The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 8 March 2016

Session 4

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HEALTH AND SPORT COMMITTEE
13th 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:

Ailsa Garland (Scottish Government)
Jacqui Macrae (Healthcare Improvement Scotland)
Robbie Pearson (Healthcare Improvement Scotland)
Elizabeth Sadler (Scottish Government)
Maureen Watt (Minister for Public Health)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 8 March 2016

[The Convener opened the meeting at 09:34]

Burial and Cremation (Scotland) Bill: Stage 2

The Convener (Duncan McNeil): Good morning and welcome to the 13th meeting in 2016 of the Health and Sport Committee. I ask everyone in the room to switch off their mobile phones as they can interfere with the sound system and with the proceedings, although some colleagues are using tablet devices instead of hard copies of the papers.

The first item on our agenda is day 1 of stage 2 of the Burial and Cremation (Scotland) Bill. As agreed by the Parliament, this committee will consider amendments to those parts of the bill that primarily relate to the disposal of ashes and the meaning of "cremation", as well as arrangements for adults and children and for losses during pregnancy. Amendments to the rest of the bill will be considered by the Local Government and Regeneration Committee at its meeting tomorrow.

The amendments being considered today start at number 1000. You will be glad to hear that there are not 1,000 amendments, but there are a lot. That numbering is being used to distinguish the amendments that will be considered by this committee from those that will be considered by the Local Government and Regeneration Committee. We will start at section 36 of the bill.

I welcome Maureen Watt, Minister for Public Health, Simon Cuthbert-Kerr, the bill team leader, Lindsay Anderson, senior principal legal officer, and David McLeish, parliamentary counsel, all from the Scottish Government.

Everyone should have a copy of the bill as introduced, the marshalled list of amendments and the groupings of amendments. There will be one debate on each group of amendments. I will call the member who lodged the first amendment in the group to speak to and move that amendment and to speak to all other amendments in the group. Members who have not lodged amendments in the group but who wish to speak should indicate their wish to speak in the normal way. The debate on the group will be concluded by me by inviting the member who moved the first amendment in the group to wind up. Only committee members are allowed to vote. Voting in any division is by a show of hands.

Section 36—Meaning of "cremation"

The Convener: Amendment 1001, in the name of the minister, is grouped with amendment 1044. I call the minister to move amendment 1001 and to speak to both amendments in the group.

The Minister for Public Health (Maureen Watt): Amendment 1001 provides greater clarity and certainty about what constitutes a cremation. The effect of the amendment is that cremation is the burning of human remains. When any further processes are applied to the bones that remain—for example, if they are turned into ashes by cremulation—that is also part of the cremation. Importantly, the amendment means that, when burnt bones are not reduced to ashes, the process is still regarded as a cremation.

The amendment also specifies that the meaning of "ashes" in the bill means anything that remains after the burning process, with the exclusion of any metal that remains. Amendment 1044 reflects that definition in the bill's interpretation section.

I move amendment 1001.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I would like to confirm the meaning. In the original version of the bill, "cremation" means:

> "the reduction to ashes of human remains ... and the application to the burnt human remains of grinding or other processes."

I think that there is still a degree of ambiguity in amendment 1001, because it could be taken to mean the burning of human remains including one of those two things, or it could be inferred that it may include burning and another process. If it is the latter, it would be better for the amendment to insert the wording "burning of human remains and may include".

There is ambiguity in the way that the amendment is worded at the moment. It is not clear whether cremation has to include those additional processes. In the original bill, it had to include the additional processes. It would be better to use the wording "and may include".

Rhoda Grant (Highlands and Islands) (Lab): I agree with Malcolm Chisholm. In evidence, the committee heard that some religious groups do not agree with cremulation but do agree with cremation. The minister might be trying to deal with that issue.

Although I support the amendment, I believe that clarity is required at stage 3 that cremation does not have to include the additional processes if they go against the beliefs of the family of the person who is being cremated.

The Convener: No other member wishes to speak. I therefore call the minister to wind up.

Maureen Watt: It is precisely because in some cases some religions, particularly Hinduism, do not want the cremulation process to take place that we brought forward the wording in amendment 1001.

The amendment uses the wording:

"where a grinding process is applied".

It does not mean that such a process is always applied: it says "where" that is likely to occur. That is why we used the word "where" in the amendment.

Amendment 1001 agreed to.

Section 36, as amended, agreed to.

Section 37—Cremation authority: duties

The Convener: Amendment 1002, in the name of the minister, is grouped with amendments 1003 to 1008.

Maureen Watt: Amendments 1003 to 1007 place various duties and powers on cremation authorities and funeral directors in relation to how they handle ashes.

Amendment 1003 specifies that a cremation authority must, before carrying out a cremation, take reasonable steps to ascertain what an applicant would like to be done with the ashes following the cremation.

The amendment provides three options: that the ashes will be collected by the applicant; that the ashes will be collected by a funeral director on behalf of the applicant; or that the ashes will be disposed of by the cremation authority on behalf of the applicant. Those options require the cremation authority to do something with the ashes on behalf of the applicant. The applicant may choose to collect the ashes from the crematorium themselves or arrange for the funeral director to collect them. The applicant may also agree with the cremation authority that the authority will dispose of the ashes at the crematorium.

Amendment 1004 places a cremation authority under a duty to follow the applicant's stated wishes about what should be done with the ashes.

Amendment 1005 sets out the procedure to be followed by a cremation authority where an applicant or funeral director does not collect ashes as agreed. In such a case, the cremation authority must take reasonable steps to ascertain the wishes of the applicant again. If the applicant responds and gives further instructions, the cremation authority is required to comply with those wishes. If the applicant does not make known his or her wishes, the cremation authority may dispose of the ashes in a manner prescribed by regulations.

Amendment 1006 sets out the procedure to be followed by a funeral director where the funeral director has collected ashes from a crematorium on behalf of an applicant and the applicant has not in turn collected the ashes from the funeral director. In that instance, a funeral director is required to take further steps to ascertain the wishes of the applicant. If the applicant gives further instructions, the funeral director is obliged to comply with those wishes. Where the applicant does not provide any further instructions, the funeral director may return the ashes to the crematorium where the cremation was carried out.

09:45

Amendment 1007 sets out the procedure to be followed by a cremation authority where a funeral director returns ashes to the crematorium under the new section inserted by amendment 1006. In such an instance, the cremation authority must take reasonable steps to ascertain the applicant's wishes with regard to how the ashes should be handled. The applicant can either arrange to collect the ashes or ask the cremation authority to dispose of the ashes for them in a way set out in regulations, and the cremation authority must comply with any such instructions. Where the applicant does not respond or give further instructions, the cremation authority may dispose of the ashes in a manner prescribed in regulations.

This group of amendments provides a clear process for handling ashes. At each stage, the applicant will be made aware of his or her choices and what will happen if the ashes are not collected as arranged. Moreover, at each stage, the applicant is given an opportunity to specify what he or she wants to happen to the ashes. Although cremation authorities and funeral directors are under a duty to attempt to contact the applicant at various points, they have a power rather than a duty to dispose of ashes where the applicant does not provide further instructions. That will provide cremation authorities and funeral directors with discretion about when they choose to dispose of ashes and when they choose to retain them.

Amendment 1008 gives ministers a power to make regulations on the handling of ashes. Among other matters, regulations may make provision for time periods for collecting and retaining ashes and for notices that must be given to applicants about the processes.

Finally, amendment 1002, which is actually a very small amendment, removes section 37(1)(c) to ensure that regulations made under section 37 do not include provisions on the disposal of ashes by cremation authorities. Such provisions are now in the bill and are supplemented by regulations under the new section inserted by amendment 1008.

I move amendment 1002.

Nanette Milne (North East Scotland) (Con): I have a question for the minister. At the moment, many funeral directors can be left with ashes for quite a long time. Will regulations put in place a time limit for funeral directors to hand back ashes?

Maureen Watt: Well—

The Convener: I will bring in Malcolm Chisholm next. You will have an opportunity to respond when you wind up, minister.

Malcolm Chisholm: I welcome the amount of detail that is being put in the bill. Originally, that detail was to be set out in regulations. I know that we sometimes have debates over what should be in regulations and what should be in a bill, but I think that in this case it is desirable for the detail to be in the bill.

