation of poor practice, we will recommend to our members that they support its central thrust. However, at this point, we are concerned that the interface between a new offence of wilful neglect and a duty of candour could produce unintended consequences. For example, although a culture of greater openness and transparency is clearly desirable, the simultaneous introduction of a wider reaching criminal offence of neglect could militate against that.

The Deputy Convener: Thank you, Councillor Johnston. If you were making that speech in the chamber, the Presiding Officer might have cut you short; she certainly does that to me when I go over my time. However, it was important for you to put all that on the record.

Norman Provan: Thank you, convener. I am pleased to be here today on behalf of the Royal College of Nursing in Scotland. The RCN is the UK's largest professional association and union for nurses and we have around 39,000 members in Scotland. As members know, nurses and healthcare support workers make up the majority of those who work in the health service in Scotland.

I state at the outset that the RCN would never condone the wilful neglect or ill treatment of a patient. It goes against the very tenets of health and social care professionalism and the ethical duty of care that our members have to their patients. However, we have serious concerns that the proposals in part 3 would undermine efforts to encourage greater openness among healthcare professionals and organisations when something goes wrong.

We also remain unconvinced that the wide range of sanctions that already exist is inadequate. There is no evidence that individuals or organisations are not being held to account when there are failings in health or social care delivery. We are concerned that the threat of criminal proceedings being taken against individuals will run counter to the building of a culture of transparency, learning and improvement within and outwith the NHS. Such a culture is key to patient safety.

I will leave my remarks there; I look forward to exploring the issue further today.

The Deputy Convener: Thank you, Mr Provan.

I asked members who have questions to catch my eye and it has been effective, because Malcolm Chisholm has been waving at me for the past few minutes.

Malcolm Chisholm: I know that we want to start with the duty of candour and the offence of wilful neglect. I found the submissions very interesting on that, particularly the contrast between the BMA and the RCN on one hand, and Unison on the other. We want to hear more from the BMA and the RCN about their problems with the proposals. In contrast, Unison seems to be supportive of both proposals.

The other interesting dimension is the extent to which we are talking about organisations as opposed to individuals. It looks as though Unison is emphasising the organisational side, although I presume that the offence of wilful neglect will apply to individuals as well as organisations. It would be useful if the committee could establish the reasons why a major healthcare union such as Unison supports the proposals while the other two healthcare unions, if the BMA will allow me to call it a union, are very much against it.

The Deputy Convener: Donald Harley, you caught my eye so it would be useful for you to come in and say a few words on that.

10:15

Donald Harley: Good morning to all. I will comment briefly on our position, which might help to clarify it for Malcolm Chisholm and other members round the table. As you would expect, the BMA supports the principles of openness, honesty and transparency in NHS Scotland and the broad principles of person-centred, safe care that lie behind the proposals in parts 2 and 3 of the bill. However, as Malcolm Chisholm rightly noted, we have concerns about some of the proposals and whether there is a need for legislation in those areas at all.

As has been noted, there is a bit of a contradiction between the proposed new offence of ill treatment and wilful neglect, and the duty of candour, with the two working against each other and against the important culture of openness and transparency that needs to lie at the heart of the NHS, which we need to build and sustain. We are also concerned that there is potential for adverse impacts on clinical decision making, which could lead to risk avoidance at the margins of clinical practice. Fundamentally, if people have undue concern about consequences, will they be open to sharing information within organisations and across the NHS and helping to build the learning, developing NHS that we all want?

We need some clarity on how the apologies that would be given under the legislation would work in practice with the UK-wide General Medical Council standards and investigatory processes. It is not clear to our members whether the safeguards in the bill would satisfy the GMC at the UK level. I guess that the same would be true for the Nursing and Midwifery Council, but it might wish to speak to that as well.

The Deputy Convener: After all that, I am still not clear where you stand on the duty of candour. Is it true to say that you broadly support it but that you want to double check whether there are enough safeguards? It aligns with the current professional standards and requirements in terms of duties, does it not?

Donald Harley: You are absolutely right. There are professional duties within both the GMC and the Nursing and Midwifery Council that make that incumbent on health professionals. It is just that there is a question mark over whether legislation is required on top of that, whether it would impose bureaucracy that would bear down on the NHS at a time when we know that services are under financial pressure and whether we want to add administrative costs to the system when we know that every penny is needed for front-line care.

The Deputy Convener: I apologise to Malcolm Chisholm because this discussion follows from his opening question, but I assume that consistent reporting and use of a duty of candour across all health professionals, via health boards, would be a positive thing.

Donald Harley: In principle, yes. It depends on how it is applied.

The Deputy Convener: I was not trying to lead you. I am just trying to establish where the BMA sits.

Dave Watson: We broadly support the bill, although we say in both our written evidence and the submissions that we made at the consultation stage that we share a lot of the concerns about it, including about costs, workload and training.

There is some conflict between employment contracts and the regulatory position, and there is at least potential for unintended consequences in relation to care. However, we also recognise that the current system is weak in places, with inconsistency of approach and, in some places, reluctance about being candid.

If there is a difference, I suppose that the evidence for legislation is probably thinner in relation to the NHS than it is in relation to social care. We also represent large numbers of members in the social care field, and you will be aware that we have made points about the introduction of commercial pressures to social care. In our report “Time to care: a UNISON report into homecare”, we set out the concerns of front-line staff in commercial organisations and the voluntary sector, who explain some of the commercial pressures that arise because contracts are in place.

You might have seen recently an employment tribunal case in which a care manager reported that she was told by her company to accept care packages even though she had no staff to deliver them. That reflects some of the experiences that people have had. I did some of the focus group work for that report, and I met staff who were clearly unwilling to report not just safety violations but carer abuse. There is an issue with that, particularly in the social care sector.

