The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 5 January 2016

Session 4

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HEALTH AND SPORT COMMITTEE
1st Meeting 2016, 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:

Jason Birch (Scottish Government)
Dr Catherine Calderwood (Scottish Government)
Paul Gray (Scottish Government)
John Matheson (Scottish Government)
Ann McMurray (Stillbirth and Neonatal Death Society)
Willie Reid
Shona Robison (Cabinet Secretary for Health, Wellbeing and Sport)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Health and Sport Committee

Tuesday 5 January 2016

[The Convener opened the meeting at 09:35]

Burial and Cremation (Scotland) Bill: Stage 1

The Convener (Duncan McNeil): Good morning and welcome to the Health and Sport Committee's first meeting in 2016. I ask everyone in the room to switch off mobile phones, as they can interfere with the sound system. You will notice that some of us are using tablet devices instead of hard copies of our papers.

We have received apologies from Rhoda Grant, who is not able to attend.

Our first agenda item is the first evidence session on the Burial and Cremation (Scotland) Bill. I point out that bills, by their nature, have to be very precise in their meaning and in the language that they use. As such, language or terminology may be used this morning that some people might find upsetting. I wish to apologise in advance, if that occurs. It is not our intention to cause any offence with the language and terminology of the bill that we are working on.

I welcome to the committee Willie Reid and, from the Stillbirth and Neonatal Death Society, Ann McMurray. We are expecting Cheryl Buchanan, whom I will welcome when she arrives.

I believe that Willie Reid is prepared to make an opening statement to get us under way. Please do that, then we will ask questions.

Willie Reid: Thank you very much for having me here today. I will give you a brief history and tell you where I stand.

I am an affected parent; my daughter died, sadly, in 1988, and was cremated at Mortonhall crematorium. I will not go into the full details of that, but will talk more about what happened since the story broke about the baby ashes scandal.

The big thing was the political side of the situation. Right at the start, I wrote to Mr MacAskill, who was then the Cabinet Secretary for Justice, but I got no reply from him. I wrote to the First Minister, Mr Salmond, and it took seven months for us to get a voice at Government level here in Parliament. At that point I was calling for a public inquiry. Although Dame Elish Angiolini was doing the Mortonhall crematorium report on behalf of the City of Edinburgh Council, Mr Salmond commissioned Lord Bonomy to chair an infant cremation commission. The downside was that there was a political fight between the Government and Lord Bonomy about having parents on the commission—no parents were on it. I thought that we were being sidelined at that point. Lord Bonomy suggested that the emotion of the situation would be too great for parents. I thought that that was how people thought about things in years gone by, as opposed to how they think about them in the modern day.

After Lord Bonomy reported his 64 recommendations, it was announced that the bill would be introduced and that Her Majesty's inspector of crematoria for Scotland would be appointed. That announcement was made in a shining light, shall we say, but when the post was advertised it was under a 2 watt bulb. The post was part time and would last only 90 days. There are 27 crematoria in Scotland: how can they be snap-inspected? How can they be inspected by someone in such a low, part-time role? However, Mr Swanson was appointed and appears to be doing a fantastic job.

The bill was then sent out in draft form, and I worked with the cremation practice sub-group of the Scottish Government's national committee on infant cremation.

The situation surrounding the death or loss of a baby normally begins at a hospital. It continues at the undertakers and then at the cremation authorities.

My personal experience was that I never spoke to anyone at a crematorium; everything was done through undertakers. I was a young lad of 22 who had lost my baby two days before, and I was asked to sign a form that they gave me. At that point, I was told that people did not get babies' ashes. However, 25 years later, on sight of the form, I saw that the back of the form could be ticked to allow dispersing of remains. Why would I have wanted remains to be dispersed if they were never there?

My point is that the funeral directors have a big part to play, but they do not appear in the bill. As the first contact, they need to be licensed and regulated, as part of the bill. I do not know the right way to do that, but an extension to the role of Her Majesty's inspector of crematoria for Scotland could incorporate it. It would be easy to say that they could be licensed at local authority level, but given the nature of the issue, they really have to be licensed and regulated nationally so that every undertaker in the land would be carrying out the same procedures, whether for an adult cremation, a baby cremation or whatever. It would be a hard job for an inspector to go round and inspect them on his own; obviously, I understand the current austerity measures, so I suggest bringing in a system that would be akin to custody visitors in

police custody centres, and prison visitors. Those people would largely be volunteers and would go round to inspect what undertakers are up to, then report to Her Majesty's inspector of crematoria for Scotland.

The big thing about the bill is that it must ensure that the procedures of the past cannot continue, and there has to be some sort of censure for those who contravene the legislation. For example, I know that if I got caught speeding I would get a £60 fine and three penalty points. If I carried a knife in public, I would be liable to five years' imprisonment, and if I committed murder, I would be liable to life imprisonment. However, nothing in the bill suggests what the censures would be for someone who contravenes any of the procedures in it.

The other big thing that we have to ensure in the bill is that, when there are contraventions, the investigations and subsequent censures are robust, swift and, more especially, fair to the parents. We are now going into the fourth year since the scandal broke at Mortonhall, and I am personally still being played as a legal football between the lawyers of the City of Edinburgh Council and the lawyers who represent parents. Should such a thing happen in the future to parents—I hope that it will not—it would not be right to expect them to be involved for the length of time that we have been involved.

We will all die at some stage, but a baby's death is slightly different; the mother and the father would have looked forward throughout the pregnancy to the arrival of the child. It does not matter at what time in gestation the baby is lost: joy turns to instant pain that takes a long time to get over. Revisiting the matter 25 years later has been the most horrendous thing that I have had to deal with in my life; I am sure that I speak on behalf of other parents who feel the same. Ultimately, the bill has to ensure that what happened cannot and will not ever happen again.

The Convener: Thanks, Willie. Does Ann McMurray wish to add anything to that?

Ann McMurray (Stillbirth and Neonatal Death Society): I agree with Willie Reid that the whole process has caused the parents who were affected renewed grief. I am a bereaved parent but was not, thankfully, affected by the ashes scandal. Those parents are taken right back to the very day that it happened to them. What concerns does the committee have for those parents and what mechanisms can we put in place to ensure that they get the right support to get through the renewed grief and trauma that the process has caused them?

09:45

The Convener: Thank you. We will move on to questions that will, I am sure, pick up some of the points that have been made.

Bob Doris (Glasgow) (SNP): I thank Willie Reid and Ann McMurray for their opening statements and for being prepared to give evidence here today.

I want to reflect back a couple of things that Mr Reid said, so that you know that we are listening. You said that you are keen to ensure that when there is a breach of the legislation, there will be consequences, that there is effective enforcement of sanctions and that people are held to account—although how that will happen is another matter altogether. I listened carefully to what you said about that, and to what you said about ensuring that there is consistency, no matter which local authority or crematorium is involved.

I will initially restrict my questions to the provisions in the bill. We will help to shape the bill as it goes through Parliament. We have to be sure about the parts of the bill that you support and about the things that you would like to be improved. That is part of the process. I would like to find out whether you support a couple of specific bits of the bill. The reason for my asking the questions is that we have to prepare a stage 1 report that will make recommendations to the Scottish Government.

I am looking deliberately at the briefing that we have received for today's session. Under section 38 of the bill, it will be expected that ashes will normally be recovered in the vast majority of cases, but where that does not occur, HM inspector of crematoria for Scotland will investigate. I understand that there might be concerns about what that means in practice, but would that be a positive step forward? It is expected that if there are no ashes after a cremation, there will be an investigation of some description.

I want to be specific about the different parts of the bill; I hope that that is okay with the witnesses. Under section 55, there will be a register of disposal of remains; there will be a duty on all health authorities to maintain a register recording the disposal of remains when pregnancy loss occurs. In such cases we are talking about loss before 24 weeks; the healthcare system is obviously not as good as it could be in relation to how it deals with pregnancy loss before 24 weeks. There has to be a register for that purpose and there has to be an investigation in each instance in which there has been a cremation but no remains are found.

We have to assure ourselves about which bits of the bill are fit for purpose and which need to be

improved, so I deliberately picked two specific bits, which I hope was helpful. The committee would welcome comments on either.

Willie Reid: It is certainly very welcome that the cremation authority will have to inform HM inspector of crematoria of any failure to recover ashes. The technical information supporting Dame Elish Angiolini's report on Mortonhall states that ashes could normally be recovered from remains after 16 weeks gestation. The definition of "ashes" has been changed, which is highlighted in the bill. If every cremation authority adopts and abides by the procedures that have been recommended by the national committee, there should be ashes from remains from every stage of gestation.

I will ask Ann McMurray to comment on the registration of remains in pregnancy loss, because I am not overly familiar with that issue and did not look into it prior to coming here today.

Bob Doris: There will be parts of the bill on which you feel the need to comment and other parts that you have not looked at, because they cover issues that were perhaps not at the front of your mind. That is fine. Thank you, Mr Reid. Ann, do you wish to add anything?

Ann McMurray: We welcome registration for pre-24-week babies. When such babies are cremated, it would still be possible in the majority of cases to obtain ashes. Only in cases of very early loss of babies—12 weeks and below—would there not normally be an individual cremation. There would be ashes from a communal cremation, but parents would not be able to get individual ashes because it would not be possible to identify them. However, there would, at the crematorium, still be ashes, which could be scattered in a sacred place.

Bob Doris: Thank you.

Richard Lyle (Central Scotland) (SNP): Willie Reid's opening statement was very powerful and I am sure that many members of the committee have taken on board what you said.

I turn to an issue on which I will bring in Ann McMurray, if possible. In one of the written submissions that we received, a parent stated that her daughter died at 23 weeks' gestation and the cremation was organised by the local maternity hospital. She states:

"At that time, I was not given the option of burial, either via the hospital or privately. Minutes after her death I was handed cremation forms to sign, I had been sedated shortly beforehand for a procedure ... was not shown the forms and they were not explained to me".

In your submission on behalf of SANDS, you welcome many parts of the bill, but say that SANDS

"disagrees with the proposal in the Bill to create a single application form to cover all cremations, both for adults, children and babies who die".

You suggest that there should be separate forms. Willie Reid mentioned who should be involved and who should explain what is happening. Should it be the undertaker? Should it be the hospital? My question is to both of you, and I am sorry if I am touching on points that might be very sore. Should there be a multipurpose form or should there be separate forms for each type of case? Can you explain what you mean in your submission, Ann? Willie Reid might also say whom he thinks the forms should be with—the hospital, the undertaker or somebody else.

Ann McMurray: The forms should most likely be with the hospital because that is where the parent is most likely to be when the event occurs. The question whether there should be separate forms relates to very early losses. Parents who have a termination because of foetal abnormality or for other reasons might not want a form that has the word "baby" in it, because that might cause them more distress. That is the main reason why we suggested that there should be separate forms.

It is unlikely that parents would go directly to a funeral director, because the event normally happens within the hospital and it is therefore the hospital that deals initially with the parents. However, it is important that parents be given the choice to speak to a funeral director, and that the hospital cannot always take ownership of the process. It happens sometimes that parents are not given the choice. In the subcommittee that has been set up to examine training and procedures, we are looking at ensuring that staff who deal with parents have as much information as possible to pass on to parents so that the parents can make an informed choice about what will happen to their baby.

Richard Lyle: Willie—I am sorry, but can you comment on Ann's point about undertakers?

Willie Reid: Things might have changed; it is almost 28 years since the loss of my daughter. However, it was the hospital that guided me to the undertaker. Basically, I gave to the undertaker all the details about what had happened, and the undertaker filled out the form and told me to sign it. My mother passed away just eight months ago; I went to see an undertaker about her cremation and, again, there was the undertaker quite happily filling in the form. Because I was a wee bit more experienced, I checked everything before I signed.