I also welcome the centrality of the applicant's wishes, which I think has been repeated in almost all of the amendments in the group. It is a very important principle that will come up later this morning.

Maureen Watt: I thank Malcolm Chisholm for his comments. We have listened to the committees involved in scrutinising the bill and what they have said in their stage 1 reports.

With regard to Nanette Milne's question, a time limit will be put in place, but it will be agreed in consultation with all the bodies involved.

Amendment 1002 agreed to.

Section 38—Application for cremation

The Convener: Amendment 1047, in the name of Malcolm Chisholm, is grouped with amendment 1048.

Malcolm Chisholm: I am sure that everyone who has followed the passage of the bill and indeed the events that preceded it will realise the centrality of the ashes issue.

These two amendments refer in particular to loss during pregnancy—I perhaps should have specified that in them but, nevertheless, that is the issue that the committee was looking at. For parents who had endured and suffered losses during pregnancy, the main issue was that they wanted to recover the ashes and the whole process of collecting ashes to be maximised.

Amendment 1047 relates to what is written on the forms. There were a lot of debates about what should be on the application form and whether there should be a standard form or various forms. I think that everybody who gave evidence was most concerned that the policy memorandum referred to the fact that ashes might not be recovered. I think that there was unanimous agreement that there should be wording to the effect that it is expected that ashes will be recovered. I thought that it would be desirable to put that in the bill, following the same principle that the minister followed in the previous amendments. Therefore, amendment 1047 is to address a concern that was raised with us on several occasions during the oral evidence.

Amendment 1048, in a sense, is related to the issue of how we ensure that the maximum amount of ashes is recovered. I was very struck by one of the written submissions that we received. It was sent in anonymously, but I will read a little bit from it. The person, whether they be a man or a woman, said:

> "We believe that standard processes and equipment (including specialist infant cremators) should be used in every crematorium to give a consistent chance of recovering ashes from each cremation in every part of Scotland. We understand that there is still no guarantee of ashes, but the knowledge that an approved approach has been applied would remove doubt and provide reassurance."

The proposal in amendment 1048 is that something should be in the code of practice that relates to that.

The minister has lodged amendments to abolish the section of the bill that relates to codes of practice and to substitute that section with references to codes of practice in various parts of the bill. My amendment 1048 is couched in the form that it is in order to get around that problem—it is a new section, rather than being an amendment to the current section on codes of practice.

I think that the parents who gave evidence to us would, in general, be supportive of my two amendments, because both seek to ensure that the maximum amount of ashes is recovered.

I move amendment 1047.

Dennis Robertson (Aberdeenshire West) (SNP): Will the minister clarify whether an inspector of crematoriums would carry out an inquiry or investigation if no ashes were recovered to ascertain why that was the case? I do not know whether that would help to answer the issue for Malcolm Chisholm, too. On those rare occasions when ashes are not recovered, my understanding is that the inspector would find out the reason for that.

Maureen Watt: Amendment 1047 seeks to expand the enabling power in the bill that would allow ministers to make regulations about applications for cremation. The bill already provides sufficient powers to allow ministers to make provisions about the duties of cremation authorities, including how they are managed, operated and maintained, as well as the form of the applications for cremations.

Dennis Robertson is correct that the relevant inspector of crematoria will be involved if no ashes are available. Furthermore, the policy memorandum has been superseded by new policy, including a new code of practice that was issued recently. The expectation is that all ashes will be recovered.

On Malcolm Chisholm's specific point, baby trays are used and cremations are subject to higher temperatures to ensure that ashes are recovered. Amendment 1048 is unnecessary because the Scottish ministers have already issued a code of practice dealing with the matter, which recommends methods of maximising the recovery of ashes. Further to that, tomorrow I will be inviting the Local Government and Regeneration Committee to agree to my amendment 91, which would require future codes of practice for cremation authorities to be laid before and approved by the Parliament before being issued.

I ask members to reject both of Malcolm Chisholm's amendments.

Malcolm Chisholm: I thank the minister for those words. In a sense, I lodged my amendments to highlight the issues in question. The fact that, according to the minister, the substance of amendment 1048 is already in a code of practice reassures me. If the same is true of amendment 1047, that reassures me, too.

There is always a balance to be struck between what is put in a bill and what is put in regulations or, indeed, a code of practice. I am not entirely clear about the legal status of a code of practice and what happens if someone does not obey it. That is the only remaining question that I have as regards why it might be preferable to have such provisions in the bill.

I will leave it at that. I may introduce a further amendment at stage 3, but I probably will not.

Amendment 1047, by agreement, withdrawn.

After section 40

Amendments 1003 to 1008 moved—[Maureen Watt]—and agreed to.

After section 45

Amendment 1048 not moved.

Section 46 agreed to.

Section 47—Arrangements on death of child

The Convener: Amendment 1009, in the name of the minister, is grouped with amendments 1010 to 1020, 1030, 1045 and 1046.

Maureen Watt: Amendments 1009 to 1016 are minor amendments, which seek to remove any reference to "still-birth" or "still-born child" from section 47 of the bill. The removal of those terms is a result of discussions with NHS colleagues and it follows further policy development in respect of the way in which arrangements for stillborn children are made. The amendments will mean that section 47 of the bill will refer only to children. Other amendments will introduce new sections on stillbirth.

10:00

Amendments 1017 to 1020 seek to insert into the bill new sections to set out the procedures that are to be followed following a stillbirth or a post-24-week termination.

In the case of a post-24-week termination, amendment 1017 allows that the woman who experiences the termination may choose to make her own arrangements for disposal of the remains or authorise the health body to make them on her behalf. Subsection (5) of the proposed new section allows the health body to make arrangements for the disposal of the remains. This subsection has effect if the woman informs the health authority that she does not want to make the arrangements herself; is unable to make the decision; or does not inform the health authority of a decision. The effect of the subsection is to ensure that the health authority can make arrangements for the burial or cremation of the remains even if the woman has given no indication of her wishes.

Amendment 1018 provides the process for making the arrangements for the burial or cremation of a stillbirth. When a stillbirth occurs, the bill provides that the nearest relative of the stillbirth has the right to instruct on the disposal of the remains. The amendment sets out a list of nearest relatives for that purpose. In the first instance, the nearest relative is defined as a parent of the stillborn baby. If neither parent is able to make a decision about the disposal, then that right moves to the next nearest relative on the list. That process continues until a person on the list is able to make a decision.

The nearest relative can make the burial arrangements or authorise the health body to make the arrangements. The amendment requires the health body to record prescribed information in the way that is described under this section. The amendment sets out the process by which the right to instruct on the disposal will move from one nearest relative to the next. That includes the specification of circumstances in which the nearest relative is to be discounted, such as when he or she is under 16 years of age. The amendment

also defines a "health body" for the purposes of the proposed section.

Amendment 1019 sets out the steps that a health body must take when it is authorised to make arrangements for the burial or cremation of a stillborn child, by virtue of the new section inserted by amendment 1018. A health body may make arrangements for the remains to be buried or cremated. In the first instance, the health body must wait seven days between being authorised to make the arrangements and making those arrangements. That period is included to allow for the person who authorises the health body to change their decision. However, the amendment allows the person who authorises the health body to indicate that they do not wish to wait seven days. That means that there will be no delay when a burial has to take place quickly for religious or cultural reasons.

Amendment 1020 provides health bodies with a general power to make arrangements for the burial or cremation of the remains of a stillborn child when it appears that no other arrangements are being made. Other amendments provide a process for making such arrangements, but in cases in which, for whatever reason, no arrangements are made, this amendment allows for a health body to make those arrangements.

Amendments 1030 and 1046 reorganise the definitions of "health authority", "health board" and "independent health care service", by removing them from section 50 of the bill and putting definitions for those latter two expressions into section 75—the general interpretation section of the bill. The definition of "health authority" is no longer needed.

Amendment 1045 changes the meaning of "fetus" so that it includes embryo, ensuring that provisions relating to pregnancy loss include those at the embryonic stage.

I move amendment 1009.

Amendment 1009 agreed to.

Amendments 1010 to 1016 moved—[Maureen Watt]—and agreed to.

Section 47, as amended, agreed to.

After section 47

Amendments 1017 to 1020 moved—[Maureen Watt]—and agreed to.