Our view has consistently been that legislation can drive culture change but that it does not do so on its own and that organisational support and other aspects are needed as well. We can see evidence for that from, for example, the legislation on drink driving and on smoking in enclosed places. We have argued the same point in relation to violence against staff. If we have a criticism, it is that the Scottish Government has not been consistent, because it says that we need legislation on care but it rejected legislation on violence against staff, which we believed would drive culture change.

Malcolm Chisholm is correct that the important point for us is that the parts of the bill on the duty of candour and on wilful neglect and ill treatment put the emphasis on organisations as well. There is a risk with this type of legislation that organisations will use it simply to scapegoat staff. We think that, as long as the emphasis on organisations is backed up in guidance, training and regulations, it will help to change the culture to what we believe it needs to be.

Malcolm Chisholm: I do not know whether the laws in England in this area have been applied long enough or are significantly different from what the bill proposes, but is there any evidence from England on the duty of candour and on wilful neglect and ill treatment? I think that there are provisions on those things in legislation there, but perhaps they are not in the same form as in the bill. Is there any evidence from England that would back up either side of the debate, or is the legislation there too different to be helpful?

Dave Watson: I do not think that the legislation is too different there, but I think that it is too early to say. We have not done a survey of our members yet to see whether the legislation there has had any impact.

The Deputy Convener: Can anyone else draw on examples from England in the way that Malcolm Chisholm suggested? If not, Rhoda Grant will take the discussion forward.

Rhoda Grant: First, I put on the record that my entry in the register of interests shows that I am a Unison member.

I was interested to see that Unison is disappointed that the bill covers only adult health and social care and thinks that it should be extended to cover young people. I want to hear other witnesses’ views on that point and on why the Government has left out young people, who are a particularly vulnerable group.

Councillor Johnston: We would support including children’s services in the bill, given that a number of health and care partnerships are already looking to include children’s services and go beyond the minimum requirement of including adult social care services. Given that children live in families, it seems strange that the bill would cover the adults in a family but not the children. It should certainly cover children’s services and the whole range of integrated services.

Dave Watson: We feel that a consistent approach is needed in that regard. In fairness, I understand why it has not come straight away in this bill. There is a complex range of other legislation that applies to children’s services, particularly on the protection of children. We need to work out how to match up the bill with that legislation because we do not want conflicting laws that would mean that staff would not know which they should be operating. We would like the Government to take a careful look at that and ensure that we have a consistent approach across all care areas.

The Deputy Convener: Does anyone want to add to that? No—there has never been such a passive set of witnesses.

Dennis Robertson: Can I come in at this point?

The Deputy Convener: I will give Rhoda Grant the opportunity to respond first, because it was her question.

Rhoda Grant: Thanks, but the witnesses’ responses clarified the issue for me.

Dennis Robertson: Do the witnesses feel that existing regulations in social work and its policies and procedures are sufficient at the moment and could simply be improved through guidance rather than by going down the legislative route? We had the Medical Act 1983 for our doctors, and I wonder whether something like that could be rolled out and embraced to cover a broader spectrum in the health sector. Should we ask the Scottish Social Services Council to look at its guidance for the care sector to ensure that that is taken forward and that the guidance is robust enough without imposing legislation?

Norman Provan: We feel that there is enough legislation at the moment to deal with that. The regulatory legislation through the GMC and the NMC can hold professionals to account for their behaviours. There is also an offence of common-law assault, which the judicial system in Scotland can make use of, and the Protection of Vulnerable Groups (Scotland) Act 2007 is slowly becoming embedded in the system. Our view is that you do not need additional legislation to deal with the specific claim of wilful neglect, because there is enough in the system to deal with it at the moment.

I would like to illustrate that with an example. There are people who are already covered under the Mental Health (Care and Treatment) (Scotland) Act 2003 in relation to wilful neglect. The RCN is currently handling somewhere in the region of 600 cases across the whole spectrum of services that we provide—including employment, personal injury and regulatory work—but we are dealing with just two cases in which someone might have been accused of neglect. My question is whether, given the legislation that is already in place, we need another layer of legislation to deal with that.

Donald Harley: I would like to follow up on the point that was made about the Medical Act 1983. The provisions that the GMC makes for doctors are clearly very onerous indeed. As you will be aware, in many instances when doctors are under investigation, that can be career limiting or career ending, so that regulatory mechanism has teeth and we see it on a daily basis. It is strange that there is nobody here from the GMC to act as a witness and to give account to that, but there have certainly been recent well-publicised cases in Aberdeen in which that mechanism has been seen in operation.

There is no doubt that the system is working and that there are strong duties on all medical practitioners to adhere to the standards in place and to account for themselves if they do not—to the extent that they might lose their career—and there are duties on other medical practitioners to report poor practice whenever and wherever they see it, so I have no hesitation in saying that we believe that there are already strong systems in place and that further legislation is not needed.

Beth Hall: I would like to pick up on some of the points that Mr Provan made. I agree that the problem is not lack of legislation. We have a huge amount of legislation in place, especially in relation to the social care field, where we have the Adult Support and Protection (Scotland) Act 2007, the Adults with Incapacity (Scotland) Act 2000, and the various pieces of mental health legislation that have been mentioned, so the problem is not lack of legislation. Rather, it is a lack of investment in social care. What we need is better leadership, better training and a culture shift. Layering more legislation on top is not the way to achieve that.

The Deputy Convener: I would like to move the conversation on a bit. I know that Malcolm Chisholm has another question. Is it on this issue specifically?

Malcolm Chisholm: I am trying to understand why there is such disagreement. In a way, the fact that the provision is in mental health legislation almost becomes an argument for extending it to other spheres. Is not the issue that ill treatment and wilful neglect are in a serious, severe and limited category, but that the arguments against further legislation seem to stray into the area of errors and mistakes? We all know that people make mistakes and that we must have a no-blame culture in which we can learn and improve, but it seems as if two separate things are getting confused. Ill treatment and wilful neglect are at the extreme end of it, and I do not think that that will impact on the no-blame culture of improvement that we want, but I wonder whether the RCN and the BMA are confusing the two categories.