However, as I have said to the committee, we are talking about a situation in which what should have been a joyous occasion is taken away from people. Forms are then put in front of them. There is an onus on the hospital—and, perhaps, the

hospital chaplaincy—as well as undertakers; I do not think that responsibility for filling in the form should rest only with undertakers and the bereaved. If it does, there should be a 48-hour or 72-hour cooling-off period, after which the parents could be told what the options are—cremation, burial or whatever—and whether they are content with what will be gone ahead with. All that would be needed then would be a countersignature. That approach would probably be better than what was there before.

Ann McMurray: Parents would have some time—three or four days, I think—in which they could change their minds about their decision.

Willie Reid: That sort of thing could be incorporated in the bill, which would mean that every undertaker and hospital unit would have to abide by it. At the moment, I would say that it is guidance rather than part of legislation.

The Convener: Is the issue not more about communication?

Willie Reid: It might well be.

The Convener: We are talking about dramatic situations. Of course, some people will be able to cope but, on reflection, do you not think that this is about asking the right questions and communicating better? Do you think that there was a wilful element in the neglect over the form? After all, these things have been reduced to a form, and one might argue that there is something paternalistic in the attempt to alleviate some of the bureaucracy for the person who is dealing with this kind of traumatic event. Is it more about communication and helping people through the process? Do we need to look at every question on the form and the language that is used—for example, whether we are talking about a baby or a foetus? Can we really have a standard for dealing with this sort of thing, given that people cope with such situations differently?

Willie Reid: You are right: my experience is that in years gone by people said, "Aw. You've lost a baby. That's no so good. Off you go, have another one and crack on with your life." That was society's view of the matter back then, but society has changed. Reflecting on what happened in my life, I can tell you that, because I was the man, I had to organise the funeral and do this, that and the next thing. It took me 20 years to realise that I had not done the right thing, and it came back to bite me. However, that is another matter.

The forms have to be correct. On my daughter's form, there was a tick-box for an option to dispose of the remains in the garden of remembrance, but the undertaker told me that there were no ashes. You asked whether there was a wilful element. I suggest that there was.

Ann McMurray: Communication plays a big part, so there needs, I think, to be a training programme for everyone across the board—not just health professionals, but funeral directors and crematoria staff—to ensure that they give a consistent message to parents who are arranging their baby's funeral.

I do not believe that people set out to mislead us wilfully—I think that they think that they are doing their best for us. Nevertheless, hindsight is a wonderful thing, and honesty is certainly much more acceptable than leading people down a different route. Had we been given the correct information at the time, we would all have made different decisions. Parents must also be allowed space to reflect on the decisions that they have made, and they must be allowed the opportunity to change their decision.

Dennis Robertson (Aberdeenshire West) (SNP): Do you have any views on who in the hospital should provide the appropriate information to the parent or parents to allow them to make a decision with regard to a baby who dies at birth or, indeed, who is stillborn?

10:00

Ann McMurray: I think that it would probably need to be an experienced staff member. A lot of hospitals now use senior midwives who have a particular interest in bereavement, so they would have most of the information that they would need to pass on to the parents. As Willie Reid said, perhaps hospital chaplains could also be involved.

There is only one paid bereavement midwife in Scotland. Others do the job but are not recognised for it. I know that that is another issue, but it should be looked at.

Dennis Robertson: If there is a disagreement with the parents about what should happen, the bill suggests that the courts should make the decision. Might there be another way forward or do you agree with what the bill proposes?

Willie Reid: I agree with what is being proposed in the bill. Things would have to be pretty traumatic to get to that stage. If it became a legal battle or even a battle of wills between the cremation authority and the parents, a swift court judgment would be the best way forward.

The Convener: Does Ann McMurray have any views on that? No? It is hard to imagine that things would get to that stage, but it has to be taken into account.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I thank the witnesses for their statements and their responses to the questions, which are helpful to us.

Willie Reid said that he wanted to see a bit more about funeral directors and he talked about inspections, which would be one way of dealing with the situation. Apart from inspections, should there be any requirements on funeral directors in the bill?

Willie Reid: Yes. I could go out and start an undertaker business tomorrow with no training, no licence—no nothing. I could get a couple of hearses together and there I am. Like any business, we will always see rogue traders. I think that all undertakers should be licensed and regulated nationally, so that they all carry out not just their services but the procedures leading up to a cremation or a burial in the same way nationally. As I said, if anyone contravened those procedures, some sort of censure would have to be available.

Undertakers are the first point of contact for a funeral, and it was the undertakers who fed me the "there are no ashes" line. I never spoke to anybody at the crematorium or the hospital; it was absolutely the undertakers who fed me that line.

I know that a lot of the small, family-run undertakers are being taken over by the bigger businesses throughout the country. The bigger a company is, the more profit it will be looking for. I am not particularly interested in the profits that companies make; I am interested in the way that they treat families and how the forms are filled out, and there should be some sort of corroboration of what they do with the forms. There should be a 72-hour cooling-off period and a requirement for a second signature from the parent, so that there is not just one signature.

Malcolm Chisholm: Does Ann McMurray want to comment on that?

Ann McMurray: Yes. A lot of us have concerns that there is no regulatory body for funeral directors. Some are affiliated to their own bodies, but there are independent funeral directors out there, too. We would like a consistent approach, in which funeral directors have all had the same training. That consistent approach should especially apply when funeral directors deal with vulnerable parents. It is traumatic to lose a family member, but the loss of a baby is unthinkable for anyone. It is something that you learn to live with; it is not something that you ever get over. Any death is bad, but when a baby dies, people's instincts go completely awry and they need the person who gives them information to be compassionate and caring and to ensure that their wishes really are adhered to.

Malcolm Chisholm: There has been a lot of discussion about ashes, and what the bill says in that regard is important. As I understand it, there will be a provision that says that ashes should be recovered whenever possible. Are the provisions strong enough, or could worries remain that ashes that could have been recovered have not been? Could anything more be done to ensure that ashes are always recovered?

Ann McMurray: The bill states that ashes are everything that remains after the last flame, excluding metals. As we have said already, it should be possible to recover ashes from every cremation of a baby, no matter the gestation, apart from very early losses, when they are in a communal cremation. Furthermore, the bill says that if there are no ashes, the reason will be investigated. I feel that the bill covers the issue and that parents can be reassured that, 99.9 per cent of the time, there will be ashes from the cremation of their baby.

Willie Reid: When I sat on the national committee on infant cremation, one of the phrases that went about was that we should minimise the loss of ashes. I suggested that we should instead talk about maximising the recovery of ashes. I think that that was put into the guidance that went to all local authorities. It is all about putting a positive spin on what is required, rather than a negative spin—"This is what we don't want." The guidance that has been issued to all cremation authorities has been to maximise the recovery of ashes in every case.

Bob Doris: I hope that I am not repeating points, but I want to be clear about a couple of things. First, you have made your point clearly about the regulation of funeral directors, although I have to get my head around how that would work.

Secondly, this is not just about identifying situations in which ashes have not been recovered, but about driving change in processes. What are the processes that lead to ashes not being recovered? If those processes are not satisfactory, how can they be made satisfactory in future? I hear what you say about that issue, and I think that the committee needs to ask questions about it.

My specific question is on the role of the funeral director. Let us work on the basis that—I hope—most funeral directors are sensitive and compassionate. Unfortunately, I recently had to use a funeral director because my mother passed away in December. The funeral director asked our family what we would like to happen and then sought to bring that about. Yes, they went through a form but, for me, what was important was not the form or what it looked like but that I understood and was very clear about what was happening.

I can only imagine how much more difficult it must be to go through the process when a baby or unborn child has died, which is why I want to return to the idea of having a cooling-off period

and a single point of contact, whether at the hospital or the funeral directors, to take people through the process.

The cooling-off period would happen after an initial conversation about what was to happen, during which a person might or might not look at a form. If there was to be a cremation, that conversation would include whether there were likely to be ashes and what the process around that would be. That would be horrific for someone who has just lost a child, so I suppose that having that conversation a second time could be doubly distressing.

I am not making a point here; rather, I have a question to ask. Is it worth risking that additional distress in the short term when a person is grieving anyway to make sure that there is absolute clarity and certainty about the process? At the time, a lot of grieving parents may not be coping, or may not think that they can cope. Is there a tension there between putting something in place and not putting something in place? Maybe there is no tension; maybe we should put something in place and go back to a grieving family after a few days. They might have been struggling initially and the funeral director or a single point of contact could help to manage them through the process. However, going back a second time might have unintended consequences. Is there a balance to be found? If we were to recommend what you are suggesting—and I like the idea—we would have to ensure that there were no unintended consequences.

Willie Reid: The best way to explain the situation is to highlight that the acts that are in place date back to 1905 and 1935. The bill needs to do not only what is right for today, but what will be right for 50 years' time. As I said in my opening statement, the death of a baby 25 or 30 years ago was seen by society completely differently from how the death of a baby is seen today. We must give humans a bit of credit that, where there is distress, that distress might be required to do the right thing. It has become apparent that there were 153 cases alone at Mortonhall in Edinburgh—funeral directors and cremation authorities got it wrong 153 times. In 50 years' time, we want there to be no such cases. In the past year, the ashes have been recovered from every single baby cremation in Scotland.

I do not think that people have to go back through the whole form again. We need checks and balances. There could be a phone call asking the person to pop into the funeral director's office, when they would be told, "This is what we're doing. Are you content with that? Are there any changes you want to make?" If there were no changes to make, they could be asked to countersign the form to say that everything was fine.

I hear where you are coming from, but I would rather that the potential grief that you are talking about was there at the time, instead of 25 years down the line.

Ann McMurray: It would be difficult but, again, if people had the right training, they would be able to approach parents so that they would not be so upset. They would not simply say, "Right, we need to go over this form again." There are ways of speaking to the parents to ascertain that their wishes are the same and that they have not changed their minds.

Parents are told at the beginning that they have a cooling-off period—a period when they can reflect and, if they want to change their minds, they can do so. At that point, those involved could say to the parents, "We'll come back to you in a few days' time, just to check that that is still your wish." There are ways to be gentle with parents, but they are not going to feel any worse than they already do.

Bob Doris: I wanted the evidence to be absolutely clear, and I found those comments very persuasive and helpful.

The Convener: Should the funeral directors' role be set out clearly in the bill?

Ann McMurray: Yes.

10:15

Willie Reid: I would say so, yes. We are looking today at what went wrong yesterday, but we really need to look at tomorrow because, in 10 or 15 years' time, this story will have been sent away into history but bad pennies can turn up more than once in a lifetime.

At the moment, the beam is on the funeral industry because of the scandal. If we take that beam away—the legislation will become the beam—the rogue trader could be back to their old practices and procedures in 10 years' time.

It is four years since the ashes scandal came out and, with regard to what I was saying about censure and punishment, no one has been put in a court of law in this country over what went on. I know that Dame Elish Angiolini is still conducting a national investigation, but I will go to my grave never knowing what happened to my daughter's ashes. The person who is responsible for that is walking about scot free. I am not suggesting that we are looking for someone to go to jail right now, but if we do not ensure that the legislation is watertight, we could face another scandal in 50 years' time.

Richard Lyle: When death comes to any family's door, it is a traumatic experience. Sadly, most of us have been through that with loved ones. I do not take away from the point that you have made about your daughter, and I certainly agree with you.

You said that you welcomed the appointment of the inspector of crematoria, but you then talked about the 90-day period, and suggested that we should appoint local visitors who could visit undertakers and so on. Could you expand on that?

I have another question, too. What is not in the bill that you think should be in it?

Willie Reid: Her Majesty's inspector of crematoria is only one person, and he has the task of inspecting 27 crematoria. If any investigations are required because of failure to comply with the changed procedures and so on, he must undertake them, too. He is a one-man band. If undertakers were regulated and licensed, they would need to be inspected, too. That would probably be too big a job. I have no idea how many undertakers there are in Scotland, but I can guarantee that there are an awful lot more than 27.