Section 48—Disposal of remains: nearest relative

The Convener: Amendment 1021, in the name of the minister, is grouped with amendments 1022 to 1026.

Maureen Watt: The overall effect of amendments 1022 to 1024 is to amend section 48 so as to require a person who makes a decision about the disposal of a deceased person's remains to have regard to the deceased's religion or beliefs, so far as they are known to the person, when choosing burial or cremation. Section 48 already requires the person to have regard to any wishes about the method of disposal expressed by the deceased, as far as they are known to the person.

Amendments 1021 and 1025 make minor drafting adjustments to sections 48(1) and 49(1)(b) of the bill.

Amendment 1026 removes references to making applications to a sheriff. Those are no longer relevant because of changes to the process brought about by the Courts Reform (Scotland) Act 2014 in relation to summary application.

I move amendment 1021.

Amendment 1021 agreed to.

Amendments 1022 to 1024 moved—[Maureen Watt]—and agreed to.

Section 48, as amended, agreed to.

Section 49—Sections 46 and 47: application to sheriff

Amendments 1025 and 1026 moved—[Maureen Watt]—and agreed to.

Section 49, as amended, agreed to.

Section 50—Arrangements on loss during pregnancy

The Convener: Amendment 1027, in the name of the minister, is grouped with amendments 1028, 1029, 1031 to 1036, 1049, 1037, 1050 and 1038 to 1043. I point out that if amendment 1036 is agreed to, amendment 1049 will be pre-empted.

Maureen Watt: The overall effect of this group of amendments is to strengthen the process that a health authority must follow when a woman experiences a pregnancy loss before or on completion of 24 weeks' gestation.

Amendment 1027 adjusts the drafting of the bill to make it clear that section 50 applies in the case of pregnancy losses that occur before or on completion of 24 weeks' gestation.

Amendment 1028 ensures that where a woman who experiences a pregnancy loss authorises another person to make arrangements for the disposal of the remains in a particular way, that person must make the arrangements in the way that was specified by the woman.

Amendment 1029 ensures that as soon as a woman makes a decision about what she would like to be done with the remains of a pregnancy loss, a health authority must record that decision and take reasonable steps to secure the woman's signature in relation to the decision.

Amendment 1031 relates to situations in which a woman changes a decision that she has made under section 50. The effect of the amendment is to provide legal certainty that the new decision that the woman makes is to be treated as though it were a decision made under section 50.

Amendment 1032 addresses a potential gap where a woman authorises a person to make the arrangements for the disposal of remains and that person then asks a health authority to make the arrangements. The effect of the amendment is to require the person to specify that the health authority must make the arrangements in the way that was specified originally by the woman. That will ensure that the woman's wishes are carried out.

Amendment 1033 ensures that where a woman chooses to make her own arrangements for the burial or cremation of the remains of a pregnancy loss, the health authority will give her the remains. Similarly, where a person who is authorised by the woman to make the arrangements wishes to make their own arrangements, the amendment ensures that the health authority will give that person the remains.

Amendment 1034 makes a drafting change to provide clarity about the process that a health authority will carry out. It replaces a reference to disposing of remains with a reference to making arrangements for their disposal. That adjustment better reflects the actual process in which the health authority will make arrangements for disposal but not carry out the disposal.

Amendment 1035 allows a person who authorises a health authority to make arrangements for disposal to specify that they do not wish the seven-day waiting period to apply before arrangements are made. That will allow the remains to be buried or cremated as soon as possible and ensure that there are no unnecessary delays in cases where burial is required to take place quickly for religious or cultural reasons. The amendment will not require a person to indicate why they do not wish the seven-day period to apply.

Amendment 1036 allows a health authority to take various steps when no arrangements have been made at the end of the six-week period from the date of a pregnancy loss. New subsection (2) places the health authority under a duty to consider whether it would be in the woman's best interest to contact her to try to ascertain what she wants to happen to the ashes.

The amendment is structured in that way to reflect the wide variety of circumstances that might have led to that point. For example, a woman might not have been able to reach a decision about what she would like to happen to the remains. In that instance, the health authority may continue to support the woman to make a decision. The amendment does not place a timescale on that outcome.

In other circumstances, however, a woman might have given no notice of what she would like to happen to the remains and might have had no contact with the health authority since the loss occurred. In such an instance, the health authority may conclude that the woman has indicated that she does not want to be involved in the process, and the health authority may therefore choose to make arrangements for the disposal of the remains.

10:15

New subsections (2E) and (2F) provide the health authority with the power to make arrangements for the disposal of remains where no decision has otherwise been made. Amendment 1036 places considerable emphasis on the health authority's judgment of a certain situation, particularly where it has an on-going relationship with the woman and knows that she is still trying to reach a decision about what should be done with the remains. The health authority is under no obligation to make arrangements for the disposal of the remains.

As the health authority will have been involved since the loss occurred, it is appropriate to give it flexibility to act according to a variety of situations that might occur and which require different responses to ensure that the best outcome is achieved in each instance. Such decisions will largely be based on the health authority's relationship with the woman. The Scottish Government will provide guidance to health authorities to support the operation of the process.

Amendment 1049, in the name of Malcolm Chisholm, seeks to allow a health authority to make contact with a woman who has experienced a pregnancy loss about arrangements for disposal where arrangements have not been made within the initial six-week period. It requires a health authority to seek a woman's views about disposal and to give her more time to make the decision about arrangements for disposal, should she request it. I accept the principle behind this amendment; indeed, that is why I have lodged amendment 1036, which, being built around a woman's best interests, will ensure that health

authorities have to seek a woman's views where arrangements for disposal have not been made after pregnancy loss and give her time to come to a decision about the matter. As a result, I do not think that amendment 1049 is necessary and I invite the member not to move it.

Amendment 1037 allows a health authority to discuss options with a woman where it is known that a pregnancy loss will occur but it has not yet happened. In such instances, it can be beneficial for the woman to consider what she would like to happen to the remains before the loss occurs. The amendment allows a health authority to discuss matters before a pregnancy loss occurs, but it does not require the authority to do so if it does not believe that that would be in the woman's best interests.

Amendment 1050, in the name of Malcolm Chisholm, requires that electronic registers must be kept by health authorities in relation to pregnancy loss. I fully accept the principle behind the amendment and, as such, I have lodged amendment 128, which will be considered by the Local Government and Regeneration Committee tomorrow and which, although having the same effect as amendment 1050, will go wider by requiring all information kept under the bill to be stored in electronic form. I therefore do not think that amendment 1050 is necessary and I invite the member not to move it.

Amendments 1039 and 1041 remove the power to create offences from the regulation-making power in section 55, while amendment 1043, which inserts a new section after section 55, sets out on the face of the bill offences in relation to registers kept by health authorities on pregnancy loss. Amendment 1040 inserts a new provision requiring health authorities to keep registers on pregnancy losses indefinitely, which is consistent with the approach taken to other registers made under the bill. Amendment 1042 provides a definition of "health authority" for the purposes of section 55, while amendment 1038, which inserts the word "or" between section 55(2)(a) and (b), is a drafting adjustment that provides drafting consistency with other parts of the bill.

I move amendment 1027.

Malcolm Chisholm: First, I think that the minister has dealt with the matter of my amendment 1050 in her amendment 128, which will be considered tomorrow. I assume that amendment 128 will be passed, so I do not need to move amendment 1050.

However, I am not so sure about amendment 1049. My starting place is a paragraph in the minister's speech in the stage 1 debate, which I am sure she will not mind me reading out. She said:

> "In setting out what will happen after a pregnancy loss, the bill ensures that the woman who has experienced the loss is at the centre of the decision-making process."

That is the first principle. The second is the provision of more time, on which the minister went on to say:

> "I intend to lodge stage 2 amendments to further support an even more person-centred approach to deciding what should be done with the remains of a pregnancy loss. That will ensure that no woman is ever rushed into making a decision and will provide extra flexibility where a woman needs more time to decide what she wants to happen."—[*Official Report*, 11 February 2016; c 86.]

I heard what the minister said, but I have struggled to find a specific reference in her amendment 1036 to a woman expressing the need for more time, so I remain to be persuaded about that.

In amendment 1049, I have made it clear that

> "If the woman informs the appropriate health authority that she requires a further period to make a decision ... the authority must take such steps as it considers necessary to accommodate that request."