The matter is obviously dealt with in mental health legislation, and I have to declare an interest in that, having been involved in framing the Mental Health (Care and Treatment) (Scotland) Act 2003. However, the fact that it is there becomes an argument, for me, for putting it into other spheres as well.

10:30

The Deputy Convener: Your question has certainly caused a reaction in one or two of the witnesses.

Perhaps I can tack my own question on to that. What Malcolm Chisholm spoke about sits at the major or significant end of the duty of candour and wilful neglect spectrum, but I note that the bill also contains a list of triggers. When you respond to Mr Chisholm, can you also say whether, irrespective of whether you agree with the duty of candour, those triggers are appropriate? After all, we are scrutinising not just whether the legislation is needed but its content.

Just for clarity, the bill proposes that where a person experiences an “unintended or unexpected incident” during their care that results or could have resulted in death or harm the health or social care service would be required to implement the duty of candour procedure. I will not read out all the triggers—I am sure that you know what they are—but the cluster includes the death of a person, “severe harm”, “pain or psychological harm” lasting at least 28 continuous days or the person “requiring treatment” by a doctor to prevent their death or any of the other outcomes that I have mentioned.

In dealing with Malcolm Chisholm’s question, can you tell us why you are resistant to the provision, given that we are talking about the extreme end of the spectrum, and whether, in the mechanics of the legislation, we have managed to strike the right balance?

Beth Hall and Dave Watson caught my eye. Do you want to go first, Beth?

Beth Hall: I think that you asked two questions; I will deal with the first, which relates to the interface between the two pieces of legislation. I recognise that wilful neglect sits at the extreme end of the spectrum, but there are concerns about how the duty would operate in practice and how it would be perceived by staff members on the front line. The question is: if, as a worker in a social care setting, I witnessed something going wrong or I caused something to go wrong because of my own actions, would I be more or less likely to be open about that or, indeed, to whistleblow if the consequences were potentially much more serious? If I decided to whistleblow on a colleague, the question would no longer be whether they were going to lose their job but whether my action might lead to criminal charges. The worry is that the interface between the two pieces of legislation could militate against the culture of openness.

It is easy for us all to sit in this room and say, “No—wilful neglect will be right up at the tight end and will be defined this or that way.” However, when I asked someone who works in social care who recently whistleblew on someone whether, if the new offence had been in place, she would have made a different decision or it would have given her pause, she said yes, she might have acted differently.

We have some concerns about the triggers for the duty of candour, especially the “pain or psychological harm” one. That can be quite difficult to define, particularly if we are dealing with someone who lacks capacity. At one extreme, there could be a lot of trigger events or, at the other, the triggers themselves could be insufficiently understood in order for what the provision is setting out to achieve to be achieved. When we thought through how that might affect the health and social care system, we were concerned originally that, say, delayed discharge could trigger some of those triggers and that all we would be doing is adding another layer of bureaucracy over the top of the process. That is the last thing that people want to do when they are trying to facilitate smooth and speedy discharge from hospital.

Dave Watson: No one disputes that there is a lot of legislation at the moment but, as is clear from our report and the hundreds—in fact, thousands—of responses that we received to our survey and in the focus groups from front-line staff who are giving care in a range of settings, although a number of people had seen events that they would be expected to declare under the duty of candour and, in some cases, matters that would come under the proposed part 3 requirements, they had not declared anything. There is clearly an issue to deal with in that regard.

For me, the important point is that the current rules do not really bear down on organisations. To be fair, the controlling voices of the organisations—the directors, managers and others—are sometimes placed under big commercial pressures. However, too often they choose to scapegoat the front-line staff for what is happening in their organisations instead of accepting that it is the policy of the organisations to chase work that they do not have the capacity to deliver, or to ask staff to deliver care without allowing them sufficient time to do so.

In that context, we think that the powers to issue remedial orders and publicity orders, under part 3, are particularly important. I also like the prosecutor’s right to appeal against failure to use those powers. Those provisions focus the controlling voices of organisations on the fact that they are not exempt—they cannot just pass the buck every time—and that, if there are failings in an organisation, that organisation could be found to be criminally responsible as well. We have argued that there is a need to place some responsibility on the controlling minds of organisations, as is the case with culpable homicide, for example. That may not work, but it is one way in which the bill can shift things in a different direction.

Norman Provan: As I said earlier, the Royal College of Nursing is currently handling about 600 cases. That is not unusual. However, in the seven years for which I have been in post, not once has the legislation protecting mental health service users been used in any case. There is very low usage of the current legislation, which is one reason why I do not think that that protection needs to be extended to the whole adult population.

One of our major concerns is that part 3 of the bill might nullify part 2. We require a duty of candour—we want organisations to have an improvement methodology whereby, when things go wrong, they are openly and transparently examined and patients are advised of the results. However, my fear is that introducing the potential for a criminal offence will nullify people's confidence to come forward and take part in the duty of candour.

I will build on a point that Dave Watson made by giving an example. One of my staff occasionally works bank-nursing shifts to remain connected with the clinical profession that he chose before he came to work for the Royal College of Nursing. He was booked to do a shift in an NHS hospital—I will not name the health board—and, when he turned up for his 12-hour shift, he was advised that the other trained nurse who was due to be on duty with him had phoned in sick and, therefore, he would be the only trained nurse on shift. The three care assistants who were going to be working with him were all bank workers, too—not one person on that 12-hour shift in that hospital ward would have known any of the patients or their routines. He immediately felt that the risks for him, as a registered professional, were too great and he advised the manager who had made the decision of that, but he was told that no additional resources could be employed to help him. He was also told that the nurse in charge in the next ward was not competent to administer drugs intravenously and that he would also have to do the drugs round in the ward next door during his 12-hour shift. It was not until he identified himself as a full-time member of the Royal College of Nursing and became insistent about the risks that he felt he was being placed under that additional resources were made available.