It is easy enough to write to someone to say that you are coming to inspect their register but, when the ashes story broke, I went to the local undertakers who carried out my daughter's funeral and found that they did not have records. They should have records, even if they just record the date and time of the funeral and say who organised it. That is probably the first thing: the undertaker, as well as the crematorium, should keep a register.

I suggest that there should be ad hoc inspections. The people who do those inspections could be volunteers who just get expenses or some sort of minimal remuneration, but they would be able to visit undertakers and ask them for, say, details of their last 10 funerals. The visits would be snap inspections, without warning. That would keep people on their toes. If undertakers know that that could happen, the likelihood of them not doing the right thing would be very much minimised.

Richard Lyle: Would those people—let us call them sub-inspectors—be appointed by the inspector, the local council or someone else? Earlier, you talked about prison visitors, but that system does not work in that way any more. Who would appoint those independent inspectors?

Willie Reid: I think that they would have to be independent of the council, given that, ultimately, the council is the cremation authority. I do not have any issues with their being appointed and vetted by HMI.

Richard Lyle: That was the answer that I was looking for. Thank you very much.

Dennis Robertson: Should the bill specify that all burial and cremation records be kept electronically and perhaps enable a transition period for anything that is currently recorded on paper—and indeed future records—to be put in electronic form for ease of access? After all, this is the 21st century. Do you believe that there should be an electronic register?

Willie Reid: Yes. Twenty-five years on, I saw the records that the City of Edinburgh Council holds on my daughter's cremation, and the register and forms were on microfiche that was difficult to read. In fact, Lord Bonomy recommended the creation of a national computerised record.

Dennis Robertson: Should the bill specify that?

Willie Reid: I would have no qualms about the bill doing that and making it clear that cremation authorities must have such a record.

Dennis Robertson: And, for the sake of ease, access to the register should always be free of charge.

Willie Reid: Very much so.

The Convener: The bill says that records must be kept of every burial and cremation, which might lead to, say, women who had lost their babies before 24 weeks being identified. Do you have any concerns about such information being available not just to certain people, but to the public in general?

Willie Reid: The information must be available to the public. However, I believe—I should make it clear that I am no lawyer—that, like anything else, once the information is computerised, data protection legislation comes into play. Names and dates of birth could be redacted, but information on the cremation procedures should be available. For official bodies such as Government organisations, that redaction could be removed, but I do not think that the public need to know names and dates of birth. I do not think that it is a big problem as far as adults are concerned, but the issue might be a little more sensitive with regard to babies.

Ann McMurray: I would not have thought it a matter of public record, but the information should be available to parents who want to check those records. Given the anonymity provision for parents whose babies are born before 24 weeks, there is an issue about how much information can be given, but it is important for these records to be kept and made available to parents who want to check them.

The Convener: Under the bill, the records will be available to the public, but the point is to ensure that the women in question are not identified.

Ann McMurray: That is right.

Bob Doris: I promise that this will be my last question.

Again, it all seems to come back to the process. We need to trust funeral directors, cremation authorities and crematoria, but we must also have checks and balances in place to ensure that they are doing what they have said they will do. Mr Reid talked about someone going in to carry out spot checks and ask about the last 10 cremations, burials or whatever. I realise that it is not your job to justify any alternative solutions that you might have, but I have a general question about that suggestion.

I suppose that a funeral director or a cremation authority could say that the forms had been filled in perfectly. However, forms could have been filled in perfectly 30 years ago, but that does not mean that people knew what they were signing up to or that they were complicit in how the forms were filled in. I imagine—again—that the only real way of ensuring that the process is carried out sensitively is by dealing with the vexed issue of going back to the parents and asking them how they feel about the process.

That brings me to my last question. I cannot possibly know, because I have not been in the situation, but three, six, nine months or however long after they have buried their baby or had them cremated, what parent wants a knock at their door, a telephone call or an email from someone asking, "Can we just have a little chat with you about what happened?" I can see issues with that. That is not a reason not to talk to parents; it is a reason to ensure that we think carefully about how we do it.

It is not for us to interrogate the detail of the suggestion that Mr Reid made—that would be unfair. Our job is to scrutinise the bill. What is not in the bill, I suppose, is how we go back to parents after they have been through that horrible experience and the process of cremations and burials to see whether they think that they have been dealt with sensitively and appropriately, and whether they think that they had clarity and assurances in the process. I suspect that that is not in the bill. Should we put it in the bill? How could we do that?

Willie Reid: I do not know.

Last year, you and I lost our mothers. A month to six weeks after my mother died, the crematorium wrote to me to ask whether I wanted her name in the book of remembrance and to ask how things went. One way of adapting that approach would be to have it as part of the initial conversation. Right at the beginning, when people have come back after their cooling-off period and have said what they want in the cremation service, they could be asked whether they would object to HM inspector speaking to them in 12 weeks' time, to ensure that everything went to their satisfaction. Some parents would say no, but I would think that the majority would be quite comfortable with that. The issue is how the message is given over. It should not be, "We're the Scottish Government and we're determined to come and see you in 12 weeks." If it is given over in a more sensitive way, I do not think that there would be a problem.

Ann McMurray: I am in two minds about that. I am all for looking to see whether things have been done, but the period would probably have to be longer than 12 weeks. If questions were asked as part of that initial conversation, there would need to be another tick box on the form to say that parents would be comfortable with being contacted. When somebody did contact them, parents would have the option to say that they had changed their minds and did not want to make a comment.

I am in two minds. I think that the exercise would mean another tick box on the form.

Bob Doris: I had those thoughts as well, so thank you for putting them on the record.

The Convener: There are a couple of wee things that we would like to ask, for clarity. I am looking at page 6 of the committee's briefing. We have looked at records with regard to funeral directors and cremation authorities. The bill explains that health authorities must keep a record of what a woman decides to do when a pregnancy loss occurs—in many cases, that is when the initial record is made—as well as what happens when the health authority is asked to bury or cremate those remains. That information will be anonymous.

I would like your comments on that approach, which was alluded to earlier. Should anyone check that the health authorities are keeping accurate records? Who would do that? How could we monitor that record keeping in the health service?

10:30

Ann McMurray: I think that, in the majority of cases, parents are dealt with by the health professionals in the first instance and that information will already be in their health records, so the onus is on the health professionals to ensure that they update those records when they have spoken to parents.

The Convener: The information should not be separate; it should just be part of somebody's medical record.

Ann McMurray: That information should be there. Obviously, there will be information that a person has had a stillbirth, a baby has died before 24 weeks, or whatever the situation is. There should be some information that they have been spoken to about funeral arrangements, that they have been passed on to the funeral director, or whatever the action was.

The Convener: That would prevent our having an overall check and monitoring of the system. I am looking around me. Medical records are private and are not shared generally, so we would not be able to ensure that the public could be aware that the practice that the bill hopes to establish could be monitored by the public, like some of the other measures.

Ann McMurray: But the hospital will have contracts—I do not know what the word is—with funeral directors if they are going to make arrangements on behalf of parents, so surely there must be a record trail of that.

The Convener: I am looking to you, as you have experience. If we tried to examine some of those records, would they be there? The bill says that they should be in the future, so we presume that they are not regularly established now. We can explore that.

Ann McMurray: If the hospital has a contract with a funeral director to inter or cremate babies on behalf of parents because the parents wished not to be involved in that, there should be a mechanism in place so that those records are there.

The Convener: Okay.

Willie Reid: I would have thought that it would be very strange for hospitals not to keep such records, but I have no experience of that matter. Perhaps you guys want to check that out.

The Convener: There are no right answers to those questions, but that is as good an answer as we will get. Perhaps we will ask those questions.

The bill says what should happen with record keeping if a woman loses her baby in the first 24 weeks of pregnancy. The catch-all in the bill is that, if the woman decides on arrangements for a funeral within a week of losing her baby, that decision must be recorded and signed, but nothing will happen for a further seven days. Is that sufficient?

On the other side, we know from our case loads—whether we are talking about children or, indeed, adults—that there are big cultural pressures in some of our communities. We regularly receive casework on the length of time that it takes to get a funeral. If the approach in the bill becomes standard, that will mean at least a fortnight before there can be a funeral. I do not know whether you support the catch-all as a standard, because if that became a requirement, it could cause cultural problems in certain defined communities that have a requirement to carry out funeral services pretty quickly.

Ann McMurray: My instinct is that, if someone has a particular culture, they would not adhere to that provision. They would not choose to wait a week or another week to make that decision; it would be decided that that was their culture and they wanted the child to be buried or cremated within a certain period of time. Whether that is right or wrong for that parent, if that is their culture and what they believe, they will just do that.

Willie Reid: I think that the bill should give people the option to wait. Even if their culture says that they should go ahead with the funeral, they should know that the act gives them an option. I do not know the best way of writing that into the bill—I am sure that it would have to be accommodating. Does doing the right thing take precedence over a culture? I do not know the answer to that.

The Convener: It is not a question that we can answer, because it might not apply to our given situation. However, the bill says that even once the decision is recorded there must be a waiting period—I think that Ann mentioned that that was very important—and that would be the rule. We can perhaps explore that issue further.

Willie Reid: I do not know what the procedures are, but surely there would be a waiting time anyway for a cremation; regardless of culture, it would not be instantaneous. I imagine that there would be a post mortem for the death of a baby, particularly for a neonatal death, so a funeral would not take place until after the post mortem.

The Convener: A waiting time might not matter.

If there are no other questions, I thank Willie and Ann very much for their time. We are sorry that Cheryl Buchanan has not been able to come, but we obviously have her written evidence, which we will take into account when we complete our initial report. As we have come to the end of this evidence session, I thank you both very much indeed. Ann wants to say something—on you go.

Ann McMurray: I did not realise that you were wrapping up. You started the session by apologising for some of the terminology in the bill because we might be upset or offended by it. I ask that, for any parent who wants to read the bill, there should be something in a similar vein in it about the terminology that says that it must be used for legal reasons.

The Convener: You have just put that on the record—it is a good, final word. However, Willie is determined that he will have the final word. [*Laughter*.]

Willie Reid: I know that more parents are coming to see committee members tomorrow in private. However, to finish what I have to say, I think that the Government needs to get the bill right. Failure to get it right—and it is not watertight—will just continue to allow the kind of trauma that I never want any other parent to go through. Babies are going to die, just like we are all going to die, but we have definitely got to avoid others having the double grief that we went through. I want to impress on the committee that we need to ensure that what we do is done right and with the best intentions.

The Convener: Thanks very much to you both for your contribution. I suspend the meeting at this point while we set up for our next evidence session.

10:38

Meeting suspended.

10:44

On resuming—

Decision on Taking Business in Private

The Convener: Item 2 is a decision on whether the committee will consider its future work programme in private at future meetings. Does the committee agree to follow that custom and practice?

Members *indicated agreement.*

Subordinate Legislation

Food Information (Miscellaneous Amendments) (Scotland) Regulations 2015 (SSI 2015/410)

10:45

The Convener: Item 3 is subordinate legislation. We have one negative instrument before us today. There has been no motion to annul and the Delegated Powers and Law Reform Committee has not made any comments on the instrument. Given that committee members have no comments to make, do we agree to make no recommendation on the instrument?

Members *indicated agreement.*

General Dental Council (Fitness to Practise etc) Order 2015 [Draft]

The Convener: Item 4 is also subordinate legislation. We have one affirmative instrument to consider. As we usually do with affirmative instruments, we will have an evidence-taking session with the Government. Once we have had all our questions answered, we will move to the formal debate on the motion. I welcome the Cabinet Secretary for Health, Wellbeing and Sport, Shona Robison, and her officials, who are Ailsa Garland, principal legal officer, from the legal directorate; and Jason Birch, senior policy manager in the regulatory unit, from the health directorate. Do you wish to make opening remarks, cabinet secretary?