The minister, quite rightly, lodged amendment 1035 to ensure that everything could be finalised in less than seven days, if that is what the woman wants. I welcome that amendment. The other side of the coin is that, if the woman wants more time, it should be longer than six weeks. That is my first point.

My second point is that I have some concerns about the words,

> "the best interests of the woman".

Obviously, we all want to act in the best interests of the woman, but who is to decide what that is? People always get a bit suspicious when someone is seen to be acting on a person's behalf without having asked them. That came up in the context of the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill last week, in relation to the duty of candour and ensuring that people are always asked rather than assumptions being made in a paternalistic fashion. I am a bit suspicious of the wording about contacting the woman if it is thought to be in her interests to be contacted. It is more straightforward to say that the woman will be contacted, which will be followed by one of three things: arrangement of disposal of the remains, in accordance with her wishes; if she does not express a wish to influence disposal, its being done without regard to her position, since she does not have one; or the woman asks for more time.

I think that my amendment 1049 deals with the fundamental principles of the centrality of the woman's view and of explicitly allowing for a longer period, if that is what the woman wants. I remain to be convinced that all that is covered by amendment 1036.

Nanette Milne: When I came to the meeting, I could not really distinguish between the two amendments. However, having listened to what has been said by the minister and by Malcolm Chisholm, I think that Malcolm Chisholm's amendment 1049 is more explicit and would ensure that the woman is contacted. I will support amendment 1049.

Bob Doris (Glasgow) (SNP): I was not going to comment on which amendment I prefer—the minister's amendment 1036 or Malcolm Chisholm's amendment 1049—although I would support the Government's amendment. If clarity is needed, there is still stage 3.

I very much welcome amendment 1037, which relates to situations in which the pregnancy is expected to be unsuccessful in the early stages and conversation with the parents about disposal of the remains of their unborn child. I have had experience of that situation in constituency casework and through family and friends, so I see the amendment as being a significant step forward in dealing sensitively with early pregnancy loss.

I acknowledge that it is a tough shift to be NHS front-line staff, but we must always reinforce the fact that sensitivity is needed when a pregnancy is deemed to be failing. Some people will go to accident and emergency units or wherever there are front-line NHS staff, and not always to early-pregnancy clinics or maternity services. When we pass the bill, we need to ensure that there is awareness-raising training for NHS front-line staff on how they should deal with such situations. However, what we have heard from the Scottish Government today is a significant step forward that deals particularly sensitively with such situations.

Maureen Watt: We need to remember that amendment 1036 makes it clear that section 54 will apply where the provision in section 50(1)

"applies in relation to a woman"

and where

"the relevant period has expired".

I also point out that amendment 1036 refers to

"the best interests of the woman",

which will be based on the authority's relationship with the woman. If the woman is still involved in the process, it will be entirely her view that is taken into account.

However, the woman might have indicated that she does not want to be involved; indeed, she might not have given a view at all and might, for example, find being contacted too painful. In such cases, the fact that the amendment refers to her "best interests" reflects that.

Amendment 1027 agreed to.

Amendments 1028 to 1030 moved—[Maureen Watt]—and agreed to.

Section 50, as amended, agreed to.

Section 51—Change in arrangements

Amendment 1031 moved—[Maureen Watt]—and agreed to.

Section 51, as amended, agreed to.

Section 52—Individual authorised to make arrangements

Amendment 1032 moved—[Maureen Watt]—and agreed to.

Section 52, as amended, agreed to.

After section 52

Amendment 1033 moved—[Maureen Watt]—and agreed to.

Section 53—Appropriate health authority authorised to make arrangements

Amendments 1034 and 1035 moved—[Maureen Watt]—and agreed to.

Section 53, as amended, agreed to.

Section 54—Duty of appropriate health authority

Amendment 1036 moved—[Maureen Watt].

The Convener: I remind members that if amendment 1036 is agreed to, I cannot call amendment 1049.

The question is, that amendment 1036 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

Against

Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 1036 agreed to.

Section 54, as amended, agreed to.

After section 54

10:30

Amendment 1037 moved—[Maureen Watt]—and agreed to.

Section 55—Duty to keep a register

Amendment 1050 not moved.

Amendments 1038 to 1042 moved—[Maureen Watt]—and agreed to.

Section 55, as amended, agreed to.

After section 55

Amendment 1043 moved—[Maureen Watt]—and agreed to.

Section 75—Interpretation

Amendments 1044 to 1046 moved—[Maureen Watt]—and agreed to.

The Convener: That ends stage 2 consideration of amendments by the Health and Sport Committee. Members should note that the bill will not be reprinted at this stage; instead, an electronic version will be produced this afternoon including the amendments that have been agreed to by the committee.

10:33

Meeting suspended.

10:48

On resuming—

Subordinate Legislation

The Convener: With the committee's agreement, we will change the order of the agenda. We will take item 3 now and take item 2 when we find our witnesses for that item. Is that agreed?

Members *indicated agreement.*

National Assistance (Assessment of Resources) Amendment (Scotland) (No 2) Regulations 2016 (SSI 2016/80)

The Convener: Agenda item 3 is on subordinate legislation. We have five negative instruments to dispose of. There has been no motion to annul the first instrument and the Delegated Powers and Law Reform Committee has made no comments on it. As no committee members have any comments, do we agree to make no recommendation?

Members *indicated agreement.*

National Assistance (Sums for Personal Requirements) (Scotland) (No 2) Regulations 2016 (SSI 2016/87)

The Convener: There has been no motion to annul the second instrument and the Delegated Powers and Law Reform Committee has made no comments on it. As no committee members have any comments, do we agree to make no recommendations?

Members *indicated agreement.*

Country of Origin of Certain Meats (Scotland) Regulations 2016 (SSI 2016/84)

The Convener: There has been no motion to annul the third instrument. However, the Delegated Powers and Law Reform Committee has commented on it. That committee has drawn the Parliament's attention to the regulations on the general reporting ground that some of the terms that are defined in the instrument are superfluous, as they are not used elsewhere in the instrument, so they should have been omitted. It must be said that the Scottish Government has advised that, although the words have no effect, they will be removed at the next convenient legislative opportunity.

As no members have any comments, does the committee agree to make no recommendation?

Members *indicated agreement.*

National Health Service Pension Scheme (Scotland) Amendment Regulations 2016 (SSI 2016/97)

The Convener: The fourth instrument is the National Health Service Pension Scheme (Scotland) Amendment Regulations 2016. I see people in the public gallery bristling and sitting up straight at the mention of the pension scheme, but I had better push on with the formalities.

There has been no motion to annul and the Delegated Powers and Law Reform Committee made no comments on the instrument. As no members have any comments, does the committee agree to make no recommendations?

Members *indicated agreement.*

National Health Service Superannuation Scheme (Miscellaneous Amendments) (Scotland) Regulations 2016 (SSI 2016/98)

The Convener: There has been no motion to annul the fifth instrument and the Delegated Powers and Law Reform Committee has made no comments on it. As no members have any comments, does the committee agree to make no recommendations?

Members *indicated agreement.*

The Convener: Thank you for that; we have made some progress.

Healthcare Improvement Scotland (Delegation of Functions) Order 2016 (SSI 2016/86)

The Convener: We move to agenda item 2, which is oral evidence on one negative instrument. The instrument gives Healthcare Improvement Scotland the power to direct health boards to close hospital wards to new admissions when there is a serious risk to life, health or wellbeing.

I welcome—again—Maureen Watt, Minister for Public Health. I also welcome from the Scottish Government Elizabeth Sadler, head of the planning and quality division, and Ailsa Garland, principal legal officer, and from Healthcare Improvement Scotland we have Robbie Pearson, interim chief executive, and Jacqui Macrae, head of quality of care.

I invite the minister to make a short opening statement. Thereafter, we will move to questions.

Maureen Watt: Thank you for providing me with the opportunity to explain the rationale behind the Healthcare Improvement Scotland (Delegation of Functions) Order 2016. Tackling and reducing healthcare associated infection and containing antimicrobial resistance remain a key priority for ministers and the Scottish Government. Latest figures show that, since 2007, cases of Clostridium difficile in patients who are aged 65 years or over have reduced by 84 per cent and cases of methicillin-resistant staphylococcus aureus—MRSA—have reduced by 88 per cent. Although that demonstrates significant progress, the challenge is to look at ways to continue the reduction in order to drive down HAI rates.