My concerns are that, if that person had not been a nurse who worked for the Royal College of Nursing and had not had the confidence to robustly challenge that decision, he might have worked the shift and made an error, and that he, as an individual registrant, would have been held accountable, not the non-clinical manager who initially made the decision to employ no additional resources. That is the risk. In my experience, if something goes wrong, the person who delivers the care is held to account. Under those circumstances, in the exercise of the provisions in the bill relating to wilful neglect, that nurse and not the organisation would have been held to account, and that feels wrong.

The Deputy Convener: That is a good example that links nicely to Dave Watson's point about systems failures and the workforce on the ground feeling that they could be held culpable for such failures. In the example that you have just given, who was the systems person who, in theory, would have been responsible for that situation? Was it the nurse co-ordinator for the health board or the co-ordinator for that particular nursing discipline within the health board? Can you give us a bit more information on that? Where do you think that the buck should stop or the improvement should kick in?

Norman Provan: It very much varies from board to board. Clinical structures are not the same in every board in Scotland. The example that I gave was of a weekend shift, when there were no professional nurses on. The decision was made by someone in a general management position who had no clinical background and was not qualified to assess the risk. They were equally under pressure, in that they had no additional resources that they could immediately move.

From a clinical perspective, the nurse in charge of that ward would have been responsible for any decisions, had he continued to work that shift without any additional resources. That is a professional decision that a person makes, based on their assessment of the risk. Arguably, the director of nursing could be the person responsible for the quality of care right the way through the system although, in providing care 24/7, it is impossible for that person always to be on site or to be available. In my experience of cases in which there have been care failures, on only a small number of occasions has that been because of the interventions or actions of an individual nurse. More often, it is systemic examples, such as the one that I have just described, in which there has been added risk for an individual. Inevitably, it is the individual registrant who is eventually held to account.

The Deputy Convener: I appreciate you expanding on that, because the committee will need to grapple with the issue of where culpability sits if and when the bill is passed. I apologise to Donald Harley, who wanted to come in on this.

Donald Harley: That is all right. I will probably echo Norman Provan and Dave Watson to some extent. The point was made that these sanctions are all at the extreme end of what happens on a day-to-day basis. That speaks to me about the fact that that is where the existing criminal, civil and professional sanctions come into play. I have not really seen any evidence that those are not appropriate or do not work. Without that evidence, it is difficult to argue that there is a case for change.

We have two concerns about the concepts of ill treatment and wilful neglect, one of which is that they are not particularly well defined. Also, picking up Norman Provan's point, how many of these issues are down to organisational failings and people being overstretched and put under pressure? We saw that in the Francis report.

Dave Watson mentioned that, when these things happen, people are held up as scapegoats and blamed within the organisations' existing arrangements. I suppose that it has to be a worry that, if criminal sanctions are applied following the passing of the bill, people would be the victims of those sanctions as much as of the organisational sanctions. An even worse wrong would therefore be committed on healthcare staff.

Fundamentally, we are worried that the bill makes things worse for staff who are trying to do their duties in difficult circumstances and that it works against the organisations' ability to learn, develop and adopt the openness and candour that are talked about in part 2.

The Deputy Convener: Witnesses have been quite clear about ensuring that there are safeguards in the bill and that it has no unintended consequences. That has been helpful.

Malcolm Chisholm asked the initial question. Do you want to come back in?

Malcolm Chisholm: No. That has been very helpful.

The Deputy Convener: I want to look specifically at the duty of candour. The procedure

> "would be triggered when, in the opinion of a health professional not involved in the person's care, the incident resulted (or could have resulted) in death or harm."

There may be some variance of views on whether that person should be an independent health professional. Is that the most appropriate way to proceed or, conversely, would it be more helpful if it was done by someone who could contextualise how the incident had happened?

We are scrutinising the nuts and bolts of the bill, not just the principles behind it. Do witnesses have any comments, to help us in our deliberations, on whether that should be done by an independent health professional and on how that might operate? Are we all happy with that procedure?

As soon as I asked whether we were all happy with the procedure, two hands went up. Let us take Donald Harley first.

Donald Harley: I just wanted to build briefly on the point that I made about being careful that the issue does not become a burden on the system. We would be particularly worried about general practices, which are very small organisations. The worry would be that the procedure would place a disproportionate burden on them. As I am sure the committee is well aware, general practice is under great strain. A number of cases have been publicised of practices that have been unable to continue. We would not want to see any more unnecessary and undue burdens being placed on general practices.

10:45

Norman Provan: In a sense, you need a bit of both, particularly when the bill is looking at near misses rather than actual events. That will require staff who are close to the patient and who have witnessed something that could result in harm to report on it. In the first instance, there needs to be a robust mechanism for staff to raise their concerns.

When the person who looks at the incident in some detail is an independent third party who is emotionally removed from the incident, that can be helpful. In our consultation response, we made it clear that the boards will require to train people to a high level to make that type of intervention by looking at an incident objectively and describing it properly for the board so that decisions about it can be made. Staff need to be supported and properly trained to undertake that role.

We would not have any objection to that person being a third party if that was appropriate, but it would have to be acknowledged that some near misses would have to be identified by the people who are close to the patient and directly involved in their care. They would have to be reported to the board so that it could fulfil its function.

The Deputy Convener: I understand that the bill refers to a "health professional" but such incidents could happen in a social care setting where most staff are involved in providing daily social care. Is it appropriate for the reference to be to a "health professional"? Are you content with that or does it not matter?

Dave Watson: Obviously, we have only the outline in the bill because such matters are to be covered by regulations. On reading the bill, it was not clear to me how the provisions would apply in a social care setting. Frankly, it is not entirely clear how they might apply in some healthcare settings, either. It is very easy to see how the model might work in hospital or a residential setting, but how it might work in a community setting is not entirely clear. I could not see anything in the policy memorandum that explained how the Government felt that the model would apply in social care settings.

The Deputy Convener: Beth Hall is next, to be followed by Peter Johnston.