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Yes, if that is okay, convener. The Scottish Government and the health departments in the three other nations in the United Kingdom are committed to making legislative change in healthcare regulation to enhance public protection. That is why changes are being made to the General Dental Council legislation through the order, which is made under the Health Act 1999.

In the past three years, the GDC has had a 110 per cent increase in its fitness-to-practise case load, which has put a significant strain on its resources. To ensure public protection, the GDC needs to be able to expedite the fitness-to-practise complaints that it receives. It is also clearly vital to prevent the GDC from developing an unmanageable backlog of cases.

Currently, the GDC legislation can make it difficult for the GDC to act swiftly when a complaint is received that a registrant's practice presents a risk to patient safety. In order to maintain patient safety, generate efficiencies and ensure confidence in dental regulation, changes require to be made in GDC fitness-to-practise processes at the investigation stage.

The order will make five key amendments to the legislation governing the GDC's processes. The first is to enable the GDC to make rules to allow decision-making functions that are currently exercised by its investigating committee to instead be exercised by officers of the GDC known as case examiners. Currently, if a complaint is taken forward, the GDC must convene an investigating committee. If case examiners are used, a full investigating committee will not be needed for each case, which will lead to the swifter resolution of cases. Given that case examiners will deal with a larger volume of cases than the investigating committees, there is the potential for greater consistency in decision making, which will further enhance patient safety.

Secondly, the proposals will enable the investigating committee and case examiners to address concerns about a registrant's practice by agreeing appropriate undertakings with that registrant, instead of immediately referring the matter to a practice committee. For example, if a case involved an allegation that a registrant's health was affecting their fitness to practise, an undertaking could address any public safety risks, avoiding costs and saving time. However, the GDC's policy is that rules will ensure that a registrant must not be invited to comply with undertakings if there is a realistic prospect of their being erased from the register at a practice committee.

Thirdly, the GDC will have the power to make rules so that the registrar can review a decision that an allegation should not be referred to the case examiners or the investigating committee. That power also extends to review of a decision that an allegation should not be referred from the investigating committee or case examiners to a practice committee.

The GDC's policy is that its rules will provide that a review can be undertaken by the registrar only if the original decision was materially flawed or if new information has come to light that might have altered the decision and a review is in the public interest. Such a review can only occur within two years of the original decision to close the case.

Fourthly, a power will be introduced to enable the investigating committee, which will be extended to case examiners through rules, to review their determination to issue a warning. At present, a registrant can appeal the issue of a warning only by judicial review which, of course, is a lengthy and costly process.

Finally, it is proposed that registrants will be able to be referred to an interim orders committee at any time during the fitness-to-practise process. That amendment removes ambiguity in the current legislation and ensures that those who are potentially unsafe to practise have their registration restricted while inquiries and investigations are made.

It is estimated that those proposed changes will delivered approximately £2.5 million in annual savings for the GDC, which will no doubt help to reduce future pressure on registrant fees.

It is also worth noting that the General Medical Council, the General Optical Council and the Nursing and Midwifery Council already use case examiners. All three regulators have seen positive benefits from the introduction of case examiners on the speed of completing cases and ensuring public protection. The detail governing the operation of the proposals will require the GDC to amend the procedural rules governing its fitness-to-practise procedures. The GDC has consulted on its proposed rules changes and the negative procedure instrument on those will be laid in the Scottish Parliament this year.

The Scottish Government considers that the best way in which to improve consistency, create greater efficiency and simplify professional healthcare regulation would be to introduce a single United Kingdom bill covering all professional groups, which builds on the work of the law commissions. I have written to the Department of Health on five occasions to ask for confirmation that such a bill will be progressed, and I understand that I will finally receive a response in the near future.

At this stage, I am happy to answer any questions that members might have.

The Convener: Thank you for that opening statement. Do members have any questions?

Dennis Robertson: What training will the case examiners have? What is in place to ensure that they have the competence to meet the standards that you have laid down?

Jason Birch (Scottish Government): The case examiners will be given full training by the GDC—we have been reassured on that point—and there will be a case review team that monitors their performance as the work progresses.

Dennis Robertson: What length of experience will case examiners have to have?

Jason Birch: Of the case examiners, there will be one registrant and one layperson. The detail will be in the GDC's guidance, which will be put into the rules in due course. We do not have the absolute detail, but we have been assured that it will be substantial.

Nanette Milne (North East Scotland) (Con): Will this change bring the GDC into line with the GMC and the other regulating bodies that you have mentioned? How long is it since those other bodies changed their regulations?

Shona Robison: It will. There will be greater consistency of approach. The other regulators have moved in that direction for the same reason, in order to have a more efficient process. The other regulating bodies have had the system in place for a number of years—the GMC has had it for quite some time; I am not sure about the exact dates, but it has operated well over that time.

Nanette Milne: I thought that the system had been in operation for some time; I was just checking that it had operated well. I think that it is a good idea for the professional regulating bodies to come into line with each other across the country.

Malcolm Chisholm: I am sure that everyone supports the proposed approach, but there are interesting issues about the things that we formally regulate and the things that the UK formally regulates. Are the processes identical for, say, a dentist and a dental technician? Is the wording of the order identical to the equivalent UK order?

Shona Robison: Yes.

Jason Birch: Yes, the regulation is UK-wide and applies to all groups that are regulated by the GDC.

Malcolm Chisholm: The regulation is UK-wide but must be approved by us in relation to certain groups—is that the procedure?

Shona Robison: Yes. The situation will be the same in Wales and Northern Ireland.

Jason Birch: Four groups are regulated by the GDC: dental nurses, orthodontic therapists, clinical dental technicians and dental technicians. Under the Scotland Act 1998, the approval of the Scottish Parliament is required for any legislation that includes them.

Malcolm Chisholm: So that is how it is done. It is not formally a legislative consent motion, but it is like that. Is that what you are saying? You have agreed that it should be done at the UK level, but we have to lay separate regulations.

Jason Birch: No. The regulations are consistent UK-wide but, because they mention the four groups, the Scottish Parliament needs to be content for the regulations to go ahead.

Malcolm Chisholm: So it is like a legislative consent motion.

Jason Birch: In essence, yes. It is similar to that.

Malcolm Chisholm: That is interesting. I thought that we had to lay separate regulations.

Jason Birch: No. There is just one set of regulations that cover the UK.

The Convener: As there are no other questions, we move to the formal debate on the affirmative statutory instrument on which we have just taken evidence. I remind you all that members should not put questions to the minister during the formal debate, and that officials cannot take part in the debate. I invite the minister to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the General Dental Council (Fitness to Practise etc) Order 2015 [draft] be approved.—[*Shona Robison*.]

Motion agreed to.

The Convener: I will suspend at this point to change the witness panel.

10:56

Meeting suspended.

10:58

On resuming—

Draft Budget Scrutiny 2016-17

The Convener: Our sixth and final item today is our second and final evidence session on the draft budget 2016-17. For this session I again welcome the Cabinet Secretary for Health, Wellbeing and Sport and her Scottish Government officials, who are Paul Gray, the chief executive of NHS Scotland and director of general health and social care; Dr Catherine Calderwood, chief medical officer; and John Matheson, director of health finance, e-health and analytics. I welcome you all this morning and wish you all a good new year.

We will move directly to questions, and the first question is from Malcolm Chisholm.

Malcolm Chisholm: We are particularly interested in the integration authorities and their funding, so everybody was pleased about the announcement of the £250 million for social care. However, questions have been asked about how it will work in practice, so my first question is this: how can you be sure that that £250 million will be spent on social care?

Shona Robison: When you raised this issue in the chamber, I was able to give you a brief response to reassure you that it is our clear intention that that £250 million needs to make a significant step change in improvement to the delivery of social care. Boards are very clear—and we are very clear with boards—that that resource will be allocated to the 31 integration joint boards; in Highland, the lead agency model is slightly different.

11:00

As the committee will be aware, discussions are on-going between John Swinney and the Convention of Scottish Local Authorities on the detail of the deal. However, we are clear that we want that resource to deliver as much additional benefit as possible for social care. The benefit to the health service is also very important, which is why this move has wide support. Although we have already invested £100 million over three years to tackle delayed discharge, this size of injection of resource into social care will be able to deliver real progress in the eradication of delayed discharge. It will also help to build new models of delivery of social care, anticipate demographic changes and ensure that, in the new world of integration, we have resources at a level that can begin to better meet the demands that are out there.

Negotiations are on-going. Once those conclude, I am happy to keep the committee

informed about the mechanics of how the resource will be delivered. However, in my position as health secretary, I am very clear that that resource must work to create a step change in the delivery of social care.

Malcolm Chisholm: The concern relates to the recent Audit Scotland report on health and social care integration, with which the cabinet secretary will be familiar. In that report, Audit Scotland said:

"There is a risk that, if NHS boards and councils seek to protect services that remain fully under their control, IAs face a disproportionate reduction in their funding, despite the focus on outcomes that all partners should have."

The issue is how this will work in practice. We can accept that £250 million will go to the IJBs. However, we do not know what the main sums are—we do not yet know how much national health service boards and local authorities will agree to put into the IJBs. Audit Scotland has reflected that concern in its report, which is encapsulated by that quote. In other words, there may be a tendency on the part of boards and local authorities not to give as much money as they should to the IJBs. It is difficult to see how you can be confident that there will be the additional investment that you clearly want in social care. We hope that that additional investment will happen, but I do not know how you can ensure that it will, particularly from the local authority side.

Shona Robison: Bear in mind that we are only in the shadow year of IJBs; they will begin their first full year of operation next April. The answer is to ensure that there is transparency on the part of local authorities and boards, not just on the resources that go into the integrated joint boards but on the outcomes. With the requirements of integration legislation comes a responsibility for the local authority and the health board to set out clearly to the public that they serve in their localities what their plans are, what the outcomes will be from the resource that they are investing and what the priorities are for the collective resource that will be invested. Those two key organisations should then be held to account for the delivery of those outcomes.

As the Scottish Government, we have a responsibility to performance manage the NHS and ensure that it plays its part, but I think that there is also an onus on local government to be seen to be playing its part, too. This has been established in statute, and that statute sets out certain requirements to produce reports and so on. A number of levers can be used, but there is far more to be gained from both organisations making this work for their local populations, and we must ensure that both are held to account for the delivery of this significant resource.

Malcolm Chisholm: I am sure that other members will want to pursue that.

I have one other question, which is about the NHS Scotland resource allocation committee. I am very concerned about the extent to which certain health boards that seemed to be moving towards parity are now moving away from it. Obviously I have a particular interest in NHS Lothian, but I am sure that Dennis Robertson sitting beside me will be interested in NHS Grampian. Based on next year's allocations, Lothian will be £30 million from parity—and £30 million is the total sum of money that you have set aside for NRAC parity. That will create particular problems for boards such as Lothian, and I wonder what your plans for parity are now. Will it take longer than you thought? Why would you not at least consider trying to bring all boards within what I think was your original target of 1 per cent? I do not think that the £30 million will do that.

Shona Robison: The NRAC process runs over a number of years. There are three main gainers from NRAC in 2016-17, but the two big ones are Lothian and Grampian, which will actually receive more resource than they had budgeted for. I will let John Matheson talk about some of the detail in a minute, but as I understand it the uplift for Lothian is 6.4 per cent and for Grampian it is 6.6 per cent. They are therefore significant gainers in 2016-17 as a result of the NRAC formula.

With regard to the 1 per cent target for parity, the allocation will bring Lothian to 1.4 per cent or just slightly above that figure. However, it is fair to say that Lothian and, in particular, Grampian have received resources beyond what they had budgeted to receive in 2016-17.

Do you want to say a little bit more on that, John?

John Matheson (Scottish Government): I have just a couple of comments to make.

Over the past five years, a cumulative total of £619 million has been spent on moving boards towards NRAC parity. The principle that we established at the very beginning of the process was that we would do it in a way that did not destabilise boards on the other side of parity, with a particular focus on the board that is obviously in that position: NHS Greater Glasgow and Clyde. We are trying to do this in a measured way.