The incidence of key HAIs has plateaued over the past two years. We need to work even harder to ensure that those figures move in the right direction as we strive to make appropriate and updated advice accessible to all who deal with infection prevention and control.

The Government will continue to drive forward improvements across NHS Scotland as we work closely with Healthcare Improvement Scotland, Health Protection Scotland and the Scottish antimicrobial and healthcare associated infection strategy group to reduce infection rates further. We will also support health boards to deliver further improvements for the safety of healthcare staff, patients and the public.

I turn to the specific measures that the order contains. The Scottish Government fully accepted all the recommendations that were made in the Vale of Leven hospital inquiry report. Recommendation 1 in Lord MacLean's report was that the

"Scottish Government should ensure that the Healthcare Environment Inspectorate (HEI) has the power to close a ward to new admissions if the HEI concludes that there is a real risk to the safety of patients. In the event of such closure, an urgent action plan should be devised with the Infection Prevention and Control Team and management."

The order implements that recommendation by giving HIS the powers to direct a board to close a hospital ward to new admissions when HIS considers that, without the direction to close, there would be a serious risk to life, health or wellbeing. The powers will not be limited to closure for reasons of cleanliness and will apply for other safety reasons, such as staffing levels and other non-medical reasons. The powers are designed to ensure patient safety and it is therefore right that they should cover all circumstances in which there is a serious risk to life, health or wellbeing.

In conjunction with the Scottish Government and other interested stakeholders, HIS has developed an escalation procedure that includes arrangements on the powers to direct the closure of wards to new admissions. The draft procedure was shared with health boards on 3 March for their views and I have asked for a copy of the final paper to be sent to the committee for its information.

I should stress that closing a ward to new admissions is intended to be an option of last

resort and that we hope that it is never needed. I assure the committee that HIS will work with NHS boards—particularly chief executives and medical directors—to address any concerns that are raised as a result of an inspection of any hospital. My officials have confirmed that the escalation procedure will provide a clear, transparent and consistent process to manage the identification and escalation of serious issues that might be facing NHS service delivery, quality, safety of care and organisational effectiveness.

The escalation process will ensure clear communication paths across all stakeholders, clarity over roles and responsibilities, and an explicit record of actions that have been undertaken in partnership with boards to secure a timely resolution. Consistent and effective communication between HIS and board officials will be crucial to achieving that resolution.

The order meets our commitment to implementing recommendation 1 of the Vale of Leven hospital inquiry report. It gives HIS the power to direct NHS boards to close a hospital ward to new admissions when HIS considers that there is a serious risk to life, health or wellbeing. The draft escalation process that HIS has published makes it clear that the power will be used only very rarely and as a measure of last resort. It is, however, an important additional tool to safeguard patient safety. I am happy to answer any questions that members have.

The Convener: Thank you, minister.

Rhoda Grant: The minister has said that she does not believe that the power will be used often. In what circumstances does she see it being used? What will the process be? We know that health boards can close wards to new admissions at the moment, so what will be the process if HIS does that rather than the health board?

Maureen Watt: The powers will be used only in unusual situations. There are powers in the National Health Service (Scotland) Act 1978 for ministers to take action when certain bodies, including health boards, are failing to carry out their functions. We do not envisage a situation where those powers would be used, given the close understanding and co-operation that there is between ministers and boards. The situation would have to be very unusual.

Does any of the team want to add anything?

11:00

Robbie Pearson (Healthcare Improvement Scotland): We are clear that Healthcare Improvement Scotland's role sits within a broader escalation framework. That framework is in place ahead of the powers and is used in our inspections when a cause for concern is found—that might be about ward staffing levels or infection control.

The key part of the existing escalation process is local resolution of concerns. In my experience as director of scrutiny and assurance for four years, in the vast majority of instances those issues are addressed and resolved at local level, with the intervention of our inspectors, who work closely with staff on the ground.

If the powers were to be applied, that would be a last resort, as the minister described. Using the powers would require escalation to Healthcare Improvement Scotland's chief executive and discussion about the concerns with the chief executive of the health board involved as the accountable officer. The chief executive of that health organisation would be asked to take steps to prevent admissions to the affected ward.

If the chief executive of HIS and the chief executive of the health organisation failed to reach agreement that preventing admissions was the most appropriate action, the steps under the powers would be for HIS to instruct that health board to stop all new admissions to the ward. It is important for the committee to understand that the escalation algorithm is at the pinnacle of an escalation process and needs to be seen in that context.

Rhoda Grant: Closing a ward to new admissions makes sense if it is for infection control purposes. Those who might already have been infected would be isolated and not moved to the rest of the hospital.

However, if the concern is about patient safety and staffing numbers, surely the patients who are left in the ward are still in danger. What steps will you take to deal with the dangers if the issue is not the more easily understood one of infection control?

Robbie Pearson: If the concern was about ward staffing levels, a reduction in the number of admissions to that ward would clearly be beneficial, as the cohort of available staff would be managing a much reduced number of patients. That would be an immediate action.

The important point for the committee is that boards already take action when there are concerns about, for example, staffing levels or infection control. In a norovirus outbreak, for example, boards take action to prevent admissions to wards if there are concerns about patient safety or a risk to life or wellbeing.

Closing a ward to admissions is an important step in relation to staffing levels, but the committee will be aware that there is a range of scenarios in which such steps might have to be taken.

The Convener: We are not necessarily aware of the range of areas that fall into the category of a serious risk to life, health or wellbeing. We have established that there are a few areas—they involve infection control, staffing levels and the staffing mix—where remedies are already in place. What other scenarios would you include in the list for potential use of the powers?

Maureen Watt: An example would be a theatre in which someone notices that cleanliness is not up to standard. Do you want other examples?

The Convener: So we have theatre situations, staffing levels and mix, and infection.

Robbie Pearson: One example would be extreme pressure at the front of a hospital from the number of A and E attendances and patients requiring to be seen in an assessment unit. That might have an impact on safety and demand in the hospital overall and on how patients are managed within the flow of that hospital.

Jacqui Macrae may wish to add other examples.

Jacqui Macrae (Healthcare Improvement Scotland): That is the only other example that I can think of.

I reiterate that our general experience is that boards take immediate action to resolve such issues and take into account the safety of patients in the whole system rather than just at the individual point of concern.

The Convener: The issue is the power that the order gives HIS. I can see a ward being closed to new admissions when there is an infection. I can see a decision to close A and E when a major accident has occurred and emergency planning is coming into place such that people are being sent to other hospitals in an immediate area. We know that that happens and we know that infection happens; we read and hear about such situations.

What powers does the order give HIS or the Scottish Government that we do not already have? What will your role be in such a decision? When will the decision be yours? Who will decide that a health board has failed to act in the face of a risk to the life, health or wellbeing of its patients? I have difficulty in seeing where the order will be relevant and what additional powers it gives us that we do not already have.

Maureen Watt: The order has been made because one of Lord MacLean's recommendations in the Vale of Leven inquiry report was that the Scottish Government should ensure that Healthcare Improvement Scotland had such a power and that the power was not left just to health boards. He felt that there might be a gap. The order comes specifically from his recommendation in that report.

The Convener: A wider point is about whether Healthcare Improvement Scotland is a regulator or a part of the health service. Was Lord MacLean getting at that?

Robbie Pearson: A broader consideration of Lord MacLean as chair of the inquiry was that additional powers were not needed, beyond those in the first recommendation. The inquiry report made it clear that there is sufficient independence and separation at present in Healthcare Improvement Scotland's role.

Rhoda Grant: I am not totally satisfied with the answer to my previous question about staffing numbers being seen as unsafe for patients. Closing a ward to new admissions means that the safety pressures do not escalate, but it does nothing to remove them, unless the hospital suddenly starts to discharge patients. However, we cannot assume that patients will be discharged, because we do not know what the nature of the ward will be—patients could be there for the long term. How will you deal with the safety risk for existing patients in the ward?

Maureen Watt: Hospitals already deal with that issue. As we have stated, a norovirus outbreak can affect not only patients but staff. That is why a ward would be closed to new admissions and why staff would be moved from other parts of the hospital, to make sure that the patients who were already in the ward and who were not fit to be discharged were looked after.