Councillor Johnston: Hopefully we will both say the same thing.

Beth Hall: That is a difficult point to answer. First, it would not be appropriate to use a healthcare professional every time but it is difficult to say what would be appropriate. The issues are complex, especially when we are dealing with people who lack capacity and when only the staff members who are closest to those people might be capable of identifying a near miss in the first place.

I am sorry that I am not proposing a solution, but such difficulties underlie our nervousness about legislating. As soon as you try to legislate for such circumstances, you arrive at an imperfect solution.

Councillor Johnston: We already have examples of integrated services such as the rapid early assessment care and treatment team in West Lothian, which has medical staff and social care staff all working in someone's home at the same time to deliver a package of care. It would be difficult for legislation to focus on the healthcare part of that integrated team without dealing with the whole team. That is why we consider that it is difficult to promote legislation that can deal with such situations and why we say that it is better to deal with such issues through improvement and a culture of openness and transparency.

Norman Provan: You made a fair point, convener. The traditional boundaries between healthcare and social care services are becoming increasingly blurred. Staff are working in a more integrated way—that is the policy direction in Scotland.

I therefore wonder who would be responsible for a duty of candour disclosure in those circumstances. Would it be the health board, the council or the integrated joint boards, which are the new entities that are coming along? I am not sure that that is sufficiently covered. The bill has to be absolutely explicit about whose responsibility it is to pick up a case, and that would presumably be determined by the environment in which the incident happened.

The Deputy Convener: We have one more question on this section of the bill—I say that in order to give a heads up to Richard Lyle, who will take us on to the next section.

We have already spoken about what and how broad the definitions of wilful neglect and ill treatment should be. That is not yet clear. In evidence, some people asked whether the definition of ill treatment could include genuine errors, such as drug errors which could, as Mr Provan suggested, be a resource-allocation issue. Let us work on the basis that the provisions become law. In that case, how would you like the terms to be defined? What safeguards would you like around that? This is your opportunity to put your views on the record and to help us with our stage 1 deliberations.

Norman Provan: The notion that a genuine error would be considered to be wilful neglect is astonishing. We need a culture in which people can learn from mistakes. Drug errors happen not because people are neglectful, but because genuine mistakes happen. I once had a discussion with a manager in a health board after a drug error by a nurse. I pointed out that, on a busy medical ward, that nurse would have perhaps 30 patients with comorbidities, and would deliver six or seven dispensing actions to each of those patients twice or three times a day. That represents hundreds of thousands of dispensing actions over the course of a year and millions over the course of a career. The chances are remote of their never making one simple error.

If people can be criminalised for simple errors, rather than be dealt with through an improvement strategy, that will drive errors underground: people will not be open and honest when errors happen because of fear of what that could mean for their careers. An environment in which improvement drives error reduction would be better.

The Deputy Convener: I am sorry now that I gave drug errors as an example. I was trying to suggest that that was the kind of thing that would not be captured in the definition of wilful neglect. I do not think that there is any suggestion that it would be.

Norman Provan: Fairly major care failures—such as the Winterbourne View case that was on "Panorama", which concerned people with learning disabilities—in which people are shown to have taken premeditated decisions to act cruelly, should be regarded as potentially being wilful neglect rather than error.

The Deputy Convener: I was trying to tease out such examples in my question. I know that a drug error is not trivial, but in relation to some of the large things that a definition of wilful neglect could capture, it would be at the lower end. I am trying to tease out what you think should be captured by wilful neglect. I thank you for mentioning the Winterbourne View case.

Beth Hall: I agree that we need a tight definition of wilful neglect, so that we can avoid criminalising behaviours that would otherwise result only in censure for poor practice. It is not that there would have been no action taken, but that it would have been of a lower order.

Until now, we have not touched on the scope or the settings in which the definition of wilful neglect would apply. The bill seems to suggest that it would take place in formal care settings. We need to be clear about whether the definition would apply in people's homes—I am thinking about people who receive social care at home. If the bill goes ahead, it will need to apply in such settings.

The bill talks about care workers but does not define the phrase. I would take it to mean paid staff, so there is a question about whether it will also apply to familial carers. Increasingly, family members are providing significant amounts of care, especially social care. In some—albeit exceptional—circumstances, families can be employed as personal assistants under the Social Care (Self-directed Support) (Scotland) Act 2013. We suggest that in such circumstances the definition of care workers should apply to those people and that they should be included in the scope of the offence of wilful neglect.

The Deputy Convener: Thank you very much.

We will move on to the next section of questions shortly, but first of all, I will take Dennis Robertson, and then I will ask the other witnesses who want to come in to mop up his comments.

Dennis Robertson: Beth Hall has more or less covered the issue that I wanted to raise. However—perhaps Mr Provan can take me through this—is it not the case at the moment that any mistake that results in death is recognised and investigated, and that any suspicion of wilful neglect in a person's care is brought to the profession's attention and can result in criminal proceedings?

The Deputy Convener: I will bring in Mr Provan to respond to that—I see that Dave Watson and Donald Harley wish to comment—but I make it clear that we will move on after this to Richard Lyle and questions on the first part of the bill.

Norman Provan: I will be brief, convener. There are, in boards and other places where care is provided, systems in place for errors, where they happen, to be appropriately investigated. Should fault be found, nurses, for example, can be reported to the NMC and removed from the register if they are unfit to practise, and under the Protection of Vulnerable Groups (Scotland) Act 2007 people can be barred from working with adults, children or both, if it is felt that they cannot provide good care. This comes back to my initial point: we do not need additional legislation. Through regulation and the law as it stands, there is enough with which to sanction people without additional legislation on wilful neglect.

Dave Watson: I was going to make broadly the same point that Beth Hall made about self-directed care. There is some vagueness in part 2 of the bill; for example, it refers to volunteers, but only to volunteers who are controlled by a particular organisation. There is even less clarity in part 3. With the growth of personalisation and self-directed care the provisions need to be clear—especially given that some of the current legislative provisions do not always cover every form of care in this particular area. It is therefore important that we keep up to date with current practice.