As for the move to within 1 per cent of parity—I note that NHS Lothian and NHS Grampian will be at 1.4 and 1.5 per cent after this adjustment—we have accelerated things and brought all this forward from 2016-17 to 2015-16. In its financial planning, NHS Lothian was expecting £12 million, and it has received £14 million; NHS Grampian was expecting round about £10 million, and it has received £15 million. In other words, they have got more than they were expecting in their plans.

As I said, we are trying to do this in a measured way and in a way that does not destabilise the other boards in Scotland, particularly Glasgow, and we have invested £619 million in this over the past five years. Nevertheless, we accept that NHS Lothian and NHS Grampian are still round about 1 per cent away from parity, and our focus going forward will be on those two boards.

Malcolm Chisholm: Thank you. I will leave that just now.

Bob Doris: Good morning, everyone. As the cabinet secretary knows, I am interested in the funding that is available to general practitioners and I have pursued that matter locally in Glasgow.

I welcome the fact that, in the draft budget that we have before us, there is a 3.6 per cent increase in the general medical services budget for GPs. That represents a 1.9 per cent real-terms increase. That includes another £45 million that has been allocated to the new primary care fund that can be accessed by GPs and health practices for new ways of working. If all that is added together, we end up with a substantial increase in funds of something like 10 per cent.

There is a feeling that the issues surrounding GP practices are sometimes as much about recruitment and retention as about the funds that are available and new ways of working. I have a particular interest in urban areas and deprived areas, but other MSPs have their own issues across Scotland.

There is a good uplift for GP services, but we are keen to know what influence the Scottish Government can have on taking some of the burden off some GP practices that are facing challenges that the cabinet secretary will be aware of, and how that feeds into recruitment and retention issues.

Shona Robison: Through the budget, we have tried to prioritise areas of investment. Doing that was not without its challenges, but we hope that the committee will see that, whether it is the £250 million for social care or the additional investment in primary care, elective centres and so on, we have tried to prioritise those areas of spend that align with the direction of travel for the NHS and health and care services generally.

In primary care, there has been an uplift for general medical services and the primary fund, which includes the £25 million of new funding, making a £45 million investment in 2016-17. It is worth noting that other significant budgets lie elsewhere that impact on and will help to realise a new vision for primary care. A good chunk of the Scottish Ambulance Service investment is about working more closely with primary care. The health visitor investment will also have a significant impact on primary care, as will the social care budget.

We need to ensure that all that works to realise that new vision and that we can make primary care an attractive proposition for the GPs of the future, which will encourage medical students to choose general practice as their preferred specialism. The resources that we are talking about will help to underpin the significant changes to the new contract, which will come to fruition through the transition contracts for 2016-17 and be ready for new contracts in 2017. I want us to seize the opportunity to have the new contract focus on tackling health inequalities and to make the allocation formula reflect that.

We are in the midst of negotiations and discussions about that, which have not yet been completed. I hope that the significant investment in primary care will help to bring all that to a positive conclusion, which will, in turn, address recruitment and retention, help to deliver a more effective primary care service and particularly address some of the health inequalities that still exist in Bob Doris's constituency and many others.

11:15

Bob Doris: That is helpful. I do not want to push you on that when negotiations are on-going. As an urban MSP, I can accept that there are areas of deprivation in remote and rural areas that have specific problems. However, because I represent areas in which there is significant urban deprivation, I am obviously delighted to hear that more thought is being given to tackling the health inequalities that extend from that deprivation.

However, we must have GPs who want to work in those practices. One of the ways in which to get that buy-in from a new generation of GPs is through their seeing themselves as close partners with others in health and social care integration. The £250 million and other moneys is where the real meaty uplift is. Can you reassure us that GPs and GP practices are central to health and social care integration? Sometimes we are not too good at talking up the opportunities in general practice, and that in itself can dissuade a lot of young medics from choosing general practice as an option. What would you say to those who are thinking about going on a training rotation to be a GP just now? Do they have a significant role to play in health and social care integration? That is where the meaty uplift of cash is.

Shona Robison: Absolutely. The Royal College of General Practitioners, the Royal College of Nursing and other bodies have frequently called for investment in social care because they recognise that it all hangs together in terms of community services and having the ability to pull

together those resources for their patients, whether it is about a care package, avoiding admission to hospital or being able to maintain people with chronic conditions at home—it is all part of the same picture.

We need to ensure that the frameworks and structures that lie behind all that can help to deliver that new vision. There have been challenges in ensuring, for example, that GPs are represented around the table of IJBs—that is work in progress, to be honest. However, we are very keen to ensure that the GPs' voice is not just heard but central to the decision making on how resources are allocated and how services are delivered and developed. That is crucial.

The vision for the next five to 10 years is to have a significant acceleration in the shifting of the balance of care, which is something that we have talked about. I have talked about it at this committee a number of times, but we really need to accelerate the pace of that change. I think that the budget and the resources around it put down a marker for where we need to head. The resources are following that and we need to see the pace accelerated, which is our commitment.

Bob Doris: You mentioned shifting the balance of care. I have mentioned before at the committee the £200 million for the six new surgical centres that the Scottish Government seeks to develop across Scotland because of our ageing population and the need to have elective surgeries for hip replacements, cataracts or whatever for elderly patients. In budgetary terms, that falls into the acute sector; it can appear as though resources are being sucked towards the acute sector.

Coincidentally, my father-in-law is in the Golden Jubilee hospital this morning for a hip replacement. I hope that he does not mind me saying that—I did not clear it with him first—but he is. However, that hip replacement will allow him to stay at home and continue to get on with what he is doing. Sometimes we are not very good at identifying what spend is purely acute spend and what spend is an investment to keep people in the community and at home, or in a homely setting, for longer. When we do our budget scrutiny and we look at that £200 million, should we view it as a dragging of more money to the acute sector? Some have viewed it like that, but I view it differently. How does the Scottish Government view that expenditure?

Shona Robison: I hope that the hip replacement goes well for your father-in-law this morning at the Golden Jubilee, where he is in good hands.

We should bear in mind that the £200 million investment is over five years. We can compare that with the £250 million injection into social care in 2016-17 alone, which makes it pretty clear that there is a significant shift in the balance of care. However, we also need to make acute services more effective and efficient. You have just articulated the demands that are coming down the line in terms of hips, knees and eyes. We could argue that such procedures are preventive measures; I think that they are because, for example, they are preventing people from falling because their eyesight is failing or because they are not getting their cataracts sorted early enough.

However, this is also about the more effective delivery of acute services per se. That will require us to avoid as many interruptions as possible to planned procedures; at the moment, those procedures are interrupted because of emergencies coming in, and the separation of elective and emergency procedures will mean a more effective and efficient flow of patients through procedures with fewer cancellations and the ability to meet future demands.

Although shifting the balance of care is absolutely key and important, we must also ensure that our acute services operate in the most effective and efficient manner. The Golden Jubilee model has proved to be very effective and efficient with regard to high-volume, high-demand procedures, and we want to replicate that throughout Scotland. That would be a good investment to make.

Bob Doris: Thank you.

The Convener: The committee would welcome that approach. We have already commented on the pressure—and, indeed, the distortion—that targets sometimes create, and allocating more money to making things more efficient and making better use of these things is the least that we can do to tackle that area.

Of course, another question arises that you might wish to respond to. The committee has continually asked—and did so in its recent report—about the continuing use of some of these targets. They might keep Bob Doris's poor father-in-law at home for a week or so, but I do not suppose that his having his operation either today or a fortnight from today will make much difference—

Bob Doris: I am sorry that I mentioned him, now.

The Convener: Well, you did—and you mentioned him the last time. It is a habit that some of you have.

There is an issue here, in that these particular targets are not replicated in some of the other areas that you have mentioned such as reductions in deprivations, inequalities and so on. We saw that with the £100 million that was put into

accident and emergency to deal with the crisis in that respect. Those of us who support this progress and the journey that you are on are sometimes stumped by some of the spending announcements that are made in the short term to deal with, say, A and E when we consider the longer-term planning that is being carried out with regard to these resources.

When at our previous meeting we raised the issue of the £200 million that will be spent over the period of time in question on A and E services—which gives a total of around £300 million—with those who have been given the responsibility of transforming how we provide health and social care and who are heading up the integrated joint boards, they told us that they have not agreed their budgets with the health service. We now do not know exactly how the £250 million for social care that has been announced will be fed into them or whether that will provide them with real opportunities. If those organisations are to be the standard bearers of this step change, should they not know what their budgets are in January in time for April? How do you make plans in that environment? How do we give them the best possible assistance?

Shona Robison: First, I reassure you that all the IJBs will have their budgets and plans in place well before they hit the ground running in April. We are talking about new territory and new ways of working, and sometimes those things can be difficult. Convener, it will come as no surprise to you that partnerships that were already quite strong have got on with the job while in other areas where that relationship was perhaps not as well developed things have probably been more challenging. That is the case now as it ever was.

However, if you look at what has been delivered in Glasgow city, for example, a relationship between the council and the health board that traditionally might not have been the strongest has managed to deliver one of the best results in reducing delayed discharges among the over-75s. It has reduced delayed discharges by a remarkable amount because of a number of things, including the devolution of power and responsibility to the operational managers of both organisations to allow them to get on and resolve issues—in other words, just get on with the job—without having to go back and get 10 different committees to sign things off.

In Glasgow, the ward staff in hospitals can directly commission social care, and I am told that that has made a huge difference to the speed of getting people discharged. A range of services is also being developed to avoid admissions to hospital in the first place. There is more development around the step-up facilities in the city of Glasgow. I cited that because it shows what can be done. The people involved are now almost able to name the cases that are delayed in the city of Glasgow. That shows how few those cases are compared with previously.

Other partnerships are not yet in that territory, but they need to be. If we can get all partnerships to be in that territory and perhaps to learn some of the lessons that have been deployed in the city of Glasgow—I know that it is sometimes a challenge to look at what is happening elsewhere—we really can make a huge change.

The integration joint boards are really only as good as what they deliver, and that has to be a change in and improvement to the services that people receive.

The convener mentioned targets. I think that I have said to the committee before that, as part of the national conversation and the discussion around the national clinical strategy, which Catherine Calderwood has been working hard on with Jason Leitch and others, we are up for discussion about what the right targets are.

I would probably disagree on the unscheduled care, as the investment in it has meant that, for example, so far this winter—touch wood—there has been a big improvement on what we saw last winter. From a patient safety perspective, it is much safer for people in A and E departments to be treated within the four-hour target, which is why it was set. If you speak to the Royal College of Emergency Medicine, it will tell you that, if you were to pick a target, it would defend the four-hour target strongly, as it is a barometer of what is happening in the rest of the hospital.

We should discuss targets in the round, but out of all the targets, the investment in unscheduled care has meant that the flow through the whole hospital has forced other parts of the hospital to get on with discharging patients and has helped to create a culture of not holding on to patients to free up beds and get patients out and get them home. The joining up with council colleagues has had a direct impact on the front door of the hospital, as beds have been freed up much earlier.

We have to look at the whole system rather than just one part of it.

The Convener: Yes. I agree with that, and I think that anyone who has sat in this committee over the past five years would agree with it and would probably argue that the solution to A and E departments lies outwith them. Who knows? We could be facetious and say that the absence of snow and ice will help A and E departments to meet their targets this year. Many factors are involved.

I can understand some of the evidence that we have received. It is a good marker that £250

million is being directed as you described; there is no doubt about that, and if it is the start of a journey, that is very good. However, what people are concerned about is the separation of the health service and social care: although we all see them as integrated, they are not integrated on the whole.

It has been suggested that the health service and social care are developing parallel systems and not working with each other, and there is a danger in that. Some of the Glasgow work shows that. General practitioners' and hospital doctors' practices are being circumvented, for example, rather than there being integration to solve problems.