Rhoda Grant: What powers does the order provide to increase staffing levels, rather than just stop admissions, to deal with patient safety concerns?

Maureen Watt: That would be discussed with all the partners who are involved because, as we have said, the decision would be taken not by HIS alone but by HIS in conjunction with the health board, the senior management and, if necessary, ministers.

Ailsa Garland (Scottish Government): The order is restricted to simply giving HIS the power to give the direction to close a ward. I understand that the escalation procedure involves discussing measures to improve the situation in hand. What to do about the situation that led to the direction to close a ward would be part of a wider procedure.

The Convener: Mr Pearson, will the order give you greater power in your relationship with health boards to get quicker action? Will it help in that discussion or negotiation?

Robbie Pearson: Yes. The order allows us a degree of direction, formality and legal power that we do not have at present. The important point is that that does not take away from or disturb the accountability of health board chief executives for

delivering safe services to their populations. They remain accountable for the safety and wellbeing of patients who are in their care and for the mix of services that are provided, which includes the workforce and staffing levels.

The Convener: Mike MacKenzie has a supplementary question.

Mike MacKenzie (Highlands and Islands) (SNP): Mr Pearson, you mentioned that an algorithm would be used in the decision-making process. That thought fills me with concern. Will the decision be made by a human being or by a computer? I am sure that you could understand public concern about that if it is a case of, "Computer says no." I am interested in finding out a wee bit more about the algorithm, so will you share that information with the committee, perhaps in writing? Will the algorithm take into account geographical circumstances and capacity issues that might be found in places such as Orkney, Shetland or the Western Isles? Will it take into account the prevailing weather conditions, which might mean that it is impossible to evacuate patients to alternative facilities on the mainland?

Robbie Pearson: I assure the committee that the algorithm is not some remote computer-generated yes/no answer. It will be informed by clinical and professional judgment on the ground and by senior inspectors working with staff in delivering those services. It is about professional judgment and about the appropriate management of risk. I emphasise that the algorithm can only guide. It is not fixed—it guides and influences. It has a number of steps but, at each step, there is a professional judgment to be made about risk and the impact on the quality of care for patients.

On the operating context, I think that Mr MacKenzie makes a general point about remote areas and rurality. Those issues would be part of the risk assessment in assessing the situation on the ground. Obviously, the delivery and pattern of health services vary vastly across Scotland. It is key that we take into account the operating context and understand the distribution and mix of services. For instance, the responses might be different when dealing with a hospital environment that has a large number of single rooms and when dealing with an open-plan ward environment.

Dennis Robertson: Mr Pearson has just pre-empted my question, but I seek clarity with regard to single rooms. A ward may be comprised of a number of single rooms. Rather than close the ward, you may wish to isolate individual rooms. Can you give us greater clarity on that?

Robbie Pearson: That is an important point. In new hospitals such as the Queen Elizabeth university hospital, which has single rooms, the response is different from the response in more traditional, open-plan, Nightingale ward environments. Again, it comes down to a careful assessment of risk for individual patients and how that is mitigated on the day to ensure that new admissions can be made to the ward as quickly as possible.

Jacqui Macrae might wish to add more detail on that.

Jacqui Macrae: It is very much about the individual context. We should bear in mind the timescales within which things might happen and how the decisions would be taken to reopen areas. Mr Robertson is right that, with a ward area that has predominantly single rooms, it might, for example, be possible to isolate a specific area and deep clean it so that the impact on the service that is being provided is minimal. However, in a completely different context, such as a Florence Nightingale-type ward with longer-term admissions, if the issue is around staffing levels, it might take longer before things can be put in place so that we have assurance that the situation is safe enough again to open the ward to patients. It is context specific.

Dennis Robertson: I was just looking for a degree of clarification that, in some of the new hospitals in particular, single rooms could be isolated and you would not have to close a ward per se. Where there is a mix of single rooms and Nightingale wards, there is the potential to move a patient into a single room, where they can be isolated. I wanted to tease out from you that there is that flexibility. I acknowledge that closure to new admissions would be a last resort.

11:15

Richard Lyle (Central Scotland) (SNP): My question is in the same vein, given that we have been talking about staffing levels and concerns about closing wards. In its submission on the order, the Royal College of Nursing Scotland said:

> "Closing a ward may be necessary because of a systemic failing in a service. It also may be the result of a health board trying to meet a Scottish Government-set HEAT standard that applies to one part of the service and has unintended consequences on another part of the service ... The RCN would not want to see a situation where individual staff members working on wards are penalised because of a systemic failing or from the unintended consequences of a health board's effort to meet a HEAT standard."

What are your views on that comment, minister?

Maureen Watt: I do not think that that would ever happen. It is not the intention that particular members of staff would be penalised. That is perhaps rather a negative view from the royal college. As I said, there is collective responsibility. The order is not about penalising staff, nor is it about meeting the health improvement, efficiency

and governance, access and treatment targets; it is about ensuring that the wellbeing and safety of everyone involved—staff, patients and the public—are paramount.

Richard Lyle: Thank you. I just wanted to have that comment on the record.

Bob Doris: The order is a response to a recommendation in the Vale of Leven hospital inquiry report. Given that that is the context in which we are considering the order, I want to put on record that my family had recourse to the Vale of Leven hospital in recent months, when my mother received palliative care there. The hospital provided an outstanding service and did very well by my mother and my family.

The witnesses have got the short straw, to some extent, because you have been urged to think of cataclysmic scenarios in which HIS would use these proposed powers of last resort, and when you could not quite come up with such scenarios members have raised issues around that. We did not foresee what happened at the Vale of Leven, and we never know when the powers might be needed—I get that.

Given that we do not always know what tomorrow will bring and that we might need to use the powers in circumstances that are currently unforeseen, I suppose that speed is the issue. I will not ask for a scenario, but I want to explore the speed of the chain of events whereby HIS's attention would be drawn to a significant issue, by whatever mechanism. I imagine that the escalation process in the health board and in HIS could take quite a bit of time and be quite bureaucratic, and I am looking for reassurance that that would not be the case if there was a significant issue.

Maureen Watt: Thank you for your comments about the Vale of Leven hospital. Lord MacLean's report contained 75 recommendations, of which 65 were for the NHS, nine were for the Scottish Government and one was for the Crown Office and Procurator Fiscal Service. All the recommendations were accepted and are being implemented.

Your question takes us back to Mr MacKenzie's question about the algorithm, which is a framework that provides a brief description of the roles and responsibilities of each national group and the people involved. By having that, we can speed up the process, as you suggest that we would need to do. I do not know whether anyone else wants to come in on that.

Robbie Pearson: Speed is of the essence in such a situation. Our current escalation process is extremely fast—I am only a phone call away from Jacqui Macrae and others in the senior inspection team, and decisions are made on the ground in real time to ensure that patient care is not compromised. The escalation algorithm cannot be a bureaucratic process: if it is a continuation of the existing algorithm, it must have the same degree of speed. We need to ensure that decisions are made as swiftly as possible.

Bob Doris: I am glad that there is some reassurance in that answer. I do not want to explore the algorithm—I will leave that to Mike MacKenzie. I want to look at the human-touch aspect, which involves people picking up the phone and speaking to the most senior person at the health board. I am talking about people phoning to say, "Who is the chief executive? Clear her diary and let's have that meeting. We have to chat. We have enforcement powers if they need to be used." That is what I was looking for. Somewhere in those answers I got that message, but I also heard about the algorithm, which I will not explore any further. I am reassured by Robbie Pearson's answer, which was in effect, "We'll pick up the phone and chat immediately." That is what I hoped to hear.

We have a wonderful NHS, but you never know when things will go wrong in such a vast organisation. There will always be a situation in which a health board, without enforcement powers, may decide to close a ward to new admissions because of unforeseen events. I would like to think that contingency planning takes place in NHS boards anyway.

I have explored the area of speed and received some reassurance in that respect. We never know where the need to use those powers may manifest itself, and I would like to think that health boards already have in place contingency planning for what they would do if something happened. It could be a fire alarm going off or a health and safety issue, or it could be to do with the fabric of the building. There does not necessarily have to be a clinical incident to bring about a situation in which wards cannot be used.

Does HIS have a role in ensuring that boards have effective contingency planning in place, or do boards make such plans anyway? What mechanisms are in place for that?

Robbie Pearson: We do not have a direct role in health board contingency planning. Health boards have a role in ensuring that they have robust disaster recovery and contingency planning arrangements in place. Chief executives, as the accountable officers, will test those plans and ensure that they are robust and effective.

When we carry out inspections, we look at how those plans are understood by staff and how they would be deployed in certain situations. Examples include healthcare environment inspections, in which we look at the plans for certain incidents, and inspections of older people's care, in which

we look at the arrangements for staff levels. Although boards have responsibility and accountability for those arrangements, we take an interest in the robustness and effectiveness of those plans.

Jacqui Macrae: That is right. If there were issues around fire regulations, for example, we would test staff on their knowledge of how they would evacuate a building in the event of fire. These issues come up periodically across our inspection programmes.

Bob Doris: I accept that contingency planning is a matter for the health boards. However, let us say that you needed to have immediate and speedy conversations, although we hope that you do not have to have such conversations, with a health board chief executive to say, "If this doesn't get sorted, we will instruct you to take this action"—closing a ward to new admissions, for example. Would you at that point expect to say, "Although we don't want this to happen, we might do it in the next few days, so what are your contingency plans?"?

Robbie Pearson: Absolutely—that is an important point. We expect the boards as of now to respond to concerns that we identify in inspections, even without these powers in place. In my experience, boards respond very swiftly, and we have follow-up mechanisms to ensure that arrangements are in place and are effective.

Bob Doris: It is probably the lack of brevity in my questions that means that I am not clear on the answers.

Dennis Robertson: Brevity?

Bob Doris: I know, Mr Robertson—I am not renowned for it. I hope that the process of escalation is quicker than my questions.

On the first occasion that HIS has that conversation with the health board and says, "We might use these powers", do you at that point say, "We must see your contingency plans"?

Robbie Pearson: Absolutely. That is the point of the powers—they are there in reserve and boards know that we have them, which informs how they respond.

The Convener: There is a much more difficult area, in a practical sense, than what we are puzzling about just now. If the place goes on fire or there is disease, it is fairly obvious: there is a smell of smoke and bells are ringing, or there are people being sick. However, a controversial area—it has been controversial in some of our discussions, and has been mentioned this morning—is the question of staff mix and staffing levels. What is your role in such situations, and how do you escalate issues quickly?

You are not there when the staffing levels on two or three shifts have dipped because of sickness, pressure or whatever; you are not there when there is only one senior nurse for a ward full of 20-odd people. How do you intervene reasonably in that situation, wag your finger and say, "If you do not get that sorted out, you are potentially at risk of having that facility closed down because you are not staffing it properly and the staff mix is not right"?

Your relationship up to now with the health boards, Mr Pearson, has been to seek improvement—not conflict, with the imposition of rules from outside. You give people lots of time—weeks or months—to deal with some of the issues that you identify in inspections. Sometimes, you trust them to tell you that they have dealt with the issue and you do not go back to inspect them again for some time.

How do you deal with issues as complex as the staff mix and staffing levels?

Robbie Pearson: There are a number of levels to consider. First, we take an interest in staffing levels—increasingly so in our inspections of older people's care, for instance. We ask to see staffing rotas not just for the day of the inspection but for the previous weeks as well as the projected staff rotas over the next period of time. That is an area of increasing interest.

On the timetable for a response, we have a fairly swift escalation of concerns within our existing algorithm, but we also set in place requirements—for example, in the Healthcare Environment Inspectorate, we set a timetable for NHS boards to respond to those requirements based on our concerns. We can say that our expectation is that our requirements will be in place when we come back the next week or the following day, so there can be a swifter turnaround.

On a broader issue, we consulted last year and are taking forward work under the quality of care reviews to look at more comprehensive assessments of healthcare and the things that impact on healthcare. Workforce and leadership are fundamental components in that regard. We have had bigger and broader reviews around that, such as in NHS Grampian, at Aberdeen royal infirmary. The intention is that we will use that much more systematic and comprehensive assessment of workforce effectiveness and leadership in the future, which will enable us to get into those more complex issues.

The Convener: The order would help HIS to make progress in that area of establishing—

Robbie Pearson: It is an important power for us to have but the broader question is how we take

forward that deeper consideration of the factors that impact on the quality of care.

The Convener: We know that the Care Inspectorate, in inspecting residential facilities, focuses on elements such as staff changes, which can sometimes cause failure. I will return to that point later and to some of the committee's recommendations about HIS and the Care Inspectorate working together and learning from each other on some of those issues.

Malcolm Chisholm: HIS does not have the power at present to direct health boards to close wards, but does it have the power to direct boards in relation to each of the other steps in the escalation process?

Robbie Pearson: For those steps that are about co-operation between HIS and the NHS boards and, ultimately, the chief executives of the boards, HIS has sufficient power at present. The final power to close a ward is informed by that co-operative relationship in the escalation all the way up to the use of that ultimate power. There is not a series of subsidiary powers underlying that. The legal directorate might be able to confirm that I am using the correct language.

Ailsa Garland: I agree with Robbie Pearson.

Malcolm Chisholm: Some people might ask why HIS is not being given a wider power; other people say that HIS should not be given this power. However, it could be argued that, if it is a process of steps, why is HIS only being given the power for the ultimate sanction rather than having a directive power over the other areas as well?

11:30

Robbie Pearson: I feel that the powers that the order will give us and the ultimate sanction are sufficient without a whole series of other separate powers, which might lead to a more bureaucratic debate and discussion at each of those steps. The key point is about the speed of the response at the moment of concern. That is what is critical, rather than a series of subsidiary pieces of legislation or powers underlying the overall sanction.

Malcolm Chisholm: During the four years that you have been director of scrutiny, can you think of occasions—without naming the place—when you would have found that power useful?

Robbie Pearson: In all honesty, I believe that boards have responded without our having that power, but it is still an important power to have in a context where there may be serious and significant service failings. We have carried out 535 reviews and inspections since the establishment of Healthcare Improvement Scotland, and we have formally escalated matters of concern to the Scottish Government on five occasions. That reflects a number of things. The main thing is about the quality of care, but it is also about the fact that, where we have escalated cases, whether informally at local level or more formally to the chief executive, the boards have responded.

Malcolm Chisholm: I do not know whether this question is for you or for the minister. Given that the cabinet secretary already has the power to direct health boards, why do you need this power specifically, rather than just going to the cabinet secretary and saying what requires to be done?

Robbie Pearson: The important point is about the overall shape of accountability in Scotland. There is quite a shallow hierarchy in the health service in Scotland and there is a short escalation between the chair of a health board and ministers and the cabinet secretary, so it is important to think about that Scottish context. The other point to make is that the powers also sit in a broader context of powers for ministers in the ladder of escalation and of the powers that ministers have to intervene in a health board more generally.

Maureen Watt: The cabinet secretary would be involved at all stages. The information flow is quick for such things.

The Convener: That relates to some of the questions that were raised by the RCN about political interference. If you feel that you have to escalate a case, but it is the wrong time of year or the wrong time in the political cycle, and you are proposing the closure of a high-profile facility six weeks away from an election, the cabinet secretary—whoever he or she may be—could say, "No, I don't want that bad news at this time."

Maureen Watt: Patient safety is paramount.

Elizabeth Sadler (Scottish Government): That is right. Patient safety is the most important thing. The powers are intended as a backstop, to be used when all else has failed. Giving the power to HIS to ask the board to close the ward removes ministers from that direct decision. Of course, ministers will be kept informed, because it is of wider interest to them given their responsibilities, but the responsibility rests with HIS and it would be for HIS to take that decision in partnership with the health board.

The Convener: You said that HIS would inform the cabinet secretary, rather than discussing with him or her whether to take that decision. You would take a decision at HIS that, in your view and based on all the information that you had received, a facility would have to close because of consistently low staffing levels or a poor mix, and you would inform the cabinet secretary of your decision, rather than having a discussion with the cabinet secretary before making that decision.

Robbie Pearson: That is correct, and the important point is about the powers that are vested in Healthcare Improvement Scotland to make those decisions.

Malcolm Chisholm: I wanted to explore different aspects of the issue. I think that it is a good power for HIS to have, just in case anyone misunderstood me.