Although the terms "ill-treatment" and "wilful neglect" are used in the bill, it is important for prosecutors in particular to understand the mens rea of the offence under criminal law. Moreover, Scots law is increasingly following the European practice of taking a purposive approach to legislation, so if I were a judge in a particular case, I would want to know what ill Parliament feels needed to be cured. As the committee teases out the strands in the bill and receives further evidence, it will help if you get that point clarified to ensure that when guidance on this and other issues is published we can refer to the ill that Parliament was seeking to correct in passing the legislation.

The Deputy Convener: Thank you. We will give Mr Harley the last word in this section of our questioning, and then we will move on.

Donald Harley: I will say very briefly that what worries us is that neglect is a symptom of systemic failings and of a system being overstretched. If people were to receive less care or less good-quality care because healthcare practitioners—nurses, doctors, healthcare assistants, social care workers or whatever—are running from pillar to post and are having to prioritise, and so are not necessarily giving everything that best practice might require of them in all situations, that might be deemed to be neglect, so those people would pay the price for systemic failings. That should be fundamentally safeguarded against in the legislation.

The Deputy Convener: That very much chimes with Mr Watson's previous comments, so we will look at that point carefully.

You have waited a long time, Mr Lyle, but you can now ask your question.

11:00

Richard Lyle: Thank you, convener. I actually have two questions, but I will try to contain them.

First, we heard last week from the Advertising Standards Authority and one of the manufacturers that the advertising of e-cigarettes on TV should be allowed even though the advertising of cigarettes stopped many years ago. What do witnesses feel about that? The BMA makes a powerful argument in its submission, and states:

> "Concerns have been expressed by BMA members over the e-cigarette marketing methods".

You state that young people are being targeted, which raises the question of the introduction of an age limit. For example, there is advertising near schools.

Secondly, most people have said that e-cigarettes help smokers to come off cigarettes, but you suggest that they also have the reverse effect because people are trying e-cigarettes and moving on to smoking. Do you want to say more about that? You state that

> "There is also evidence internationally suggesting that e-cigarettes may act as a gateway to smoking."

What are your views on advertising and about an age limit? Let us face it—a child could walk into a shop today and buy an e-cigarette, although we hope that that is not happening. Do we need to change the law and ensure that there is an age limit?

Donald Harley: We have seen internationally—particularly in the US—that manufacturers are adopting many of the marketing approaches that were used for tobacco decades ago, with lifestyle approaches that are aimed at attracting youngsters from an early age into a lifetime of using a particular product. E-cigarettes may represent a lesser risk than conventional cigarettes, but we are nonetheless concerned about the potential for addiction and luring people at an early age.

On the balance of harms, although there seems to be some evidence that supports the use of e-cigarettes for helping existing smokers in cessation, that might to some extent be offset by e-cigarettes attracting people at the other end. We are not yet fully aware of all the harms that may be associated with e-cigarettes, but we already know that they are not harm free. In our view, that points to the need for clear regulation and study of the harms.

Councillor Johnston: The challenge is to strike the right balance between assisting people to quit smoking through use of e-cigarettes and not leading new users into the market. TV advertising reaches everybody, so TV advertising of e-cigarettes would not be acceptable because it could induce young people and non-smokers to consider the products. However, as I said in my opening comments, appropriate point-of-sale advertising could help people to move away from smoking.

We think that the current balance is about right, although we recognise that the jury is still out and that it might be a decade before we have results that show that e-cigarettes are not harmful.

Brenda Knox: We agree that it is important to reduce young people's access to e-cigarettes. There does not seem to be any reason to try to induce young people to use e-cigarettes apart from increasing their use of nicotine and the profits of the people who sell the products.

The other thing to bear in mind is that young people are not the same as established smokers in that they will not have the same level of nicotine addiction, and their use of e-cigarettes might increase their addiction to nicotine on the basis that e-cigarettes are safer. The idea that e-cigarettes are useful in supporting people to stop smoking is something to be pursued, but we should certainly put in place a restriction for young people.

The Deputy Convener: Mike MacKenzie wants to come in. Please catch my eye if you want to comment on the age restriction or on advertising before Richard Lyle moves us on to the next section.

Mike MacKenzie: I will be brief, convener. Would the witnesses be good enough to share with the committee—perhaps in writing, later—any evidence that they can cite to support the views that have just been expressed? It would be interesting to see evidence, particularly from the BMA, which I would expect—most of all—to operate on the basis of evidence.

The Deputy Convener: I will come back to Donald Harley at the end to let him say a little bit more about that, but other folk have indicated that they wish to comment. Dennis Robertson wants to come in on the same point and the witnesses can then mop up all the questions that have been asked.

Dennis Robertson: Councillor Johnston mentioned point-of-sale advertising. Should such advertising include advertising in pharmacies?

The Deputy Convener: That is a very specific point.

We now come to the list of people who we are coming back to. We will come back to Donald Harley and Councillor Johnston, but Norman Provan is first: he has been waiting patiently.

Norman Provan: We support the age restriction on such products because we think that there is a risk that this could be a new route to market for tobacco companies and nicotine.

On advertising, we believe that there is growing evidence that e-cigarettes and vaping can be a good route to stopping established smokers from smoking. That should be encouraged. In response to Dennis Robertson's question about pharmacies, the products could be advertised as a method of stopping smoking, as are nicotine patches, gum and all the other nicotine-replacement products. We have no objection to that type of advertising, but we do not support the principle of advertising on television to entice people to take up vaping in the way that companies used to advertise to entice people to take up smoking.

The Deputy Convener: I come to Donald Harley in relation to evidence. Feel free to write to the committee—I do not know whether you want to say something about the evidence.

Donald Harley: I think that we have provided the evidence in our submission, which includes a long list of references.

The Deputy Convener: Okay. Thank you. We will interrogate that in more detail after the meeting. We now come to Councillor Johnston.