How do we avoid the situation developing in which there is parallel running, which some people are concerned about? How do we get the integration that we need to deliver, and how do we get money going to places that it should go to when at this stage—whether we like it or not—the budgets have not been agreed?

11:30

Shona Robison: Ultimately, the issue comes down to accountability, visibility and transparency. All of that has to be laid out, and the partnerships have to be able to show how they have agreed their priorities, what those priorities are, what investments they have made, what new services have been developed and delivered, and what the outcomes have been for their populations. All of that will be laid bare in the reports that those partnerships will need to make through their IJBs.

Of course, we are talking not just about the local authority and the NHS. There are also the third sector partners and the private sector, both of which will have a role at the table and are important delivery partners, but the axis is really around the interface between the NHS and the local authority.

As you will know, convener, we had to legislate because the pace of joint working was not cutting it and was not delivering what needs to be delivered. The legislation contains levers that will help to ensure that things are delivered but, as my Glasgow example makes clear, we are already beginning to see the fruits of this approach. Would all of that have happened without integration? I do not think so. It has forced partners to think about things in a different way, to have a collective responsibility for the resources that they spend in their localities, and to think in more innovative ways.

Part of the process also involves trusting operational managers to get on with the job of delivering the services that it has been agreed will be delivered. If I were to pick out one element of the Glasgow success that should stand as a lesson to others, it would be trust in the front line to get on with the job instead of operational managers having to continually refer back to the parent host organisations.

There is a bit of risk in that approach and trust will be required, but it has meant that operational managers in the city of Glasgow have been able to identify some of the inevitable issues and glitches that have arisen, agree solutions and get on with sorting them out.

When I met the operational managers of both organisations in Glasgow, I found that they felt quite empowered to take that approach in a way that they had not been previously. I am not saying that that is a magic wand by any manner of means, but it appears to me that it has been a significant factor in successfully getting those delayed discharge figures down in Glasgow in what I think has been a bit of a stand-out way.

The Convener: I do not want to go on about this, but we have heard about great examples before. The Highlands has been on a five-year journey, and we have heard evidence of other great examples and pockets of good practice, but there has been no outbreak of this joint working. It has certainly not proven to be infectious—after all, we have had to legislate for it. Many examples can be highlighted, but the fact is that in carrying out its draft budget scrutiny the committee has to look at specific pockets of money that are being directed at different areas.

The committee also knows that we need to get the social care aspect in local government working effectively, because we cannot achieve one without the other. There is a big power gap here; in fact, it is sitting here in front of us, with the cabinet secretary and all these people with responsibility for health taking their place at the table, while local government faces cuts and increased pressures. The balance is not equal, given the expectation on that part of the system to deliver effectively for us. As I have said, that power relationship is in no way equal.

Shona Robison: It is now one system. It has to be one system, and it has to see itself as one system. Five years ago, would we have invested a quarter of a billion pounds a year into another part of the system? Probably not.

The Convener: But you do not even know whether it is going there.

Shona Robison: I can assure you that it will. We have been clear with boards that the money will sit with IJBs. That is quite groundbreaking—it is a significant resource—and it is new territory for health boards, too. It is challenging, it is different and it will mean that people will have to think about things in a different way. They will not be

able to say, “That is so-and-so’s money”; they will have to have a different thought process around the collective resource and make it work more effectively.

The £250 million is a significant injection, but people need to look at the global resource that they are now collectively responsible for and find ways of making it work more effectively to deliver a better service for patients and service users in their area.

Dennis Robertson: Malcolm Wright of NHS Grampian put on record the fact that he welcomes the additional money that is coming to Grampian. There is a fantastic capital spend going on in Grampian, too, and there are a lot of good news stories in the area.

I welcome the additional money for mental health. Could you explain a little more about how that money could be spent in the mental health programme? In addition, what money will be spent on digital technology to enable distance examinations of patients in rural areas such as those in my constituency and places such as Orkney in order to prevent them from having to travel if they need to speak to, for example, a specialist consultant in Aberdeen?

You touched on the issue of preventive spend in relation to elective surgery. Do we have an idea of, for example, how much money cataract operations save in relation to the treatment of trips and falls?

Shona Robison: To take your last point first, yes, that modelling has been done. We can probably get you some additional information from the work that John Connaghan has done on how much money is saved as a result of effective preventive measures, which you could argue a cataract operation is.

I will answer the mental health question and John Matheson can answer the digital question.

The top line is that, over the next five years, there will be investment of around £150 million. That builds on the investment of £100 million in child and adolescent mental health services that Jamie Hepburn has already announced. It has a focus on bringing down waiting times; increased access to specialist services and psychological services; and an investment in mental health in the field of primary care, as we know that many GP appointments are taken up by people with mental health issues—there is compelling evidence that, if we can provide more referral options for GPs, we can help to reduce the risk of those people developing further and more severe and enduring mental health issues. Work is going on around what that might look like.

The additional £50 million was a result of the consequentials received from the UK Government through the health budget. We took the decision to allocate that to mental health. We will look at and discuss what the priorities for that should be over the next five years.

Dennis Robertson: I am sure that we can help with that.

Shona Robison: I know that in this place there has been significant interest in investment in mental health, not least from yourself and others. We absolutely are determined to get that right. We need to get the balance right between investing in specialist services and—this is was why I was keen to see some investment in the primary care ambit—avoiding some of our more enduring mental health challenges further down the line through prevention and early intervention.

As we develop those plans, I am happy to keep the committee informed about the thinking on where that additional resource will be invested.

I ask John Matheson to talk about the digital investment.

John Matheson: I will give three examples. The first is that we have put some recurring resource into digital. We have put £10 million into technology-enabled care and looking at how we can support people to live in their homes. Dennis Robertson made a point about videoconferencing. We are using that resource to look at how, rather than having to travel a long distance for a 20-minute out-patient follow-up, people can have such an appointment through a VC link.

Following on from that, we have allocated to individual boards the Highlands and Islands travel scheme funding, which is about £15 million. That is intended to allow boards to look at whether they can reduce the amount of air travel and ferry travel for patients by investing money in enhancing videoconferencing facilities. Those are two examples.

We are doing some very powerful work with European colleagues. We are learning from others’ best practice and sharing our best practice. We are also looking at what is happening in Scandinavia and Alaska regarding distance healthcare and how healthcare is provided.

My final example is the eight innovation centres that we are taking forward in Scotland. One is the digital health and care institute, which will be based at Eurocentral in Maxim business park, just outside Motherwell. It is looking at developing a simulation laboratory, which will include a ward and a domestic setting and will allow small and medium-sized enterprises to take their products forward to market in a real-life environment.

There are European examples and examples of innovation. We are looking at how we can use the Highlands and Islands travel scheme and the

technology-enabled care money. We are keen to proceed with that at pace. With the way that technology is advancing, the ability to take the work forward will be greatly enhanced over the next few years.

Nanette Milne: I have a couple of comments. I was pleased to hear what you said about the success of empowering front-line staff in the Glasgow area. Giving key front-line people responsibility for what they are doing is one of the key aspects of getting things right.

I want to ask about funding. I hear what you say about tackling health inequalities, which is clearly very important. As someone from Grampian, I worry that, given the long time that it has taken to bring NHS Grampian close to parity under the NRAC formula, we might suffer again under a new funding formula, which might be more likely to take money away from Grampian into central Scotland, where I agree money is needed.

In its written evidence, the RCN expressed continued concern about the presentation of the budget and the lack of any direct linkage between spending and priorities and outcomes. It also noted the lack of scrutiny of in-year allocations of resources. It cited the six new elective treatment centres as part of that. The British Medical Association said that the treatment centres appeared suddenly on the horizon and it was not sure what the rationale for them was. Can you give us some elucidation of that?

11:45

Shona Robison: We talked about NHS Grampian receiving more in its allocation than it had budgeted for, which it seems pretty content with. When we talked earlier about the allocation formula, that was more about the GP contract.

Such things are open to debate, but we need to find a more systematic way of tackling health inequalities. I want to move away from the approach of having an initiative here and an initiative there. We must build tackling health inequalities into how we do business, and one of the most effective tools for that is primary care intervention, because that involves community services. If we can get that right through the new GP contract, we will be on to something significant. That will be debated—as I said, we are in the midst of early negotiations, so I cannot give too much detail—but as cabinet secretary I am keen that we take the opportunity to make a step change in how we tackle health inequalities in our most deprived communities.

I hope that it will not have escaped members' notice that we have listened to what the committee said about outcomes and in-year allocation. Instead of having 65 budget lines, or whatever it was, for boards, we are bundling the resource and they will have far more flexibility to manage that. They will still require to deliver outcomes, and we are working with them on an outcomes framework, which Paul Gray can say more about, but that is with a view to boards managing more flexibly and in a way that uses resources better and avoids more of the in-year allocations that the committee commented on.

Nanette Milne referred to the comments of the RCN and others on the elective centres. The elective centre model has been well tested through the Golden Jubilee model. We wanted to take the learning from that and look at the best models to ensure the right diagnostic and treatment capacity in the NHS. The national clinical strategy, which Catherine Calderwood might want to say more about, provides an opportunity to discuss such matters further. However, if something works and is shown to work—the split between elective and emergency treatment goes back to the Kerr report, so it is not particularly new—we should make it happen.

The rationale for having six centres is to ensure that each area has access to enough capacity to make a difference in how acute services operate and to meet the growing demands in future and to ensure a geographical spread. We know that there have been challenges in making referrals from areas that are further from the Golden Jubilee hospital, so it was important to apply the learning from the Golden Jubilee model and to come up with the elective centre model. Work is still going on to decide what procedures will take place where, so there is still scope for discussion and engagement. The best place for that is through the national clinical strategy.

Paul Gray (Scottish Government): If we think about the three parts—local delivery plans, the outcomes framework and the clinical strategy—we can see that we are creating a strategic framework in which the NHS and its delivery partners can operate. I will explain the point of putting the outcomes framework alongside the local delivery plan as part of the process.

We still want to be sure that boards are operating within financial balance and to be certain that they are meeting the standards that we have set, subject to the discussions that the committee and others are having. However, instead of having, as the cabinet secretary described, 65 separate lines of accounting, which means that people probably spend as much time accounting for what they have spent as they do on delivering what they ought to deliver, it seems more coherent to us to set a framework of outcomes for boards, which takes account of the significant set of outcomes that are to be delivered by statute through the integration joint boards.

Catherine Calderwood, the CMO, will say a little about where we are headed on the national clinical strategy. The point is to ensure that clinical decision making remains central to the delivery of national health services. Of course there must be proper financial management and proper administration, but leadership and clinical decision making are central to the delivery of safe, person-centred and effective services to patients.

Dr Catherine Calderwood (Scottish Government): Let me start by talking about the elective treatment centres. The Golden Jubilee currently performs 25 per cent of the hip and knee replacements—the major joint replacements—that are carried out in Scotland. Mr Doris's father-in-law is in a place that carries out a high volume of procedures. The national hip registry, which Scotland has run for many years, shows that the outcomes for those hip replacements are the best in the country; rates of infection, operative complications and readmission are way above the line that is regarded as very, very good. We therefore have a model of a high-volume centre that is doing high-quality work with the best outcomes, which is what we are aiming for. That is a driver behind some of the national clinical strategy work.

We can see the converse in relation to re-do surgery. For example, there is a high volume of knee replacements, and there will always be people who need another knee—or another hip—because the replacement has worn out. There are smaller numbers of such procedures, but they are spread out across the country, and we know that that does not produce the best outcome. If a surgeon does more operations, the outcome for the patient is better, particularly when the procedure is complicated.

The national clinical strategy builds on some of the medical evidence on volume. It is also about enabling us to deliver rehabilitation closer to home. That is where integration and the primary care aspects, with initiatives such as hospital at home, come into play.