The Convener: Does anyone want to respond to Malcolm Chisholm?

Malcolm Chisholm: I was just making a comment.

Nanette Milne: The RCN has suggested that the new power could give you a conflict of interests, given your dual role of scrutiny and improvement. Do you agree with that comment, or would you like to say anything about that?

Robbie Pearson: I do not agree with that comment. The important thing is how we utilise the mix and blend of expertise, skills and capabilities within Healthcare Improvement Scotland.

The King's Fund recently published a paper about improving the quality of healthcare in England. It encourages people in England to study what is happening to improve quality in Scotland, the work of Healthcare Improvement Scotland and the mix of things that we have in our organisation, such as the Scottish health council, our evidence base, scrutiny and improvement. We need to make sure that, when we scrutinise, we are seen to be independent, we act independently and we provide recommendations without fear or favour. The bigger opportunity for us is in how we use the range of things in our organisation to make us more efficient and effective than we would be if we had to transact with a range of bodies.

Nanette Milne: Thank you.

Richard Lyle: I will try to tie this up. HIS is going to get an extra power, which it may or may not use; do you have sufficient staffing levels to cope with it?

Robbie Pearson: I think that our staffing levels are not directly related to the power. We have an excellent group of inspectors in the team, who come with a clinical background, for example those who carry out our inspections of older people's care. An increasingly important point about our workforce is that we will never have all the skills and expertise in Healthcare Improvement Scotland and we will be increasingly reliant on the skills and expertise of professionals coming to join us and work with us in all parts of our organisation, including inspections. There will be an increasing demand on health boards to provide clinical experts, for instance, to carry out inspections.

Richard Lyle: Thank you.

The Convener: As there are no other questions from members, I just want to touch on the context in which Healthcare Improvement Scotland and the Care Inspectorate operate. I refer back to the committee's inquiry into the regulation of care for older people, which reported in 2011. At that time, there was a big focus on national care standards and there was agreement that we would have in place a set of national care standards that everyone would work to. That report included recommendations on staffing levels, staff mix and so on, particularly in residential settings and the community.

Are we all working on the development of national care standards in the context that regulators work under? Do we now recognise that there are very similar arrangements as a result of the integration of health and social care? That is a pathway and a journey for people. How much are all the agencies that work in this field learning from one another? Are we working closely together to develop good practice across those agencies, if not bringing them all together?

Maureen Watt: The short answer is yes. I will leave Mr Pearson to give you the fuller version.

Robbie Pearson: We have been working on several levels. First, there has been an excellent consultation on the national care standards, and a set of principles has been agreed that is very much human rights based. Jointly with the Care Inspectorate, we are now carrying out work to take forward more detailed national care standards that will be fundamental in supporting more integrated health and social care in communities and care settings. That is the first thing to say; that is happening now.

The Convener: Can you make any of that information public? We are working on our legacy paper and that important recommendation was made way back. How old are the Russell care standards now? When were they last reviewed? Was it 15 years ago?

Robbie Pearson: I think that it would have been in about 2002. Work is now under way to take forward those new standards.

The Convener: How much information can be shared with the committee at this stage?

Robbie Pearson: We are very happy to share with the committee the work on the national care standards and the principles that have been agreed.

The Convener: Thank you.

Robbie Pearson: One of the key things arising from the committee's review concerned joint working more generally with the Care Inspectorate. We have been carrying out joint inspections with the Care Inspectorate for the care

of older adults. We have now done quite a number of inspections across Scotland—probably eight or nine—and they have been really informative in looking at the different models of care and sharing good practice. You made a point about that, convener.

We are now undertaking a review of that methodology and ensuring that it is fit for purpose in the context of health and social care partnerships. That work is being led by two non-executives from Healthcare Improvement Scotland and the Care Inspectorate, John Glennie and David Wiseman. The fact that we are taking forward that piece of work jointly emphasises again the importance of the Care Inspectorate and Healthcare Improvement Scotland going with the grain in respect of service delivery in individuals' communities.

The Convener: That is good to hear. We look forward to the additional information being provided to the committee.

As committee members have no further questions, I express our gratitude and appreciation to the minister and her colleagues, who have been here for quite a while this morning, and colleagues from Healthcare Improvement Scotland. Thank you to you all.

11:40

Meeting suspended.

11:44

On resuming—

Petitions

Orphan Diseases (Access to Therapy) (PE1398)

Pompe Disease (Access to Therapy) (PE1399)

Paroxysmal Nocturnal Haemoglobinuria (Access to Therapy) (PE1401)

The Convener: Okay, folks, we have got back to our agenda. I see that our audience has been released for good behaviour, after listening all morning.

Item 4 is consideration of three petitions that relate to access to new medicines and medicines for rare conditions. As members can see from paper HS/S4/16/13/11, the petitions were central to the committee's consideration of access to new medicines. As you will remember, the issues were discussed with the cabinet secretary at our meeting last week.

Members are aware that the system for accessing new medicines has been considerably changed. The changes have been broadly—indeed, extensively—welcomed, as we heard in evidence. Even if not everything is perfect, the system has certainly improved. You will recall that the Scottish Government is about to carry out a review of the changes to the medicines appraisal system, which I am sure that we all welcome. Given that all that work has been done, I ask the committee to consider whether to close PE1398, PE1399 and PE1401. I invite members' views.

Bob Doris: I think that it would be reasonable to say that the Government has indicated that it does not regard the review process as an end in itself. The Government acknowledges that, as technological and pharmaceutical advances are made and expectations evolve, processes in the Scottish Medicines Consortium must also evolve. Although there is yet another review, which will build on the improvements that have been made, I am content to close the petitions on the basis that the review will not be the end of the process and the issue will be work in progress as advances outstrip structures.

The Convener: Do we agree to close the petitions on that basis?

Members *indicated agreement.*

Speech and Language Therapy (PE1384)

The Convener: Item 5 is consideration of PE1384, from Kim Hartley, on behalf of the Royal College of Speech and Language Therapists.

In paper HS/S4/16/13/10, members can see the timeline for the committee's consideration, which includes the lodging of a Scottish Government amendment on voice equipment at stage 2 of the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill, which was passed last week. Given the action that has been taken, we wrote to the petitioner to seek her view on whether we should close the petition, and members have a copy of her response. I invite members' views. Should we close the petition? Are there issues that we should include in our legacy paper?

Nanette Milne: I agree that we should close the petition. Kim Hartley Kean—as she now is—has put a huge amount of effort into the petition and into speech and language therapy in general. I note that in her letter she suggests that we recommend to a future health committee that it consider conducting an inquiry into the state of and demand for allied health professional services. That is an issue that this committee has not looked at closely, and such work probably needs to be done.

The Convener: I hear that.

Malcolm Chisholm: I was going to express a similar view. Kim Hartley Kean accepts that the petition should be closed but expresses a level of dissatisfaction about the lack of progress on some of the issues during this parliamentary session. I have been on this committee for only six months, so I do not know the detail of what it has been doing, but perhaps AHP services in general, and speech and language therapy in particular, need a bit more attention in the next session. We could mention that in our legacy paper.

The Convener: We can draw our successor committee's attention to the issue in the legacy paper. We are not in a position to set the new committee's work programme, but there is no harm in mentioning the issue. If we had had more time, we might have done more on the issue. We might have had a meeting on it, for example, but we were not able to do so.

Dennis Robertson: I declare an interest: I am convener of the cross-party group on heart disease and stroke, and Kim Hartley Kean is a representative on that cross-party group. She is also part of a sub-group of the CPG. We should suggest in our legacy paper that there is a piece of work to be done on AHPs, given that we are moving towards integration of health and social care and there will be a greater role for AHPs in the community, which is to be welcomed.

The Convener: It is very good to put the issue in that context.

I will not prevent other members from commenting if they want to do so, but there seems to be a consensus in the committee that, although we can close the petition, we should include some of Kim Hartley Kean's comments in our legacy paper and highlight that, if we had had more time, we would have looked at the role of AHPs in developing the workforce for integrated care. That is not something that we have spent much time on. Do members agree to proceed on that basis?

Members *indicated agreement.*

The Convener: Thank you. That ends the public part of the meeting and we move into private to consider our legacy paper.

11:51

Meeting continued in private until 12:06.

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