Councillor Johnston: Mr Provan has covered the points that COSLA would make and we agree with his position that if pharmacies are going to sell the products, it makes sense for them to have point-of-sale advertising for the product as a non-smoking aid.

Brenda Knox: We in the smoking cessation field would like more evidence on which e-cigarette products work best. Because they are not regulated, it is difficult for those of us in the smoking cessation field to say, “This product will work for you,” or, “That product won’t.” What we do say is, “If you find e-cigarettes useful, we will provide you with behavioural support.” Regulation of the market should also be considered in relation to providing support for smoking cessation, so that it is not just a case of advertising the products. If it is being claimed that the products support smoking cessation, the market should be better regulated.

The Deputy Convener: That is helpful. I will not bring Donald Harley back in, but I put it on the record that he was nodding when Brenda Knox was speaking.

Does Richard Lyle want to move the conversation on?

Richard Lyle: Yes. I turn to smoking on NHS premises, particularly outside hospitals. I again put it on the record that, as a smoker, I abhor people smoking outside hospital entrances. However, as a smoker, I also suggest that we should have a perimeter outwith which people are allowed to smoke or even—dare I suggest it—a shelter where people can be spoken to in order to try to get them off smoking. Someone could maybe stand beside the shelter to do that.

Most people will be coming out of hospital having seen their loved ones, who may have died or been told that they have a serious illness. In that situation, people might come out to have a cigarette, although I would suggest that they should not smoke. Going outside the perimeter of some hospitals can mean a walk of a quarter of a mile, or doing so could be dangerous late at night. Let us face it: patients also go outside hospitals to have a cigarette. We have all seen them.

I am sorry, but I am going to put Brenda Knox in the firing line. I will also put Councillor Johnston in the firing line and ask him, with the respect that I have for COSLA, about its position. I note that, unlike other health authorities in Scotland, NHS Ayrshire and Arran has moved to a total ban on smoking in hospital grounds, which seems to be working. Can Brenda Knox explain the reasons why?

The Deputy Convener: I will bring in Brenda Knox in a second. Maybe we will put the witnesses on the spot rather than in the firing line.

Richard Lyle: I am sorry; I will rephrase that. We will put them on the spot.

The Deputy Convener: Councillor Johnston got a name check, so we will come to him in a moment. Brenda Knox can speak first.

Brenda Knox: I suppose that the difference between Ayrshire and Arran and some of the other health board areas is that we took a stepped approach to the implementation of a ban on smoking on hospital grounds. I can describe our experience.

With our first version, which was just after 2006 when the first smoking legislation came in, we introduced a 15m rule to try to get people away from the doors, but we found that totally impractical because people do not know what 15m is. Trying to map that distance out around huge hospital grounds is almost impossible. There is not just one building on a hospital campus; there are many. If we start to say that the distance is 15m from one building and then from another, things become complicated. That is confusing. People really did not like that, and it opened up the route for people to say, “I’ll just smoke wherever I like.” That led to huge numbers of complaints from the people who were coming and going through the doors. They thought that the health board was supposed to protect them but was not doing so.

We then looked at our next phase in the stepped approach, which involved people smoking in only one designated area, with the view that we would move towards smoke-free grounds at some time in the future. At that point, the time had not been decided. We moved to smoke-free grounds when the guidance from the national policy came in.

At each level, the number of people who comply increases. We are now moving to a small number of people not complying. Generally speaking, there are not lots of people standing and smoking outside hospital doors, although perhaps people will think that, because there is no way that anything will happen to them, they will just do it anyway. That may well mean that there will be a regressive move in the future.

We would welcome legislation that supports smoke-free grounds. Although it is about protecting the people who go in and out of the doors, it is also about the message that smoking will harm health. A health organisation has to get that message out to people. It is not about being anti-smoker; it is about being anti-smoking. If there are images of people standing around doors and smoking on grounds, the message that we will give is that smoking is harmful but not really that harmful, because we will not create a smoke-free image in our grounds. That is the important message, and that will be the thing that moves us forward.

What has made us successful is that over the last year—before the implementation of smoke-free grounds—we had a plan of engaging with people. We engaged with the general public and with the local press, who were very helpful in advertising and letting people know what the policy was going to be.

11:15

Also, all smokers within the hospitals are now given an intervention by the smoking cessation service to help them manage their smoking. The officers have a conversation with smokers who are in hospital for treatment to look at the options that are available to them. They get symptomatic relief through nicotine replacement therapy, which means that they are not making a commitment to stop in the long term but are being given support to handle withdrawal symptoms while they are in hospital.

Those patients are also given information on the importance of keeping their homes smoke free, which protects their loved ones and themselves. They are given information about how stopping smoking can help them in the longer run by alleviating health problems and about how, if they want it, they will be given support to try to quit.

Those patients are followed up when they leave hospital. We give them telephone support and encourage them to go along to a group or to meet with us individually when they feel able to do so. That has helped us to be successful.

The Deputy Convener: Thank you. We will bring you back in later as the discussion develops.

Councillor Johnston, you may have thought that I had forgotten about you but I had not—you were name-checked.

Councillor Johnston: The first thing to say is that the COSLA position is that we are absolutely signed up to the principle of stopping smoking in public areas. What concerns us is the difficulty of delivering on that commitment. We are not sure that legislation currently can be justified, given that it was only in April that the NHS began the process and local authorities have until the end of this year to introduce the policy.

In my own council we had a discussion about the civic centre in Livingston. You may have seen it on television; it is where the High Court meets. Currently we have an area of about 15m from the door where no smoking is allowed. What happens is that people gather from the 15m mark for the next 20m. Now we are going to extend that area to the perimeter, where the footpath is; we are looking to do it by the end of this year.

We recognise that only changing a culture is going to deliver the policy. We would be looking to have no smoking in children’s play areas, but it is a long time since local authorities had parkies to maintain children’s play areas or went round and enforced behaviour in them.