In the national clinical strategy, we are very much asking about how we line up what we know. Operative procedures are probably easier to benchmark, because there are known complication and re-do surgery rates. If we know that a particular volume gives a better outcome for patients, we must ask why we are not delivering in that way throughout Scotland.

We are asking questions of that type as part of our once for Scotland programme—for the elective surgery that I am talking about, the answer might be six times for Scotland—and in our strategy we are starting to ask why, where there is evidence such as I described, we are not moving towards a system in which outcomes for patients are the top line.

There are always issues of interpretation and finance in relation to all of that, but we must consider whether there is a pragmatic solution, which takes account of value for money but in which the clinical drivers are always key. We must think about rurality and travel time. For some elderly patients, travelling a long distance every week, for chemotherapy for example, might be the wrong thing. We are looking for a solution that is clinically focused on patients.

Our strategy will ask some uncomfortable questions and there will be some uncomfortable conversations with medical and nursing professionals, because people hold on to their patches, and someone who is keen on doing a particular procedure but is doing a low volume might not want the procedure to be done somewhere else. Such discussions are not going to be easy in every committee meeting. However, if we keep saying that our approach offers the best outcome for the patient, we will get past such difficult situations.

Nanette Milne: I do not disagree with anything that has been said; it makes an awful lot of sense. Therefore, is there a communication difficulty, if organisations such as the RCN and the BMA are saying, "We didn't know about this"? I have nothing against elective treatment centres, and I do not know that the RCN and the BMA do, either, but as far as those organisations are concerned, the policy seems to have suddenly appeared and I wonder whether there has been a failure of communication somewhere.

Shona Robison: I have an on-going dialogue with the BMA, the RCN and others, and we discuss a multitude of issues. I would like to think that there is a pretty broad consensus on the need to build the right capacity in the right places. Among doctors, nurses and other health professionals in NHS Tayside, NHS Grampian and NHS Lothian—and indeed in NHS Highland at Raigmore hospital—there has been a welcome for the concept, but there is still room for discussion about what will be done where. It is really about establishing the principle that the model is a good one, that we want to do more with it and that these are places that would benefit from the additional capacity and the separation from emergency procedures.

Through the national clinical strategy, we are now in the position of discussing what we want to do. After all, we might not want every centre to do hips, knees and eyes; one centre might become the centre for X, Y or Z. Those are the areas that we need to discuss. We also need to anticipate demand for such procedures in the future and

ensure that we have the right capacity in the right places to help to meet it.

The Convener: Have some of those difficult discussions been around sustaining consultant-led A and E services at their current level? From memory, I recall that one of the worries about what was derogatorily described as a system of centralisation, but which was better described by Dr Calderwood as getting good-quality outcomes from people who do thousands of knee operations a year, was that withdrawing services from local hospitals would diminish the opportunity to provide seven-day, 24-hour, consultant-led A and E services at some of them.

Shona Robison: The national clinical strategy has not yet been published—it will be published in due course—but I can say that the model is more about sustaining our district general hospitals with a range of, if you like, the core services that one would expect to find at one's local hospital, including your front-door and A and E services. Obviously a certain level of service has to lie behind that for a safe and sustainable service to be delivered.

Those are what we would call core services, but what we are talking about here are services that are more specialist in nature or which are provided if there is clear evidence that doing low volumes of such procedures might not be the safest approach. There is, for example, good evidence that outcomes for patients requiring vascular services are better where specialist centres are involved. It is all about looking at the distinction between the general core services that people might expect to receive at their local hospital and the more specialist services that people might need, say, once in a lifetime but which, as patient safety outcomes show, are better delivered at a regional or national centre.

Of course, none of that is fixed in tablets of stone—those debates are still to be had—but a clinical evidence base is emerging for such an approach. These things are not plucked out of thin air; they are based on clinical evidence and an examination of the distinction between what local hospitals will continue to provide, which will be the services that most people receive most of the time, and those once or twice-in-a-lifetime services that people do not expect to receive every day.

12:00

The Convener: Does that development make seven-day working more possible?

Shona Robison: I would say so. Catherine Calderwood will be able to say a bit more about this, but the way in which those services could be configured will make that more possible, although there are obviously challenges to be overcome around ensuring that we get the right definition of what we mean by seven-day services. We are not doing what has been done down in England and giving a perception that we are talking about everything being able to be done 24/7. That is just not realistic. Just because a procedure could be done in the middle of the night does not mean that that is the right or the safest thing to do. We are talking about ensuring that services that we would expect or that are required to be delivered over seven days are delivered in that way and in a safe and consistent manner and that the once for Scotland approach is taken.

We want to ensure that, for example, diagnostics are available at the weekend. We know that if they are, there is more chance of having someone discharged more quickly. It is all part of the same picture of more efficient and effective services. In some parts of the country, that has already been developed. For example, in Glasgow, diagnostic procedures have been developed over the weekend.

I ask Catherine Calderwood whether she wants to say anything.

The Convener: Just a second. Could we maybe go back to some of the budget implications of that seven-day working? Has that sort of thing been factored into the budget? Is that part of the £200 million?

Shona Robison: It is part of the £13 billion, if you like. The sustainable seven-day working group has been working for some time on what is required to deliver safe and sustainable services over seven days, and it has produced an interim report. That has been factored in to ensure that boards, in their allocations and their outcome frameworks, which Paul Gray touched on, are delivering the services in the right places and in the way that they need to do to deliver them over seven days. It is not about having all-singing, all-dancing services 24/7 for everything—that is not what we mean by seven-day services. It is about ensuring that, over the weekend and in the evenings, the services that need to be provided are provided safely and consistently, particularly in the area of diagnostics.

Dr Calderwood: The national clinical strategy will also talk about doing things differently. An example of that is the virtual fracture clinic in Glasgow, which has reduced the number of patients returning to be seen by an orthopaedic surgeon by 38 per cent. In the past, patients who were seen through A and E and who had an X-ray done all used to come back, because there was not a consultant there 24/7. Now, using digital technology, the consultant can access the films virtually and not with the patient at all. A nurse phones the patient to check the details and find out whether symptoms need to be checked. Now,

38 per cent of the patients no longer come back, which has freed up 10 per cent of the time of each consultant orthopaedic surgeon in Glasgow royal infirmary. The time in their week is being used differently to provide a more consistent service throughout the week. So in fact, if we work differently, seven-day working does not need additional resource; it can be done and a saving can still be made.

I suppose that we are talking about re-examining. The committee will maybe not be surprised to hear that there has not been an outbreak of virtual fracture clinics all over Scotland because we need the orthopaedic people to talk to each other. The approach has spread outside Glasgow but, at the moment, that has not happened across all of Glasgow. The conversation very much needs to happen though. Initially, orthopaedic surgeons said that the approach would be a disaster, because they would not see patients, they would miss a lot of fractures and there would be all sorts of adverse outcomes. Of course, there are not, if it is done in a very robust way. Some of the issue is about culture change and about reassuring people that working differently can be better for the patients and does not lead to less good outcomes for things such as fractures.

Richard Lyle: If you walk into a hospital—as I had to do over the new year—and look up at the signs, you can see all the different services that are being provided.

Last year, our budget for health reached £12 billion; this year, our budget will reach £13 billion, and I compliment the health secretary on that. The territorial boards and the special health boards are going to get over £500 million more. There are also other factors.

Can I go slightly off-message for a second? One third of your budget is spent on health. Since I have the opportunity—I cannot pass it up—I want to mention that we will shortly have a discussion about the Penrose inquiry, which, as we all know, is to do with the blood products disaster. People may make substantial claims. Will those claims be paid out of individual boards' budgets, or will the claims be made against the health system as a whole? Mr Gray or Mr Matheson may want to enlighten me as to whether we are insured for that. The amount could reach something like £50 million or more for Scotland alone, although that may be a figure that was plucked out of the air and people may dispute it.

What are we doing to address that issue? I do not see it covered in the draft budget at all; indeed, I am sure that it will not be. However, we cannot suddenly find that money. Where will it come from? Can you enlighten me about that?

Shona Robison: I will let John Matheson say a word about litigation and how the NHS handles that more generally in a second.

On the positive side, we received a report just before Christmas from the review group that was set up under Ian Welsh's chairmanship to make recommendations on the financial provisions for people who have been affected by contaminated blood and blood products. That series of recommendations is quite far-reaching.

The recommendations are to substantially enhance both the one-off payments for people at stage 1 of illness and the on-going payments for people who have the greatest healthcare needs. There is also other support for widows, support in the form of one-off hardship payments and so on. It is a substantial package. Resources have been set aside within the budget to meet the needs of those who are affected. At the moment, I am considering the recommendations and I will make an announcement about them in due course.

However, I will put on the record—as I have done previously—that I am absolutely determined to ensure that we provide a better level of support to people in Scotland with regard to some of the hardships that I have been told about very directly by those who have been affected and their families. Obviously, I am not responsible for what happens elsewhere, but I am determined to make those improvements here in Scotland.

As regards litigation and court cases, there has already been some litigation around the issue. John Matheson may want to say a word on that.

John Matheson: We have a general clinical negligence insurance scheme, which is used primarily for obstetric and gynaecological cases—they tend to be the prime examples. Money is allocated to boards, which pay a premium. In my almost eight years in this role, I have moved from the traditional position, in which a lump-sum payment was made, to the position in which a reduced lump-sum payment is made for housing and transport adaptations and then an annual payment is made for the lifetime of the individual affected.

As well as dealing with the cost of the legal claim, the key factor is to learn lessons from clinical practice to ensure that we reduce the chances of such a situation, which has caused such tragic events and in which the NHS has accepted that it has been negligent, happening again.

With regard to infected blood patients, we have been making some payments in parallel with England. As the cabinet secretary said, a sum has been set aside centrally—not in the board allocations—to meet those costs going forward.

Richard Lyle: How much is that central sum?

John Matheson: As we have not yet concluded negotiations, it would be inappropriate to say.

Shona Robison: I am looking at the recommendations. If I accept them, resources will be made available to meet them.

However, John Matheson has made an important point. Around £30 million has already been paid to the Skipton fund and the other fund. This is all done on a UK basis, and we pay our share for Scottish recipients into those funds.

Richard Lyle: I have a final question, but first I want to thank the cabinet secretary very much, because I know that, like me, the Government has been working hard on this issue. Can people be assured that any funding that is required will be made available?

Shona Robison: Yes, and I certainly want to recognise the work that you and the campaigners have done on this area. Indeed, when I was a member of the committee, it was one of the earliest issues that we looked at. It has certainly been a long-standing matter.

The recommendations have been brought together by the group on the basis of compromise. I am not going to sit here and say that everyone is happy with them, but they are born out of pragmatic discussions that have been led by the people affected. Those recommendations are now with me, and if any of them are accepted, we will absolutely ensure that the resources are there to meet them.

Richard Lyle: Thank you.

The Convener: I will call Malcolm Chisholm next, but does any member who has not yet asked a question wish to come back on anything?

Dennis Robertson: Yes, convener.

The Convener: You have already been in, Dennis, but I will let you back in.

Malcolm Chisholm: I just want to get to the bottom of the capital budget, which I find very interesting, because of all the things that have been happening.

I note the large increase in the budget, a large part of which is the £215 million up-front capital to provide cover for non-profit-distributing projects. I suppose that you cannot really say for definite, but are you still hopeful that that money will not be required and that changes can be made to those projects to take them off the balance sheet? Is such a hope unrealistic at this stage?

Shona Robison: It is difficult to say. John Swinney, who is leading on this, is having very close discussions with the Treasury. Obviously this has all been triggered through the Office for National Statistics and Eurostat, and Mr Swinney is still in the midst of all that activity. The decision that was made on the Aberdeen western peripheral route has significant implications, but perhaps John Matheson can say something about the rationale for providing that cover.

John Matheson: There are two different aspects to highlight here. At the beginning, two things—the NPD projects, including the Aberdeen western peripheral route, and the hub projects—were conjoined, and there was concern about a number of the hub projects being caught up in all of this. We have now had clarity from the ONS that the hub contract is acceptable, and we are able to proceed with, for example, the Greenock and Inverclyde health centres as well as other projects that have been held up.

As for the position with NPD projects, the ONS has given us a view on the Aberdeen project. It has not given a specific view on any of the health projects, but the expectation is that, on the current shape of the contract, its view will be similar to that for the Aberdeen project, which means that we will need capital cover. That is what we are prudently covering at the moment and, with the Scottish Futures Trust, the Scottish Government will continue to pursue whether the NPD contract can be adapted to make it compliant and to ensure that we can revert to a situation similar to that for the hub. We are taking that prudent position at this point in time to enable the five NPD projects—the sick children's hospital, the Dumfries and Galloway project, the blood transfusion centre, the project in Ayrshire and Arran and the Balfour hospital replacement up in Orkney—to proceed.

12:15

Malcolm Chisholm: We do not need to go into the details of the changes to the hub projects, but are there any budgetary implications of those changes?

John Matheson: There are not.

Malcolm Chisholm: Apart from the £215 million cover for NPD, there seems to be an increase in the capital budget, which we would welcome. Can you say more about that? In the past, that has not been increased. A lot of the reason for that is that it has been funded through the NPD method. I am not objecting when I ask why there is an increase to the capital budget, but I suppose that, if you add the natural increase to the cover, it is a very substantial increase in the capital budget. What implications does that have for other parts of the capital programme—either in health or in the Scottish Government more generally—or are we just able to have a bigger increase in the capital

programme because of our new borrowing powers?

John Matheson: The increase is not specifically connected to the new borrowing powers. If we put the £215 million for NPD to one side, we see that another major area of increase has been an additional £50 million for capital. As you mentioned, the capital position has generally been tight across the Scottish Government, and health is no different. As part of our 2015-16 financial modelling, we anticipated having to transfer £47.5 million from resource to capital to give us an adequate capital budget for backlog maintenance and non-NPD projects. The additional £50 million that we got as part of the draft budget settlement has enabled us to remove the resource-to-capital transfer and to proceed with such things as the £250 million investment in social care. We also got an additional £23.5 million for the diagnostic and treatment centres, which will also be spent on taking forward the cancer plan.

Dennis Robertson: Is there a budget allocation for community pharmacies to take on minor ailments, to prevent people from going to their GPs? If so, what is the sum? Is there money for raising awareness and educating the public to use community pharmacies in a better way than they do at the moment?

Shona Robison: There is an allocation for the pharmacy contract, which is part of an on-going negotiation, along with other contracts. You may recall that an element of the primary care fund is to increase the number of pharmacists attached to primary care premises, who can do the medicines reconciliation work and relieve GPs of a lot of their workload and use their specialist skills to better and more effectively manage medicines in the patient populations of their localities.

The role of community pharmacies more generally in the vision for primary care is very important. As we take forward the concept of the multidisciplinary team and the community hub model, in which patients go to see the most appropriate professional, in many cases that professional will be the community pharmacist. We know that there is a lot of interest in clinical pharmacy and that many people who study pharmacy want to take on that role. We want to create opportunities for them to do so.

That will mean far more patient-facing work. It is all part of the new multidisciplinary model in which community pharmacies, which are very open, accessible with seven-day working and well located, can play a significant role. The budget supports that, but through the primary care fund it also provides additional resources to ensure that we are pushing at the boundaries, that community pharmacy plays a continuing role and that pharmacists' skills are attached to GP practices in order to reduce GP workload and make primary care a more attractive proposition.

Dennis Robertson: Have you been able to determine how much patients are using pharmacists instead of going to GP practices?

Shona Robison: We can certainly get you more information on that, but the evidence is that, for a start, patients like using their community pharmacists and get a good service through the minor ailments and chronic conditions medication services. Particularly for those who have chronic conditions and the elderly population, the service is good and well regarded, and it is also very cost efficient.

However, we want to build on that approach and make it more of the mainstream way in which people receive their community health services. As a result of that more systematic way of accessing community health services, you will not always see a doctor; instead, you will see the most appropriate health professional. That is the territory that we are in with the test sites that will be developed over the next few months and which will really push the boundaries of multidisciplinary working and the better outcomes that it will deliver.

Bob Doris: On the spending plans for sport, I see from the draft budget that there is a flat cash commitment for sport, with the figure staying at £45.8 million; it is, in fact, a small real-terms decrease in funding. I understand the budgetary pressures that the Scottish Government faces, but health has done particularly well out of this budget, and it would be quite good if you could give us some information on how the revenue budget for sport might be used.

I also draw your attention to two other lines in the health budget: the 7.9 per cent increase for health improvement and health inequalities and a 69.8 per cent increase—which I grant equates to only £15.7 million—in the mental health improvement and service delivery budget. I want to put those two figures on the record alongside the figure for sport, because I wonder whether, instead of looking at that £45.8 million sport budget on its own, we should, in these tight financial times when we are looking at early intervention and preventative spend, also be looking at connectivity in the health budget to ensure that people get more physically active and sporty. How would you envisage that budget being spent, and what connectivity is there between sport and physical activity and the core health budget?

Shona Robison: This has been a tough budget. The settlement for the special boards has been relatively tougher, and the departmental allocations have been reduced. I thought that it was right, particularly in this budget, to make a

very clear statement of our priorities and to point out that, although other budgets might be tough, we still had to help organisations and bodies such as sportscotland agree their own priorities. Obviously, that will be done in our letter to sportscotland, in which we will set out our expectations of what sportscotland should deliver in 2016-17 for its budget.

Those priorities will include sportscotland's work with Education Scotland on physical education provision. The delivery of the two hours and two periods of PE a week has, I think, led to a stabilisation of the physical activity levels of kids in Scotland and ensured that, as a result of that PE provision and through the active schools network that sportscotland also delivers, they are getting more activity throughout the week. Within that, we will be working with sportscotland to agree its priorities. Its capital budget has been reduced because of the delivery of the national performance centre and the para-sports centre, but it also receives lottery moneys and will be able to utilise those moneys in order to continue its investment in sport.

You are right to point to the interface with the health improvement, education and mental health budgets. There is an opportunity to do more around early intervention and collaboration and using some of those resources in a more effective manner; for example, some work is being done on the physical activity brief intervention, which primary care is in a good place to deliver. The evidence shows that the more physically active people are, the better it is for their health and wellbeing, and we need to find a way of building that into the work of community health services and making it clear that this is not just about treating illness but about helping to keep people well.

In that respect, the work of third sector organisations will be critical, and there is far more scope to do more there. We have only been scratching at the surface of some of that. In taking forward new models of delivery for community health services, I want a stronger link with third sector organisations to ensure that health professionals are more routinely referring people to the exercise classes, walking groups and so on that those organisations deliver. That already happens, but I think that it could happen more systematically.

Bob Doris: Thank you.

The Convener: You touched on sport and, obviously, we have an interest in the Commonwealth games legacy. We had a quiz earlier and nobody could answer this question: what was the total cost of the Commonwealth games?

Shona Robison: Oh no.

The Convener: I did not intend to put you on the spot.

Shona Robison: I think that it was £525 million.

John Matheson: It was just over £525 million.

The Convener: It is not unreasonable to look for a legacy from that. I understood from our previous discussions that the ambition was for an increase in activity.

Shona Robison: Absolutely.

The Convener: The committee agreed with you that—I think that these were your words—

"A strong and sustainable coaching and volunteering base"

would help us to deliver that legacy. In our inquiry, we focused on identifying, sustaining and replacing that base, and on understanding where it is, what it is doing and where the gaps are. The link is already weak, as we have not had much of an increase of volunteers and we do not understand where the gaps are. Can you assure us that the cut to the sports budget will not impact on that area?

Shona Robison: Legacy is very important, but it builds on what without a doubt is already the mainstay of how sport is delivered in Scotland: the 10,000 or so volunteers who support sport, without whom local clubs would not exist. The Commonwealth games legacy sought to build on what is already a fairly well-advanced infrastructure by trying to reach people and communities who did not take part in any physical activities, exercise or sport.

12:30

The legacy will probably be more of a slow burn, to be honest. We knew that there would not be a eureka moment when everybody suddenly took up exercise and sport; it will take place over a longer period. Part of the solution is creating easier opportunities. I have always thought that the school day is very important. When I was sports minister I drove forward the link with education, to deliver more rounded opportunities in the school day through PE, active schools and sport. Since then, sportscotland's role has changed. It sees itself not just as a sport delivery organisation but as an organisation that supports physical activity and PE. That has been a big change for sportscotland. Getting those early habits right, through the school day, will be an important legacy as children get to their teenage years and into adulthood.

If we think a wee bit more imaginatively, we can see the scope within the shifting of the balance of care to community services. Community hubs will

of course deliver primary care services and all the services that we want to see, and they will keep people out of hospital and all of that. However, there is scope for good work between third sector organisations and the hubs, so that primary care health professionals use third sector assets—whether the local walking group or patient-led groups, however formal or informal they are—in a more systematic and mainstream way. That can help to deliver more physical activity in the community.

Will that happen on its own? Probably not. We would need to push that through the new primary care models and get primary care professionals to see it as an important opportunity for them, when they have patients in front of them.

The Convener: I suppose that I am asking whether there is anything in the budget to establish what volunteering capacity we have. When we looked at the number of people who were volunteering, we saw that it compared poorly with the number in other European countries. We both recognise that the greater the volunteer base, the greater the opportunity and access that will be derived from it. We identified that there were 15,000 games volunteers. Has any work been done to establish how many of them have remained volunteers to deliver sport in the community?

Shona Robison: Yes. That assessment is part of the on-going reporting on the games' legacy. That is happening at set periods and includes an analysis of how many volunteers have remained active. Of course, a lot of work was done to keep in contact with those volunteers. You will remember the data sharing that took place at the beginning of the process, so that other organisations could approach those volunteers and encourage them to keep active—maybe not in sport but in whatever walk of life. That work continues and will be assessed at key points right the way through to the final evaluation of the games' legacy.

The Convener: Will that take place in 2017?

Shona Robison: Yes.

The Convener: The National Union of Students and you proposed initiatives about the recognition of volunteers. Has there been any movement on that?

Shona Robison: I think so. My memory of that from my previous role is a wee bit hazy, but I could get you the latest on that, if it would be helpful.

The Convener: Yes.

I have only one other question on sport, which links to deprivation and the lack of support for some children. When we looked at the issue, we saw that 25 per cent of children could not swim when they left primary school. That figure is probably higher in communities that do not have the support of volunteers and other things. The reduction in the sport budget should not affect how we deal with such issues. You would think that we could give that support.

Shona Robison: It is all down to the priorities that we agree with sportscotland. Clearly, sportscotland will have to deliver a level of performance support—that is part of its job. Preparations will be being made for the Commonwealth games in the Gold Coast, which are fast approaching, but sportscotland's role has changed. It carries out more community work and it sees the value of its work in schools and what it is doing on participation, which is a key plank of its work. We need to work with it to agree its 2016-17 budget priorities. I will feed back to Jamie Hepburn.

The Convener: I appreciate that. We heard earlier about the analysis of what works. The only measure that we use is the household survey. If we do not know where the gaps in volunteering are, how do we nurture the workforce that will deliver for us? The committee agreed that there is an absence of rigorous analysis to give us a true comparison of levels of volunteers, how we are coaching them, the level that they are at and all that sort of thing. Could some academic work be done on that?

Shona Robison: I will certainly feed back and reflect on that.

The Convener: That is enough pleas for one day. I do not think that there any other questions. I thank you and your colleagues very much for your attendance.

Shona Robison: Thank you.

The Convener: We have a couple of quick things to do in private before we leave, as previously agreed.

12:36

Meeting continued in private until 13:01.

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