That leads me to the concern about who, if there is legislation, will enforce it. Will it be local authorities that get the phone call? Coming back to the example of Livingston, if somebody is smoking in the grounds of St John’s hospital, are we supposed to send someone from the council, a quarter of a mile away, to enforce the policy? We do not have the resource to do that.

What is the point of legislation that is not going to be enforced? At this stage COSLA is saying that we do not know whether proceeding with legislation is the right way to go. If it is going to be proceeded with, the resources to enforce it have to be made available—otherwise, what is the point of it?

The Deputy Convener: Mr Watson, do you want to come in? I suspect that enforcement might be on your mind too.

Dave Watson: Indeed. We support the principle and have done from the outset. There have been some areas where the approach perhaps has been clumsily applied, but we have resolved issues locally in partnership with the employers.

We need to recognise that it is particularly our members in hospitals who find that the policy can be a challenge, such as security staff, porters and others who often end up having to deal with the issues.

I had concerns when I initially looked at the bill that there was an offence of knowingly permitting others to smoke outside a hospital building and how broadly that might be applied. It is not entirely clear. The definition mentions the one who is

> “having the management and control of the no-smoking area”.

Is it the management’s responsibility? Is it that of the individual porter or a member of the security staff? It is not entirely clear to me. However, the phrase "knowingly permits" is fairly good and might well give some comfort to our members.

I understand Brenda Knox's point that it is difficult to draw perimeter lines, but some hospitals have enormous grounds and there must be some way of dealing with that issue. It will be hugely difficult to do that, given the signage and other things that will be necessary, but it is probably not practicable to say that the ban should extend to all grounds.

We also represent the environmental health department staff who are tasked with enforcing the current provisions, and I can tell you about the resources of those departments. Last year, we produced a report on a survey of environmental health staff, and they made the point that they have abandoned whole areas of legislation that they are supposed to enforce—including legislation on health and safety issues and food inspection—because of a lack of resources. They are not going to be on the end of a phone, charging up to a hospital to enforce the smoking ban; that is just not going to happen.

It is fine to pass legislation—as I said in relation to parts 2 and 3, it can change the culture, which is why we have always supported the smoking legislation—but we need to be realistic about the resources that are available in local authorities to enforce it.

The Deputy Convener: I do not see any of my MSP colleagues or any witnesses indicating that they want to comment further. We have a little time in hand, so, as we draw naturally to a close, I will give each of the witnesses the opportunity to reflect on something that has been raised in today's evidence. It need not be a speech or a long statement—a couple of sentences will do. It is just the opportunity to comment, if you feel that you have not had the chance to say what you wanted to say.

Norman Provan: As I remain a registered nurse and a committed non-smoker, I feel obliged to do a brief intervention with Richard Lyle and tell him that smoking is very bad for your health. [*Laughter*.] Your health board can help you to stop.

Richard Lyle: My grandson, who is aged 3, is now telling me that smoking is bad for my health.

Norman Provan: Indeed. More seriously, I go back to the point that we made about parts 2 and 3. Our fear is that part 3 will nullify the intention of part 2. We very much support the principle of a duty of candour, but we are less keen on having additional legislation on wilful neglect.

Dave Watson: I suspect that Norman Provan is wasting his breath talking to Dick Lyle about his smoking.

There are some differences in our views on the bill, and there is a fine balance to be struck. We accept the risks in the bill and the fact that, if we do not focus on resources, it could result in unintended consequences. Our consistent view—this is why I highlighted the issue of violence against staff among other issues—is that the legislation can drive organisational change, but it will not do that on its own. We urge you to make the point very strongly that, particularly in the area of social care, some of the things that are going on are not pretty and need to change. However, that is largely about organisational culture and resources. We need to change the way in which social care is commissioned in this country if we are going to raise the standards in the way outlined in the bill.

Brenda Knox: I further emphasise the importance of legislation to support smoke-free hospital grounds. Although we can be pleased that the prevalence of smoking is at 20 per cent at the moment, the prevalence of smoking among those with long-term conditions is at 48 per cent, and we could add to that figure the number of people who previously smoked and still have long-term conditions. We need to give the absolutely clear signal that a health organisation cannot compromise on its message in relation to smoking.

Councillor Johnston: There are a couple of messages that we would want to put across. First, we are pleased that there is a clear consensus on the need for a duty of candour and on our having no tolerance for poor-quality care. Secondly, we think that improvements are best delivered through cultural changes, and we are concerned—as are others—about the possibility of part 3 negating part 2. We do not want to see that happen. We have had a healthy discussion today, which I have been delighted to be part of.

Beth Hall: I echo Councillor Johnston's point about the consensus that exists, especially on the issue of wilful neglect and, mostly, on the duty of candour. Even Mr Watson, who is slightly more supportive of the duty of candour than we are, has highlighted that the problem that we are trying to fix stems from entrenched organisational issues that are mainly to do with a lack of resources and a historical lack of investment in social care.

We, as a society, do not value social care in the same way that we value healthcare, and that will have to be tackled. Many of the problems stem from pressures with resources, staffing ratios and low pay in the sector, which lead to problems with recruitment and retention. Therefore, instead of simply saying that the bill is not the way to fix the problem, we need to move on to a discussion about what is required.

Donald Harley: I re-emphasise that we think that the part on ill treatment and wilful neglect, although clearly well meaning, would be counterproductive and would work against the openness, honesty and candour that we all want to build. It leaves unaddressed the issue of the culture that exists in organisations, which is a real problem right across the NHS, and it works against learning and developing best practice. There is also a real worry that staff will pay the consequences of systemic failures.

The Deputy Convener: Thank you all very much for a very useful evidence session, which will help the committee to draft and complete our stage 1 report on the bill.

11:27

Meeting continued in private until 12:24.

Published in Edinburgh by the Scottish Parliamentary Corporate Body

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

Information on non-endorsed print suppliers
Is available here:

www.scottish.parliament.uk/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk