HEALTH COMMITTEE

Monday 3 October 2005

Session 2

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CONTENTS

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HEALTH COMMITTEE
24th Meeting 2005, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Paul Martin (Glasgow Springburn) (Lab)
*Mr Kenneth Macintosh (Eastwood) (Lab)
Mary Scanlon (Highlands and Islands) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Lewis Macdonald (Deputy Minister for Health and Community Care)

THE FOLLOWING GAVE EVIDENCE:

Dr Keiran Breen (Parkinson's Disease Society)
Veronica English (British Medical Association)
Helen Farquhar (Scottish Organisation Relating to the Retention of Organs)
Mr Andy Kerr (Minister for Health and Community Care)
Dr Donny Lyons (Mental Welfare Commission for Scotland)
Geraldine MacDonald (Scottish Organisation Relating to the Retention of Organs)
Adam Rennie (Scottish Executive Health Department)
Professor Bill Scott (Scottish Executive Health Department)
Dr Kevin Woods (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 2

Scottish Parliament

Health Committee

Monday 3 October 2005

[THE CONVENER *opened the meeting at 14:00*]

Item in Private

The Convener (Roseanna Cunningham): I welcome everyone to the meeting. We have received apologies from Nanette Milne, and from Helen Eadie, whose attendance at the Edinburgh Tram (Line One) Bill Committee again clashes with the timing of this meeting. I ask Ken Macintosh to confirm that he is attending the meeting as a Labour substitute in place of Helen Eadie.

Mr Kenneth Macintosh (Eastwood) (Lab): I am.

The Convener: Item 1 is to consider whether to take in private item 5 to allow us to consider points that we wish to make in our budget report. Do we agree to take in private item 5?

Members *indicated agreement*.

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 11) (Scotland) Order 2005 (SSI 2005/455)

14:01

The Convener: We move on to item 2, which is subordinate legislation. The committee is asked to consider the order under the affirmative procedure. I welcome Lewis Macdonald, the Deputy Minister for Health and Community Care, who is accompanied by Chester Wood from the Food Standards Agency Scotland. The Subordinate Legislation Committee has considered the order and had no comment to make on it. Do members have points for clarification? Do you wish to debate the order?

Members: No.

Motion moved,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 11) (Scotland) Order 2005 be approved.—[*Lewis Macdonald*.]

Motion agreed to.

Human Tissue (Scotland) Bill: Stage 1

14:02

The Convener: We move on to item 3, which is the Human Tissue (Scotland) Bill. This is our fourth opportunity to take oral evidence on the bill. We will hear evidence from two witness panels. The first comprises a range of organisations that have an interest in the bill. I ask that panel to take their seats at the committee table.

I welcome Veronica English, of the British Medical Association; Dr Keiran Breen, of the Parkinson's Disease Society; and Dr Donald Lyons, of the Mental Welfare Commission. Unfortunately, the British Heart Foundation was unable to send a representative, although we received written evidence from it.

I invite each witness in turn, starting with Veronica English, to explain their interest in the bill and comment briefly on it, saying whether they support the bill's provisions. Witnesses can mention any issues that they think are worthy of further consideration by the committee or matters that they feel are controversial.

Veronica English (British Medical Association): I represent the British Medical Association—the professional association for doctors in the United Kingdom, which represents more than 133,000 doctors from all specialties. I am deputy head of ethics at the BMA and I led its work on the Human Tissue Act 2004. I have also been heavily involved with BMA Scotland in work on the Human Tissue (Scotland) Bill.

We welcome and support the bill. Our main disappointment, though, is that an opportunity has not been taken to opt for a shift to presumed consent for transplantation for adults. To avoid confusion, I stress that our support is for presumed consent only for transplantation and only for adults, and that we strongly support the need for authorisation for hospital post-mortem examinations and for retention and use of organs. I will highlight a couple of points from our written evidence and mention one development that has happened since we made it.

It is unclear why there is no role for a nearest relative when there is no one with parental responsibility for a child at the time of the child's death. For example, if parents and a child are killed in a car accident and nobody has parental responsibility, an adult child could give authorisation on behalf of the parents, but not on behalf of the sibling. That issue should be considered, so that there is a role for nearest relatives in respect of children.

Again on nearest relatives, it is not clear to us why—as the bill is drafted—if two people are within the same category in the hierarchy and there is not agreement between them as to who should make the decision, the oldest person will get to make it, irrespective of how close he or she is to the individual or whether they know about the individual's wishes. We would prefer a system whereby one person could give consent but in which there was also flexibility to take account of individuals' circumstances and the wishes of each person within the hierarchy in making the decision.

I will update the committee on a development related to living donation that has occurred since we submitted our written evidence. We mentioned that we were reassessing our position on incapacitated adults and children as living donors. The matter was discussed at last week's meeting of the Medical Ethics Committee. The committee has decided to recommend to the BMA that it should change its position on mature minors—[*Interruption.*]

The Convener: I am sorry; Duncan McNeil coughed so I suspect that we missed a key word.

Veronica English: The committee decided to recommend to the BMA that mature minors who are competent to make such a decision for themselves should be able to be living donors. There should be adequate safeguards to ensure that, for example, there is not pressure on them. We will retain our opposition to incapacitated adults and young children who are not able to give consent being living donors. That recommendation must go to the board of professional activities for formal approval, which will not happen until next month, but it is the recommendation from the Medical Ethics Committee. I will let the Health Committee know when the decision has been made.

Dr Keiran Breen (Parkinson's Disease Society): I am director of research and development at the Parkinson's Disease Society. The society broadly welcomes the bill and its provisions although we have a number of concerns, most of which are mentioned in our written evidence, so I will not go through them.

Our first concern is about derivation of stem cells from brains and the definition of the brain as a tissue or an organ. Our second concern is about the potential for a human tissue authority, or the lack thereof, in Scotland; the bill deals with consent to give tissue, but it does not deal with what will happen to the tissue afterwards.

Finally, we have some concerns about the derivation of tissue from people who have undergone operations. There is nothing in the bill about giving consent in such cases.

Dr Donny Lyons (Mental Welfare Commission for Scotland): I am director of the Mental Welfare Commission for Scotland. Our role is to safeguard the rights and welfare of adults who have mental disorders, which gives us roles under the Adults with Incapacity (Scotland) Act 2000. I am here to address whether the provisions in the Human Tissue (Scotland) Bill are consistent with the 2000 act, and to advise on what the commission sees as being appropriate safeguards. I think that the committee knows that the matter of benefit for the adult is a key principle of the 2000 act. We have not been asked to make a written submission, but when we were told about the committee's consideration of the issue in response to the further consultation we felt that it was important to be here to listen to the arguments and to give appropriate advice.

It is also worth saying that we would seek to discuss with the committee whether anything that falls out of discussion of the bill might result in possible recommendations for change to the Adults with Incapacity (Scotland) Act 2000, especially on the position of welfare attorneys and guardians with regard to donation or consent for a post mortem.

The Convener: I will kick off on adults with incapacity, so that we can establish the views of the panel members. I know that the Executive is undertaking a separate mini-consultation on that aspect of the bill, which it felt did not have sufficient coverage in the original consultation. Panel members might answer some of my questions simply with a yes or no, but others might need elaboration. Should incapable adults be excluded completely from making living organ or tissue donations? Should there be a blanket exclusion of people who are deemed incapable?

Dr Lyons: The question comes down to benefit. Section 1 of the 2000 act says that no intervention shall take place in the affairs, welfare, finances and so on of an adult with incapacity unless that intervention will benefit the adult. We must be careful about how much the elastic of benefit can be stretched, which I say having read the consultation document. We see that an argument might exist for people with incapacity to donate regenerative tissue, but only in exceptional cases. We do not envisage how it could in any way be appropriate for people with incapacity to donate whole organs that do not regenerate when those people are not in a position to appreciate the possible risks. We would be extremely anxious about any such provision.

The Convener: To paraphrase, you say no, but donation of regenerative tissue might be okay occasionally.

Dr Lyons: That is possible. The question is whether it would benefit the adult involved—the donor, not the recipient.

The Convener: That dealt with the second question that I intended to ask. Does either of the other two witnesses want to respond?

Veronica English: I support what was said. We take a similar view. In exceptional circumstances, bone marrow donation might be acceptable, but organ donation would not be. The reasons for that relate to the level of risk and the improvements in immunosuppressive drugs. Those improvements mean that a less strict match of kidneys is needed, so a cadaveric organ could be used, for example, or perhaps that of another living donor.

There are a couple of possible exceptions. One is domino donations. If somebody needed a lung transplant, they might have a cadaveric heart and lung transplant, and their heart would be suitable for onward donation. The operation would be done for the benefit of the incapacitated adult and not for the benefit of another person. That raises a slightly different issue and we do not want such donations to be prohibited.

A slight possibility is that somebody might, while competent, express a competent wish to be a living donor. We have not considered that.

The Convener: I will deal with that later. Does Dr Breen have views on the initial question?

Dr Breen: Dementia is one factor that is associated particularly with late term and long-term Parkinson's disease. People with incapacity should be considered to be in a position to donate their brains to a brain bank. Such people should not be excluded totally from the bill. Each case should be taken on its merits.

The Convener: The issue is the point at which people are incapable of making decisions. You think that, even in the circumstances of incapacity, a person should still be allowed to donate.

Dr Breen: Such people should not be excluded from donating.

The Convener: That would be hard to legislate for.

Dr Lyons: We may be talking about two different issues. Dr Breen is talking about post-mortem donation, but we are discussing live donation. We have no difficulty with excluding live donation, but post-mortem donation is another issue.

The Convener: You think that even if somebody has incapacity in other terms, they are capable of making a decision about post-mortem donation.

Dr Lyons: The question that we were asked was about live donors; it was about the donation of

tissue by people while they live and when they will continue to live. We were not discussing donation after people die. Have I misunderstood the question?

The Convener: Does Dr Breen think that people should be able to make a live donation?

Dr Breen: It depends on their state of capacity or incapacity. We feel that, with consultation of relatives and appropriate bodies, they should be considered to have the potential to give post-mortem donations.

14:15

The Convener: I am not sure that we are much further forward with that. If somebody authorises the use of their body and subsequently suffers incapacity, which means that they are not then capable of making a decision about withdrawing the original authorisation, should the original wishes be respected or should it be considered that a decision has not been made? That is a slightly complicated example, but severe head injury can result in incapacity where there was none previously.

Dr Lyons: That question is different to that which we were asked before. You asked previously whether somebody who is living can go on living and donate tissue.

The Convener: You are saying that they cannot.

Dr Lyons: They cannot, other than in exceptional circumstances. We are now talking about whether—

The Convener: No. Even if we are talking about living donors, somebody might have signed up to the organ donor register and agreed that their organs can be used in the event of whatever happening—although that would of course apply if they were dead. There is an issue about the withdrawal of consent, which we are trying to work through.

Dr Lyons: I return to what we said earlier. I agree totally with the BMA that there might be a situation in which a person has made an advance statement that if somebody in their family would benefit from a kidney while they are still alive, they would donate it. That is an unusual and not readily foreseeable situation, but I would be happy to discuss it; I see merit in that. We are now talking about people who have said "After my death I wish organs of mine to be used for transplantation or research", but who before their death become incapable.

The Convener: Yes. Such people will have the right to withdraw their consent, but if they have incapacity, their capacity to make a decision about withdrawal will be gone.

Dr Lyons: When it comes to the crunch, the decision has to be made on the basis of the person's wishes and any evidence that they might have changed their mind. If there is no such evidence, the previous wishes should be stuck to. Discussions are going on around the code of practice and part 5 of the Adults with Incapacity (Scotland) Act 2000 as to whether we should obey somebody's previous or present wishes. Where somebody has made a capable decision, unless there is clear evidence that they have made statements that would significantly alter it, it should stand.

The Convener: Should nearest relatives have the same power to authorise donation for adults with incapacity as for others?

Dr Breen: We have found that people with Parkinson's and Alzheimer's who have decided that they wish to donate their brains for research have made that decision in consultation with their nearest family or friends. When a person has decided that he or she wishes their brain to be donated to a brain bank, for example, it is done with the prior knowledge that they might suffer dementia at some stage or might become incapacitated. The fact that a person has made that wish known beforehand should be respected.

Veronica English: We agree with that.

Shona Robison (Dundee East) (SNP): I move on to authorisation. The BMA has stated that a definition of authorisation is required in the bill. Will you summarise your reasons for saying that? Do the other panel members agree with that?

Veronica English: The main reason is that authorisation is a new concept. We have traditionally talked about consent, even though we agree that authorisation is a more appropriate term. A definition would help to ensure that people understand why it is being used. The framework of legislation is one thing, but we need to get the definition used in practice. Anything that helps to achieve that will be useful.

Dr Breen: We agree that the term "authorisation" should be used. However, it should be explained either to the person concerned or to their nearest relatives, following death, what exactly is meant by it.

Dr Lyons: I agree. The word "consent" suggests an on-going process between doctor and patient. Here we are dealing not with an on-going process, but with something that is decided in advance. The term "authorisation" is better.

Shona Robison: In its written evidence, the BMA says that it is concerned

"that the requirements for 'authorisation' differ depending upon the activity being undertaken."

You have touched on that issue again today. In its submission, the BMA also states:

"This may cause confusion and uncertainty."

What would you like to see? Are you calling for authorisation to be the same for the different activities? Would not that cause other problems?

Veronica English: It is important that our members are clear about what authorisation they require. Sometimes authorisation needs to be in writing, sometimes it can be verbal, sometimes one witness is needed and sometimes two are needed. That is incredibly confusing. We are worried that our members may inadvertently breach the law. They may think that they need only one witness when they need two. One standard form of authorisation would solve such problems because the situation would be clearer and people would know what the requirements were.

Shona Robison: Would you standardise authorisation at the higher level of two witnesses, rather than one?

Veronica English: Not necessarily. We need to consider the practicalities, because authorisation includes registration on the organ donor register, for which two witnesses are not required. In evidence to the committee, Will Scott said that although the requirements look confusing in the bill, they will be clearer when they are properly set out on consent forms. There is some truth in that. However, our main concern is that our members will be confused. We need to find a way of getting over that problem. The issue is not just the number of witnesses. Authorisation of the part 1 activities can be given verbally by an adult, but must be withdrawn in writing. We are not clear about why it must be made more difficult for someone to withdraw authorisation than to give it. Authorisation for children must be in writing, but it is not clear why there should be a higher threshold for mature minors than for adults.

Shona Robison: There are inconsistencies.

Veronica English: Absolutely.

Dr Breen: I agree with what has been said.

Dr Lyons: I have nothing to add to that.

The Convener: That was commendably brief.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I will focus on the BMA's written evidence—specifically, on the issue of presumed consent. You make it quite clear that you are very much in favour of presumed consent, but the bill moves away entirely from the notion of consent—presumed or otherwise—towards authorisation, which we have just discussed. You say that one reason why you are keen on presumed consent is that survey after survey shows that up to 90 per cent of the British people are in favour of donation. Are you concerned about the other 10 per cent or more of people who do not want to donate? In previous evidence, we have heard that people have been very careful when asking families about donation, so that there is no dissonance. If the state takes someone's body and becomes responsible for it, leaving that person's parents, children or other family members with no say in what happens to it, will not that cause trauma, upset and difficulty? That will not help us to achieve the aim of the bill, which is to increase the amount of organ donation.

Veronica English: I think that that would cause "trauma, upset and difficulty", but it is not what we are proposing. We are proposing a system of presumed consent with safeguards. I will explain briefly how we envisage the system working. A shift to the presumed-consent system would need to be preceded by a great deal of high-profile publicity, which would have to make it clear to people exactly what that shift would mean. It should be made easy for people to sign up to opt out of organ donation—they should be given many opportunities to do so. The fact that people who did not want to donate would be able to record their wishes represents an improvement on the present system, under which there is no way for someone who opposes donation to record those wishes formally. The proposed system would enable such people to express their wishes more clearly and would provide them with assurance that their wishes would be respected.

Mike Rumbles: Do you not see that that is not the case, because even if there was a system for people to register their objection to donation, many people would not do so because people do not do such things? It is a fact that many people who do not register would be quite willing to have their organs donated.

Veronica English: That is why we are not proposing a strict opt-out, such as the one that operates in Austria. In Austria, if someone has not signed up to the opt-out register, their organs will be available for donation. That is not what we are suggesting. We are talking about a system in which the relatives will still have a role to play.

In practice, what would happen is that it would be mandatory to check whether a potential donor was on the register. If they were not, the relatives would be approached and informed that there was a presumption to proceed with donation. We would then ask whether they were aware of whether the person had an objection to donation or had had

any discussions that indicated that they had an objection that they had not registered. If there was no opposition and no indication that the individual had an unregistered objection, the intention would be to proceed unless it was clear that to do so would cause severe distress to the relatives. The relatives' views would still need to be taken into consideration. In exceptional cases, it would be possible not to proceed with donation, if it was clear that to do so would cause severe distress to the relatives.

There are safeguards. The state would not be able just to take people's organs on the assumption that they were available for donation. You spoke about the state making a presumption, but that presumption is based on evidence that 90 per cent of the population want to be donors.

Mike Rumbles: We have responsibility for scrutinising the bill. If an amendment that sought to incorporate a system such as you propose was lodged, we would have to examine the issue. Basically, you are asking us to legislate for a situation in which the state would have control over people's bodies. Is that correct?

Veronica English: No. Our proposal is about the individual's wishes. There would be the opportunity to opt out of donation and the relatives would be talked to.

Mike Rumbles: Let me put my question in a different way. You are saying that there would be an opportunity to register an objection. When there was a potential donor, the register would be checked automatically. If no objection was recorded in the register, consent would be presumed and the body could be used for transplant or organ donation. In other words, in practice the family would have no legal basis on which to object.

Veronica English: That is not correct. Under our proposal, the involvement of the relatives would be written into the legislation. That would be an important part of the presumed consent that we support.

Mike Rumbles: Are you saying that the relatives would have a veto?

Veronica English: They would be able to say that the individual had an unregistered objection, so there would be additional scope not to proceed. The legislation would give authorisation to proceed; it would not require that donation be proceeded with. In any circumstance, if it was clear that to proceed would cause severe distress to the relatives—

Mike Rumbles: Would the relatives have a veto?

Veronica English: No, but they could say that the individual had suggested that they did not wish to donate.

Mike Rumbles: You are saying that, at the end of the day, even if the relatives did not want donation to go ahead, it could happen anyway.

Veronica English: That is what the current proposal is—the bill will not give relatives a right of veto. It says that the individual's wishes should take precedence.

Mike Rumbles: That is correct, but what you are proposing is quite different to what is in the bill.

Veronica English: It is. Our proposal turns the situation round the other way. We are saying that we know that the majority of people—90 per cent—support donation, but that not everyone gets round to making those wishes known. Under our proposal, we would presume that consent had been given. Unless there was evidence that someone did not support donation, that would be a reasonable presumption because we know that 90 per cent of people are willing to donate. There would still be scope not to proceed with donation.

The bill is based on the principle of respecting individuals' wishes. Arguably, presuming consent respects the wishes of individuals to a greater extent than would an opt-in system. We know that 90 per cent of people are willing to donate, so, if we have to presume something, it is arguable that we should presume consent rather than objection.

14:30

Mike Rumbles: You just said that we should "presume consent". How can that be fair and equitable? You would be making a huge presumption. The bill focuses entirely on authorisation. In effect, what you are saying is, "We know best."

Veronica English: No, because we base the presumption on knowing that 90 per cent of the population want to donate.

Mike Rumbles: But 10 per cent do not.

The Convener: When you say that 90 per cent of people do not mind, what you mean is 90 per cent of people who were asked in a survey.

Veronica English: Repeated surveys.

The Convener: Yes, but let us be clear about this. Those people have not signed the register.

Veronica English: That is right. There are three different groups of people: those who strongly want to donate their organs and who will go out of their way to ensure that their views are known; those who strongly do not want to donate their organs, who will also go out of their way to make their views known; and the majority of people, who

are quite happy to donate but who never get round to doing anything about it or registering their wishes. For a person in the third group, the relatives have to make a best guess of what the person's wishes were. Often, relatives will go for the default position, which is not to donate.

Dr Lyons: My day job used to involve looking after people with advanced dementia, so I often dealt with the relatives of people who were dying. I want to make some comments on that basis, rather than on behalf of the Mental Welfare Commission.

When somebody is dying, it is a very difficult and stressful time for relatives. There are many changes and many decisions to be made. I wonder whether it would be better for relatives if the default position was to use the person's organs for transplantations. We would not then be asking the relatives for authorisation; we would presume authorisation unless the relatives objected. The question that would arise then would be whether objectors should have a right of veto, or whether there should be a discussion in which the objectors' views must be taken into account.

I wonder whether such a presumption would be better, kinder and fairer for relatives who are in a very difficult situation. Would it be better than asking them to make a decision to authorise? I offer that just as a thought.

Veronica English: The evidence from countries that have operated this type of system is that many relatives find it easier because they are not being asked to make a decision when they have recently been bereaved.

Dr Breen: The Parkinson's Disease Society deals specifically with a tissue bank. We have found that education and information are key factors, and we can tell members of the society—from whom, of course, the message then spreads out—that people are very willing to donate their brains after death. I agree with what was said about 90 per cent of people being willing to donate, but I would still say that it should not be assumed that a person should donate unless they have said otherwise. Educating people properly beforehand would get over some of the difficulties that have been mentioned.

Mr Macintosh: May I—

The Convener: I really want to move on, because we are already—

Mr Macintosh: I wanted to raise a point that was made in evidence by the British Heart Foundation, which is not represented here today. The BHF has put forward a different argument.

The Convener: Well, there will be very different arguments.

Mr Macintosh: The bill already contains presumed consent of a certain type. The British Heart Foundation's point is that any system should be based on trust and that going as far as the BMA suggests would undermine public trust. I wondered whether the BMA agrees with that.

Veronica English: We would not want to make changes without public support, but we believe that there is growing public support for what we propose. I admit that not everyone has been surveyed, but surveys over the past five years have shown increasing support. The most recent survey, in May this year, showed 60 per cent support—and that is before we have had a sustained debate and educational campaign. Public opinion is crucial and we believe that there is growing support for our proposal.

The Convener: I think that we should move on.

Kate Maclean (Dundee West) (Lab): I have a question on withdrawal of authorisation, which is an issue that we have discussed at the past two committee meetings. Although the subject seemed not to challenge some of the witnesses, it certainly challenged committee members.

The organ transplant co-ordinators raised the fact that relatives can withdraw authorisation for organs to go for transplant and said that they are concerned about the stages at which that can happen. From our questioning of witnesses last week on the issue, it seems that there is a point of no return. We feel that the bill should specify the point after which a relative is not allowed to withdraw authorisation. Obviously, lives will be jeopardised if consent is withdrawn when someone is on the operating table and has had their organ removed. Surely it is unreasonable for a relative to be able to withdraw consent at that stage. What is the reasonable cut-off point for withdrawal of authorisation? Is it once authorisation has been given or at a stage beyond that?

Veronica English: I agree that there comes a point at which it is no longer practicable to withdraw authorisation, which would be in the type of circumstances that you described. I am not in a position to say whether the cut-off point should be at a particular stage. I would want to talk to transplant surgeons about how the procedures work and about the point at which the cut-off should be set.

It is crucial that guidance is made available on the subject to set out clearly the stage beyond which it would no longer be possible to withdraw authorisation. Relatives must be informed either when they give authorisation or when the procedure is discussed.

The Convener: No other member has a comment on that subject, so we move on to the issue of living donations.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): My questions are on definitions, the first of which relates to the Parkinson's Disease Society submission and ties in with the British Medical Association's suggestion that it would be a better idea to have a separate authorisation for research and education. I also note the point that the BMA made on post mortems. I think that it would like the general public to be clearer about what a post-mortem examination is.

The other question relates to a subject that we have discussed already, which is body parts. It was said that the brain and not slices of the brain is considered to be tissue and a body part. It would be helpful if the panel could expand on those definitions.

Dr Breen: Obviously, it is difficult to define the brain as a tissue or an organ, as our knowledge of the brain, how it functions and what exactly can be done with it after death is evolving all the time. Our main concern was in relation to taking tissue for research, particularly for stem cell research, in which we are very interested. When people think of stem cells, they tend to think of embryonic stem cells, but an increasing amount of evidence suggests that one can take stem cells from the brain that could subsequently be used for transplantation. We think that the position in relation to research needs to be clarified.

Dr Turner: You would like that to be made clearer on a form so that people could agree to it?

Dr Breen: Yes.

Dr Turner: That might also be what is in the mind of the BMA.

Veronica English: There are two parts to your question about having a separate authorisation for research. From our reading of the bill, it appears that the authorisation for a post-mortem examination will be an all-or-nothing authorisation that includes authorisation for use in education, training, audit and research. A good argument can be made for seeing education, audit and training as integral parts of the post-mortem procedure. That is explained to people when they give authorisation.

Our slight concern is that although some people are willing to give authorisation for a post-mortem examination, others are not because they are concerned about residual tissue being used for research. We think that, if people were given the option of agreeing to a post-mortem examination either with tissue being used for research or without tissue being used for research, the number of people who would agree to a post-mortem examination would increase. Our main argument is that some people do not go for a post-mortem examination if they have to sign an all-or-nothing authorisation.

The meaning of the terms that we use must be unambiguous. It is essential that people who are giving authorisation are clear about what we mean by "organ" and "tissue". We are less certain about whether that needs to be on the face of the bill; perhaps it should be dealt with in guidance or codes of practice.

Dr Turner: Could that be dealt with on the form that people will sign?

Veronica English: It could be. You would want to have a consistent approach across Scotland; you would not want different places to have different forms.

Dr Turner: Should something about stem cells be written on the form, along with an explanation, because not everyone will know what they are?

Dr Breen: I do not know whether one would use the term "stem cells" because, as you say, many people would not know what it means. If one said that research could include subsequent use of the tissue for regenerative purposes, for example, I would be happy with that. The form should define exactly what is meant by research rather than leaving it open to an individual's interpretation.

Kate Maclean: I want to ask about authorisation for live donation. I would like Veronica English to respond. I understand that the BMA agrees with the proposals in the bill but that the General Medical Council has a different view in relation to live donation for under-16s. Earlier, I think you said that the GMC is in favour of mature minors being able to consent to living donation if adequate safeguards are put in place. However, I do not think that there are safeguards adequate to stop a child feeling that they are under pressure, particularly if their donation would save the life of a sibling, and I definitely do not think that safeguards can be put in place to protect a child from the pressure that they would put themselves under if a sibling died because they had not agreed to a live donation. Would keeping the bill as it is rather than amending it be better in terms of safeguarding a mature minor?

Veronica English: A number of issues came up when the medical ethics committee discussed this issue last week. One is that setting the age at 16 would exclude someone who was 15 years and 11 months of age. People mature at various ages and the important aspect is maturity rather than chronological age.

Our general view is that mature minors should be encouraged to make as many of the decisions about their care and treatment as they can, and

our position on the issue that we are talking about goes along with that. We acknowledge that there might be more pressures on a younger person, particularly as they will be dependent on their parents. Of course, a young person who is sufficiently mature to make a decision for themselves can gain satisfaction from the altruistic act and, if they are not allowed to donate, could also understand that they might have been able to save their sibling.

There need to be safeguards. The safeguards that are proposed under the Human Tissue Act 2004 in England—and I understand that similar procedures might be used for authorising living donation in Scotland—involve the person being interviewed by a third party specifically about coercion. We need to be conscious of the fact that there might be coercion, but we do not need to assume that there will be sufficient coercion in every case to mean that procedures should not go ahead.

Kate Maclean: I am not as concerned about coercion as I am about the repercussions for a mature minor who decides not to go ahead with a live donation. I am thinking about the kind of pressure that a mature minor might be put under if they decided not to donate a kidney and their sibling died. I feel that the state should protect mature minors against having to make such a decision. If the state made the decision for them, they would not have to deal with coercion or the repercussions.

Veronica English: That is a good point. However, we need to view those people as being sufficiently mature to make a decision, although the question of where to place the chronological age limit remains.

Coercion might come into play in relation to other family members as well, including adults. We need to be aware of that and take steps to provide protection.

The individual will have a discussion about their intentions, but that does not mean that they have to go ahead and donate—they might decide that they do not want to donate.

14:45

The Convener: We have probably exhausted our questions. I thank the three witnesses for coming in. If anything occurs to you that you want to follow up, please contact the clerk directly and it will be included in our deliberations.

I ask the next panel of witnesses to come to the table.

I welcome Geraldine MacDonald, Helen Farquhar and Donna Leese from the Scottish Organisation Relating to the Retention of Organs. If the witnesses would like to say anything before we proceed to questions, I ask them to be brief.

Geraldine MacDonald (Scottish Organisation Relating to the Retention of Organs): SORRO welcomes the opportunity to appear before the committee in support of the Human Tissue (Scotland) Bill. Our particular focus is the retention of organs at post-mortem stage. As I am sure members know, families have waited a long time for the bill and they have worked closely with the independent review group and the Scottish Executive to ensure that the initial questions that we posed to the then Minister for Health and Community Care, Susan Deacon, were answered to our satisfaction. Our concerns were that no other family should find that their baby's organs had been removed without their knowledge or consent and that a change in the law was essential. We will always support research and education as long as they are based on appropriate authorisation and in the expectation that the cause of our babies' deaths will be discovered.

Many of our parents would have given authorisation to retain organs had they been asked to. Our families' initial problems came from the Procurator Fiscal Service's lack of open engagement with families and parents. It would be helpful if the Lord Advocate would examine closely the bill's contents to avoid any further problems.

We believe that the bill will help to restore the trust that has been lost because of past practice in the NHS in Scotland and, therefore, we support the bill.

The Convener: You heard the exchange with the previous panel about adults with incapacity who, for whatever reason, are not capable of making the kind of informed decision that you or I would make. Have you been consulted on that aspect?

Geraldine MacDonald: No.

The Convener: Do you have any views on the position of adults with incapacity? I appreciate that your focus is children rather than adults.

Geraldine MacDonald: I do not think so. Our expertise does not lend itself to that area.

The Convener: That is fair enough. You mentioned concerns about your relationship with the Procurator Fiscal Service. How can its process in relation to post mortems be improved? Has the bill got it right?

Geraldine MacDonald: The bill covers hospital post mortems; it does not really cover the Procurator Fiscal Service, which is where our big concern lies.

I know that the Procurator Fiscal Service has changed how it operates and is more open with families. The lack of openness was the downfall at the time of the organ retentions—the process was kept secret. We hope that the Lord Advocate and the Procurator Fiscal Service will look at the bill and take note.

The Convener: Could specific practices be done better than at present or are you aware that things are already changing for the better?

Geraldine MacDonald: Things are changing for the better. We do not want to go back to what happened in the past; we are looking to the future. As you know, we have campaigned for five years to ensure that what happened never happens again, and I have faith that it will not. I hope that the Lord Advocate takes that on board and supports the bill.

The Convener: Shona Robison has questions about authorisation.

Shona Robison: You listened to the previous exchange about authorisation. Does SORRO have concerns about the various processes? Some require verbal and some written authorisation; some require two witnesses; some require one witness; and some processes are different for different ages. Will you comment on that?

Geraldine MacDonald: Authorisation should require two witnesses. I do not care which way it goes, as long as the authorisation is written down and is witnessed by two witnesses, so that there is clarity throughout.

Shona Robison: A couple of issues might be of particular interest to you. For example, should medical staff be allowed to be witnesses for hospital post-mortem authorisations? Do you have a view on that?

Geraldine MacDonald: No. I do not think that it makes any difference. I assume that a medical person would take the authorisation. However, when we did peer-review visits with NHS Quality Improvement Scotland, we talked to pathologists and all the medical staff, who said that it would be helpful if they had bereavement officers in post. That would alleviate any problems, whether medical staff or the bereavement officers took the authorisation. Obviously, the big concern is money.

Shona Robison: So you would not have particular concerns about medical staff giving out post-mortem authorisations.

Geraldine MacDonald: No.

Shona Robison: How should we deal with disputes between parents or with authorisation where there are no parents? Those are difficult issues.

Geraldine MacDonald: The families that we have discussed that with feel that, to avoid any confusion, if there is a dispute, the post mortem should not go ahead. There may be disagreement in a split family. The situation is difficult. If the husband and wife are confused and disagree, the post mortem should not go ahead.

Shona Robison: Should weight be given to the parent who has had most to do with the child's upbringing, rather than to the more distant parent?

Geraldine MacDonald: How long is a piece of string? There could be disagreement for many reasons. One parent might say, "I don't like the way you're bringing up my child." A judgment cannot be made. To keep everybody right, if there is a disagreement, the post mortem should not go ahead.

The Convener: How involved were you in the lead-up to the introduction of the bill? Did you find the process useful and helpful?

Geraldine MacDonald: In what respect?

The Convener: Were you consulted? You talked about visits and so on. Were your views taken into account in the lead-up to the bill?

Geraldine MacDonald: Yes, they were. The McLean report was published two or three years ago. Since then, consultation has been on-going. We have had information from the Scottish Executive. We went to the publication of the post-mortem standards earlier this year. We were consulted all along and we responded in turn.

The Convener: Short of hanging, drawing and quartering, which is probably your immediate idea of an appropriate penalty, are the penalty proposals in the bill satisfactory? Looking at them objectively, do you feel that they are appropriate?

Geraldine MacDonald: Families initially said to Susan Deacon that the bill should include provision for penalties for anybody who retains organs from a post mortem without anybody knowing about it. I think that the bill's penalties are fair. However, I am sure that the issue will never arise, because there is no chance of pathologists getting into penalties. We whole-heartedly support pathologists, who have had a raw deal. We now understand where they are coming from.

The Convener: Are there any further, brief questions?

Dr Turner: Did the witnesses hear the discussion with the previous panel on a separate authorisation form for research? Would the witnesses like a form to make it clearer that they might be signing up for a separate request after a post mortem?

Helen Farquhar (Scottish Organisation Relating to the Retention of Organs): I have something to say on that. My baby Amanda Jane died a long time ago—42 years ago—and members will know that, at that time, we were not told anything at all about what was happening. I did not find out what had happened to my baby until five or six years ago, when I got her hospital papers and saw what they had done to her in the post mortem. I suppose I was naive, because she died of a heart condition and I thought that they would just examine her heart. That was the normal procedure that I would have expected. However, they took out her brain, liver, kidneys—you name it, they took it out. That really upset me when I read about it.

The worst thing that I found out, though—about four years ago—was that she had been used for nuclear research as well. They had removed her femur for nuclear testing, which was a separate thing. I remember reading in the papers that the hospital said that that was part of the post mortem, but it was not in the post-mortem report. I was not asked up to the hospital until a month after she was buried to talk to a doctor about research that they were doing at the hospital. The thing had already been done long before I was asked to speak to the doctor. I was not told what it was. He just asked a lot of questions about my diet and about what I had done when I was pregnant.

Dr Turner: Obviously, it is important that we all know what we are talking about—definitions matter.

Helen Farquhar: Yes. Doing research is different from doing a normal post mortem. I was shocked when I found out what they had done to her.

Geraldine MacDonald: The new authorisation forms were supposed to be published last year, but they are still being made up. However, the sample form that we received and discussed had separate parts for authorising research and retention, and we were happy with that.

The Convener: Thank you. You are free to go. You can sit in and listen to the rest of the meeting, but I am not sure that you would find it interesting, because we are moving on to budget matters. Thank you for taking the time to come in.

Geraldine MacDonald: Thank you.

Budget Process 2006-07

15:00

The Convener: I remind committee members that we opted to follow the Finance Committee's guidance and focus on specific initiatives as well as on the health budget as a whole. We have already taken evidence from officials on the efficient government proposals. This week, we have with us Andy Kerr, the Minister for Health and Community Care, and those same officials.

I welcome the minister to the meeting and ask him to make any brief introductory remarks that he wants to make. After that, we will move on to questions.

The Minister for Health and Community Care (Mr Andy Kerr): Thank you for your welcome, convener. I reconfirm to the committee our drive for a more efficient and effective health service. Since I became Minister for Health and Community Care, my discussions with chairs and chief executives in the health service have focused on that drive. We need to deliver efficient services while maintaining high-quality services for the public. I also want to put it on the record that the efficient government initiative will reinvest resources in the health service. It is not a question of removing resources for spending elsewhere; it is about making sure that we realign resources to meet patient need—that is the driver of our work.

I know that the committee has some specific areas of interest and that there was a lot of discussion of those at the committee's meeting two weeks ago. They include the logistics project, prescribing and the work that we are doing with the Scottish Commission for the Regulation of Care. I am happy to expand on those matters and any others that the committee wishes to raise. I will not spend any further time on opening remarks.

The Convener: Thank you. Your letter to me has been circulated to the committee, so members are aware of your written evidence.

Mr Kerr: On the subject of the letter, I advise you that although the cost of employing prescribing advisers is given as £2.5 million, the actual total cost is £3.2 million. We got the figure to you as quickly as we could but some additional support costs and other costs were not identified. I wanted to correct that for the record.

The Convener: Thank you.

Mike Rumbles: I tried to get an answer to a technical question from the civil servants who appeared at our meeting two weeks ago. I wanted to know about the process that is involved in the efficient government initiative, making savings and

reallocating funding. Did you, as the minister, say to your department, "I want a 2.5 per cent saving in this financial year and a 5 per cent saving by 2007-08. Go away and find them"? Alternatively, did you say, "We need major savings. There must be some savings in there. Go away, look at your department and come up with figures"? Which of those two methodologies was employed—was it one or the other?

Mr Kerr: It was the other—in other words, the latter of the two options that you described. I want to save as much as I possibly can—I do not want to rest with the numbers that we have given you. In the Health Department, we have a constant drive to realign resources to ensure that we can do even more with the substantial budget that is available to us.

The outcome of the process is based on our previous experience of efficiency in the health service and on the valuable work that we have been doing on the shared services agenda, procurement and logistics. In those areas, savings have already been made. We used that work as the formative stage for developing our plans. Two weeks ago, if I recall correctly, Scott Haldane tried to indicate to you that there is a bottom-up process in relation to the health expenditure that we can realign and redirect to patient care. There was no instruction from ministers saying, "I want X per cent." The instruction was, "I want to get as much as I can out of our service. The more money we save on logistics, procurement, shared services, streamlining care, e-booking systems and all the other initiatives in which we are involved, the more money goes to patients." That was my approach and I will continue with that focus throughout.

Mike Rumbles: I am glad to hear you say that there is a bottom-up approach. I absolutely agree that that is the right approach. However, the planned savings are around £50 million from NHS procurement, £20 million from improved prescribing of drugs, £10 million from NHS support services, £10 million from NHS logistics and exactly £1 million from care commission efficiency savings. It seems to me that those round figures are indicative of an approach whereby the department was told to come up with certain savings.

Mr Kerr: I noticed your fascination with zeros in your exchange with the chief executive at the committee's meeting two weeks ago. Given the scale of the budget and the billions of pounds that are available to us, we have a process of setting targets and rounding up.

If you recall, I think that we indicated in the letter to the convener that the care commission's savings are £1,000,700. You should not get suspicious of what we are saying or try to look the gift horse in the mouth. I am setting out the absolute parameters of what we should be able to save from these processes. We have aggregated the initiatives that we have undertaken—the umpteen procurement processes that we have centralised, the e-auctions that we have carried out in relation to the revised procurement process and so on—and have given you a figure that is expressed in round numbers. Those numbers are minimum levels and I want to exceed them.

We are not saying, "Go and get me £50 million out of procurement"; we are examining what we have managed to do in the past and rounding up the figures that that historical analysis shows us. It would be odd for an organisation that is the size of the health service—the biggest employer in western Europe, with a budget in billions of pounds—to say that it will save, for example, £47.600 million. The figures are aggregates and are levelled out. Nevertheless, they are targets that we will meet, if not exceed.

Mike Rumbles: I am delighted to hear that. I would like the civil servants to tell me why they could not tell me that when they appeared before us at our last meeting. I thought that that was odd.

Mr Kerr: I had great joy watching the DVD of the committee's deliberations of the week before last. To be fair to the officials, I think that they tried to answer that question. Either Adam Rennie or Scott Haldane said that the figures were set but that the reality could be on either side of them, and I want the outcome to be on the upper side, as opposed to the lower side, of the figures.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): Following your lead, minister, I would say that I think that the Executive anticipates cash savings of £342 million and time-releasing savings of £174 million. What proportion of the anticipated savings has already been reallocated and where has it been allocated to?

Mr Kerr: Under each of the headings, we have identified the money that we need to free up in the health service at board level so that we can continue to innovate in the delivery of services. The incomings and the outgoings have not been finally determined, but we are saying to boards that they must deliver on this agenda in order to free up resources and to spend money on patient care. There is no exact balance sheet for the money that we will save through efficient government and where it will be spent, but we are clear that that money must be reinvested in patient care. In the context of historic growth in NHS budgets, that will allow us to release even more resources to go into front-line patient care. The money will simply come through the budgeting process of each health board. Money that we save at the centre will also go into patient priorities. As we develop our budget in future years, we will take

cognisance of the savings and will include them in our plans.

Mr McNeil: You might have to go over that again for my benefit—the fault might be mine. Are you talking about notional savings that you anticipate that the boards will make? What if they do not make those savings?

Mr Kerr: They will make those savings. If I do not achieve the savings that I am responsible for in some of the central services, there will be a shortfall in my budget, which I will need to take action to deal with.

The process is built on extensive and hard monitoring. As we go along, I will be able to monitor—on either a quarterly basis or a six-monthly basis, depending on the length of the lead-in time of the projects—the progress that the boards are making towards achieving those savings.

Mr McNeil: You will not be able to reallocate funds to other services, so some services could be caught in a vicious cycle. What happens if the boards cannot achieve the savings and therefore cannot reallocate funds to front-line patient care?

Mr Kerr: It depends on the individual circumstances. For instance, if a board is, for some reason, sitting doggedly outside e-procurement and knowingly buying a nurse's tunic for £20 when we can get it for £15, I shall deal with that directly. In other words, I shall, if necessary, instruct that board to become part of the e-procurement process, unless it can provide me with a reason for not doing so. This is simply an extension of my previous life as Minister for Finance and Public Services, when I told local authorities that even if they did not take advantage of e-procurement and shared services, we would assume that they had done so and remove the resources from their budgets.

However, I do not think that that will happen in the health service. There are already good examples in the service of people embarking on patient-focused booking and system redesign, and I simply want to ensure that that good practice is spread throughout the whole organisation. There are no excuses and I expect health boards to achieve the savings. As I monitor the performance of the health service on that minimum quarterly basis, I will know what is happening, and if I need to draw attention to certain boards and chief executives, I shall do that to ensure that the savings are made, because they need to be reinvested.

Mr McNeil: In front-line services?

Mr Kerr: Absolutely.

Mr McNeil: Do you include in front-line services the objective of reducing the health gap between the most affluent areas and the most deprived areas?

Mr Kerr: Absolutely. I shall respond to the Kerr report in due course; I cannot tell you when, because the matter is with the Parliamentary Bureau and that is how the bureau works—as you know better than I. However, when I respond to the report in Parliament, you will see that health improvement and health inequalities will be a significant part of our attempts to reconfigure our health service, as identified in the Kerr review. That is where we need to find the resource to deliver change in the health service. Therefore, during that process, I expect not just to have the so-called normal budget of the health service but to achieve the additional resources that we can reallocate to those priorities. That is critical to the implementation of Kerr and to our challenge around health inequalities.

Mr McNeil: Those initiatives will depend partly, but not solely, on the reallocation of resources. Will there be new money in there for them?

Mr Kerr: I would certainly argue that the response to Kerr and our challenge around health inequalities will not solely rely on the realignment of resources through the efficient government programme. We are doing many good things in relation to health inequalities at the moment that do not rely on realignment.

Shona Robison: Four NHS boards currently have an overspend totalling nearly £62 million, and Audit Scotland has claimed that the overall deficit is increasing annually. At the same time, you are saying that you expect efficiency and time-releasing savings to be made. If you are so confident that they can be made, why are you not being more specific about where the money will be reallocated to?

Mr Kerr: First of all, you paint a picture that I think is inaccurate.

Shona Robison: That is what Audit Scotland has said.

Mr Kerr: There is one board with a significant deficit—Argyll and Clyde NHS Board. The other boards—Lanarkshire, Grampian and the Western Isles—have delivered to me a five-year recovery plan that clearly points out how they will recover their situations. There is a clear route for how they will respond to their current deficits, so the picture that you painted of four boards with deficits of £62 million is not quite how I would describe the situation. There is one board that sits outside that picture quite dramatically, and you will appreciate the action that we have taken in relation to it. The other boards have presented to me a recovery plan, which has been signed off by the NHS finance department in concert with the boards to

ensure that we achieve that plan. Let us get that matter resolved.

If you look at what we are seeking to achieve, you will see that the aggregation of procurement—the installation of management systems around how we procure in the health service—the work that we are doing around logistics and patient-focused booking and, indeed, all our redesign work will have an absolutely positive effect on our ability to realign resources. We are simply learning. If you look at the best of the private sector logistics companies and consultants, such as Tibbett and Britten, and other companies, such as Tesco and Marks and Spencer, you will see that they have well-honed logistics operations. We simply want to be part of that work and to learn the latest about logistics. What we are trying to resolve in the health service is basically supply-chain management. It is a matter of looking at the patient journey, or the product journey, and of ensuring that we cut the journey back to the most efficient way of doing things; that is what we are going to do.

I am confident that the savings can be obtained if we simply re-engineer the processes, because such models exist elsewhere in the public and private sectors and we want to adopt that best practice in the health service. That is why I am confident that we will achieve what we want to achieve.

15:15

Shona Robison: I take it that the recovery plans that have been submitted include the cash-releasing and time-releasing savings.

Mr Kerr: I am not conscious of the absolute data. Kevin Woods may be able to comment.

Dr Kevin Woods (Scottish Executive Health Department): When a board is in deficit in the way that Shona Robison described, we require a separate recovery plan for it to show us how it will achieve recurrent balance over a period. It also has to deliver its additional 1 per cent efficiency savings. At the end of July, which is early in the financial year, something like £25 million of savings had been made throughout Scotland, which is 28 per cent of the target. Therefore, we are on track to deliver the efficiency savings.

Shona Robison: So that is a yes. The recovery plan takes into account the additional savings that you require.

Mr Kerr: The boards have to do both.

Shona Robison: Going back to Duncan McNeil's point, if it happened that a health board was not going to be able to make the savings, perhaps because they cannot get their sickness absence under control or because consultant productivity does not rise as you expect it to, what would be the result of that failure? Would the health board have to compensate for that from within its own budget, or would the overall savings picture be considered, so that savings would perhaps be reallocated from one health board to another? How would you manage that process?

Mr Kerr: I would not reallocate money from a successful board that has taken tough decisions to one that has not.

Shona Robison: So the health board would have to find the money from within its own budgets.

Mr Kerr: If you recollect what I said in response to Duncan McNeil's question, the monitoring and analysis of reporting systems that we and the boards have show us, in relation to procurement for instance, that we are making substantial progress. Kevin Woods commented on the management of absenteeism at the previous meeting. We had a very good response to our desire to tackle absenteeism in the health service, and people want to work with us.

The circumstances that you describe are unlikely, but I expect the boards to be responsible for any deficit in the savings that we expect them to make.

Shona Robison: They would have to manage such a deficit within their own budgets.

Mr Kerr: Yes. I would need to consider whether something particular was going on. For instance, sometimes there is a human resources problem and a board cannot recruit people. However, in response to the stark way in which you put your question, I would expect the board to consume its own smoke in relation to the savings that it should have made, unless it has a good case for not doing so.

Shona Robison: Would it be possible for the Health Committee to be included in the regular reporting of how health boards are performing in relation to cash-releasing and time-releasing savings?

Mr Kerr: I would have to consider that. What I do not want is sensationalist reporting on a regular basis. Those quarterly results are short term in relation to a much longer-term process.

Shona Robison: If you are so confident that things will be fine, I am sure that you will not have a problem.

Mr Kerr: We have to be responsible with the information. Politicians have been irresponsible with information in the past.

The Convener: Surely not.

Mr Kerr: If we are tracking progress over a significant number of years I want to ensure that we do not have a situation in which a report from a board in crisis gets reported while another report, from a board that has made great achievements, does not get reported. However, I will consider the systems.

Shona Robison: I am sure that the committee will use that information sensibly.

Mr Kerr: I will decide that.

The Convener: I was taken with your "consume its own smoke" metaphor, which is not one that I have come across before.

Janis Hughes has a question on logistics reform, which the minister has already touched on.

Janis Hughes (Glasgow Rutherglen) (Lab): We have talked a lot about savings, and my question is about investment and single electronic health records, which is an issue that we discussed with Kevin Woods when he gave evidence recently and which is mentioned in your letter to the committee. I am concerned about the timescale for rolling out the single electronic health record. You say in your letter that you hope to be going to procurement next year. The timescale that we have been working to is three years, although evidence from elsewhere in the United Kingdom suggests a timescale of three to four years. My concern focuses on the new initiatives in health care provision. In my area, an ambulatory care hospital is being built at the Victoria hospital, and there is another one at Stobhill hospital; they are due to go online in 2008. Those new ways of delivering health care focus heavily on electronic patient records and data exchange. My concern is that if you are talking about a timescale of three years, 2008 is pushing it, and if you are talking about a timescale of four years, we could be looking at significant problems. What assurances can you give me?

Mr Kerr: First, to get the context right, we are not starting at year zero in relation to some of our systems. We have general practitioner prescribing and airline booking systems in many boards, and procurement is also working effectively in many boards, therefore, some systems are already working. At the centre, we have to provide the infrastructure—the plumbing—for those systems to work, and the protocols so that systems are compliant with one another.

I reassure Janis Hughes that the specification that we will produce to ensure that all systems are interoperable in Scotland's health care system will be available to the planners in Glasgow so that anything that they design is future-proofed in relation to any systems that we move to. Developing that spec is a significant issue for those who are designing systems elsewhere in the NHS. Their systems must fit with our specification, to ensure interoperability. Does that help?

Janis Hughes: It does, but my concern is that we are about to start building new buildings, and the infrastructure has to be laid now. Do we know what infrastructure is needed, so that we do not build a building that has to be taken apart or in which—this would be worse—we are told we cannot have particular systems because of the way in which the building was built?

Mr Kerr: We have planning networks; for example, the boards feed in to the department's e-health group and, recently, I met finance directors to discuss some of the work that we are doing with them. It is not as if people in Glasgow are sitting there saying, "Let's design a Glasgow system." They are aware of and plugged into the other work in the Scottish health service. I will seek to provide further reassurance in correspondence, but we are rolling out the specification and stating what we intend to do at a national level, and the boards have been part of that work. Therefore, anything that they roll out in their local environments will be able to operate with the national system.

Essentially, we are providing the bridges between the information. I note your point about what is happening in the rest of the UK. We have some very good systems in Scotland, such as the picture archiving and communications system—PACS—the general practice administration system for Scotland—G-PASS—and the accident and emergency system that we are going to develop.

Janis Hughes: They just do not talk to one another at the moment.

Mr Kerr: As I was about to say, convener, we are providing the bit in the middle—the sky store—where information can go and then be dropped in to other parts of the system.

Janis Hughes: I would welcome that reassurance in writing.

Mr Kerr: No problem.

The Convener: You mentioned prescribing, on which Jean Turner has a question.

Dr Turner: The first thing that one thinks of when making cuts is prescribing more generic drugs to get the drugs bill down. We have probably reached the ceiling on that. I assume that a good bit of the £20 million of savings by 2007-08 is to come from e-procurement. Has the £20 million efficiency saving been factored into projected spend? Do we know exactly from where we are getting the £20 million? I take it that that is the figure for Scotland.

Mr Kerr: I remind members that we are not talking about cuts but about the NHS making good

use of efficiency, e-procurement and hard bargaining with service suppliers.

A substantial amount of that resource comes from the use of generics, on which there is no ceiling. There is more work to be done in that direction, and on the use of prescribing advisers, who examine efficacy. I am amazed that we can always do more to reduce wastage in the drugs bill. Prescribing advisers, better ways of working through the pharmacy contract, better management of patients, and pharmacists' involvement in the management of long-term conditions will all drive a much harder bargain than £20 million of savings in the prescribing budget.

Dr Turner: As you will be aware, there is a difference between the primary care sector and the secondary care sector in charges for drugs. However, a crossover occurs when people go into hospital. They take their drugs in with them because doing so is easier than getting new drugs. When drugs are taken in, they quite often disappear into a void and the general practitioner has to write basically the same prescription again—only one or two items will be different. To me and to a whole lot of other people, that might well be an area in which savings can be made. However, who would get those savings?

Mr Kerr: That is an interesting question. We are dealing with the issue of inappropriate prescribing when people go back into the community. I ask Bill Scott to add some points of detail.

Professor Bill Scott (Scottish Executive Health Department): Within the next three years, a number of generic drugs will come on stream. They will cost less than their branded equivalents, which accounts for part of the savings of £20 million.

On the issue of patients taking their own medicine into hospital, our strategy for pharmaceutical care promotes the use of patients' own medicines in hospital. We have a number of initiatives around original patient pack dispensing and prescribing to ensure that the drug follows the patient around the system.

The drugs bill combines the primary care drugs bill and the secondary care drugs bill. The savings, therefore, are part of the global sum for prescribing.

Dr Turner: Will a health board be able to use the savings within its area?

Professor Scott: Yes.

Dr Turner: Will you check that?

Mr Kerr: Yes. We will regularly monitor the health boards' performance in relation to that work.

Dr Turner: Although it is cheaper to buy generics, the problem is that using generics means that the patient can get a white table one week and a peach tablet the next week. With elderly people—and sometimes with younger people—that can mean that, although money is saved, compliance is not achieved because people get confused.

Professor Scott: I agree that that might confuse patients. The first thing that I must say is that 80 per cent of prescriptions are for generic drugs. That has taken a lot of hard work on the part of front-line staff, who have worked with patients to help them to understand what generics are. Because the products are licensed in Europe, we cannot set a Scottish or a United Kingdom standard for the colour and packaging of every generic drug; that is a commercial decision. However, over the past 20 years or so, people have become used to going into a supermarket and purchasing own-brand products. That shows that the concept of the generic product is understood by the public and there is now less resistance to using generic drugs. People realise that using them is a way of ensuring value for money in prescribing without adversely affecting patient care.

Mr Kerr: Interesting work is being done in the private sector in relation to the idea that dose boxes—those boxes with compartments that say, "Monday lunchtime", "Monday evening" and so on—can be designed around the individual patient's needs. That would mean that, regardless of whether the Monday lunchtime tablet is pink, blue or purple, the one that is in that compartment is the one that is taken. Some interesting work is being done to find ways in which we can better manage patients who take a number of drugs.

The Convener: As Jean Turner has graciously conceded that we can move on at this point, Shona Robison will ask about one of the key issues that we want to raise with regard to the care commission.

Shona Robison: The care commission is becoming self-funding and I am sure that you are aware of the concerns that some organisations, particularly smaller ones, have raised about the fee level and their ability to pay those fees. The care commission's efficiency saving is estimated to be £1 million by 2007-08. Can you confirm that any efficiency savings that are made in one part of the care commission can be reallocated to other parts of the care commission and could, therefore, be used to keep the level of fees down, should the commission decide to do that?

15:30

Mr Kerr: Before I let Adam Rennie in to respond to that, I should say that I have noted with interest the discussion in this committee and elsewhere about the care commission, its fees and its impact on service providers. In other work that we are doing we are trying to ensure that we set tolerance levels in the audit process. We focus on those areas in which there is more difficulty and we allow those who are performing better a longer time between audits. Adam Rennie will advise the committee of some changes in relation to child care and childminding resources.

Adam Rennie (Scottish Executive Health Department): The care commission is resourced from the fees that it receives from the service providers that it regulates and from subsidy from the Executive, which is called grant in aid. The vast majority of the cost of regulating childminders and day care of children services is met through grant in aid. The £1 million saving from the care commission is being achieved by various changes in the regulation of childminders and day care of children services. I described those changes to the committee a couple of weeks ago. The impact of the £1 million saving is to reduce by £1 million the amount of subsidy that the Executive would otherwise have to give the care commission. That £1 million is available within the Health Department's overall budget.

Shona Robison: So it is not really a saving to the care commission at all.

Adam Rennie: It is a reduction in the care commission's total costs.

Shona Robison: That is a different way of describing it, is it not?

Adam Rennie: It is an efficiency because it is achieving the same output for a lower amount of inputs.

Shona Robison: But it will not be there for the care commission to reallocate.

Mr Kerr: Not on the basis that we give the money to do that work; it is our investment and we get the return on it.

Shona Robison: Are there any other examples of that type of efficiency saving, which is about the amount of money that comes from the Executive rather than about the money going into front-line services?

Adam Rennie: The purpose of the care commission is to regulate providers in a way that improves service quality for service users. Clearly, both we and the care commission want that to be done as efficiently as possible. In the case of childminders and day care of children services, the costs of regulating which are, as I described, heavily subsidised by the Executive, efficiency savings lead to a lower subsidy for that activity from the public purse.

For other care commission services, where the policy is to move to all the costs being met through regulatory fees, any benefits from improvements in efficiency will be reflected in lower fees being paid by service providers.

The Convener: That concludes our specific questions. We now move on to more general issues. Kate Maclean has a question on objectives and targets.

Kate Maclean: I was interested to hear that the minister watched a DVD of the Health Committee. I would say that that was an unwelcome insight into Andy Kerr's social life.

Mr Kerr: You missed the freeze frames.

Kate Maclean: If you took that a bit further and watched a DVD of last year's Health Committee meetings you would see that I asked questions about targets because I was concerned about the way in which they had been dealt with. Last year, there was a reduction in the number of targets because some were amalgamated and some disappeared altogether. It was not clear whether the targets had been met or why they had been amalgamated. One of our recommendations was that changes to the Executive's health targets should be published as a matter of course along with the draft budget so that there is some explanation for them.

It seems that last year's targets 5 and 8 have been amalgamated into this year's target 5. Will you explain why that has been done? Also, are you aware of any further changes that might be made to targets? Will you address my comment about the committee's previous request that changes to the Executive's health targets should be published? Could you comment on that—and say whether you watch all the Health Committee DVDs and whether they are available to the wider public?

Mr Kerr: I am also an avid viewer of teletext—that was a joke.

If my recollection is correct, the targets were what came out of "Fair to All, Personal to Each: The next steps for NHSScotland", in which we explained to Parliament how we saw the future delivery of services, so I hope that those targets were well explained in the public arena. I shall reflect on what Kate Maclean has said about that, but if we are both on the same page of the budget document—page 60—those are the targets that I am referring to. Are you on the same page?

Kate Maclean: No.

Mr Kerr: That is interesting.

Kate Maclean: I am not on a page at all. I do not have the document in front of me. The targets that I am talking about—the ones that have been amalgamated into target 5—surround waiting times, essentially. I do not have the document in front of me but, from memory, that is what they are for.

Mr Kerr: Those were the targets of 18 weeks from GP to out-patient and 18 weeks from out-patient to treatment, for hips, cataracts and heart interventions. I would argue that those targets were loudly announced around Parliament and elsewhere in the context of "Fair to All, Personal to Each". That is how they have become part of the budget process, because they were a significant part of the "Fair to All, Personal to Each" document. I will reflect on what you have said about clarity and will try to provide any further information that you may need on the subject.

Kate Maclean: To clarify matters, I am not necessarily saying that targets should not be amalgamated. I am just saying that it is not always clear. It was not clear last year why the numbers had gone down from one amount to another amount—I cannot remember the figures—and why some targets had been amalgamated, while others had disappeared, although that was not obvious. The targets are largely the same this year, but there has been the change where targets 8 and 5 have been amalgamated into target 5. I do not think that that is clear, so an explanation in writing would be useful.

Mr Kerr: I will reflect on that and ensure that, if there is any variance, we explain that variance to you.

Mike Rumbles: I refer to page 70 of the draft public plans, under the heading "General Dental Services". You will see that the budget heading goes from £203 million in 2002 right up to £253 million in 2005. In a statement six months ago, on 17 March, when Rhona Brankin was the Deputy Minister for Health and Community Care, she said that the spending would move from a baseline of £200 million last year to a baseline of £350 million within the next three years. We knew that six months ago, when the statement was made to Parliament, so why are the two columns for 2006-07 and 2007-08 blank in the document before us today?

Mr Kerr: If I recollect what was said at the time—I am happy to hear from Kevin Woods on that point—we are still going through a negotiation process, and the allocation of exact resource around that will be part of the outcome of those discussions. In a sense, it is to do with those negotiations about how we see that resource being spent, so it will follow through into the budget itself.

Dr Woods: That is essentially it.

Mike Rumbles: But surely Rhona Brankin said to Parliament that that money was there and that it was going from £200 million last year to £350 million in three years' time. I would have thought, therefore, that that was the entire purpose of having a draft budget for 2006-07. You have blank columns there, although you told Parliament that they should be filled in. What I am looking for is a commitment that that should be there.

Mr Kerr: My apologies. I have got you now. I think that that is fair comment. I shall find out why that money is not in the document. What we have tried to do with the specifics around that additional resource is to await the outcome of the negotiations and not to reveal our negotiating hand.

Mike Rumbles: Will you get back to us on that?

Mr Kerr: On the global amount, you have a fair point.

Mike Rumbles: Thank you.

I move on to "Modernising medical careers: the next steps", which is obviously a UK-wide reform. The aim is to reduce the time spent moving from senior house officer to consultant from 12 years to seven years, and training for the new posts is starting in 2007. Has the Executive assessed the likely impact that that will have on health care delivery, and will there be an increase in the total number of training posts available following the introduction of the reform?

Mr Kerr: Kevin Woods led on this discussion as we went around the country doing the annual reviews, so I will let him deal with your point. First, however, I will say that we have told all boards that they must ensure that they have effectively reconfigured their services to deal with the challenging fact that, instead of having someone working in an accident and emergency unit for six months, they will have them for only four months. They must consider what that means in terms of training and the help that can be provided in the environment that that person used to work in. We have been working with boards to ensure that they are redesigning aspects of their service—using ideas such as the hospital at night initiative—to ensure that they are prepared for the challenges that MMC will bring, along with its benefits. Boards have to work out how they can supplement or replace the skills that will be lost to certain working environments.

Dr Woods: Modernising medical careers is an extremely important initiative that will bring significant benefits. It is a work in progress; the implementation has already started. The key issue to which the minister is referring relates to the fact that we will have people properly trained, which

might mean that we have less time available for services in some specialties. That is why, with NHS Education for Scotland and the NHS boards, we have set in train detailed examination of the impact of MMC, specialty by specialty, board by board, so that we can assess how it will unfold on the ground and ensure that we can take the necessary action in good time.

Already, a number of initiatives are being developed across Scotland to take account of MMC. You might have heard of the hospital at night initiative, which will enable us to ensure that we have high quality services, having taken account of reducing doctor hours, which is a general trend in the NHS but is also important in the context of MMC. That work is under way at the moment and I expect a progress report later this month.

It is true that there are areas of uncertainty around MMC. The royal colleges, on a UK basis, have to give us further guidance on the curriculum that doctors in training will follow and we are also awaiting guidance from the Postgraduate Medical Education and Training Board, which oversees a lot of the relevant work.

We are very much on the front foot. We are working with NHS Education for Scotland, the royal colleges and boards to understand the implications of MMC as information becomes available. We are examining not only the cost but the practicalities of how we put effective services on the ground if there is a reduction in the number of doctor hours available.

Mike Rumbles: Although we will get more consultants faster this way, which is good news, it means that we will not have the doctors there for as long as we do at the moment.

I know that one of the Calman report recommendations was that the number of doctors should be increased. With regard to the 2007 date, do we have enough doctors coming through training at the moment?

Mr Kerr: I would argue that we do but, of course, we would want to verify that through our workforce planning processes, for which we have a national framework.

Dr Woods: As the committee knows, earlier this year, we published the workforce planning framework in order to put in place a proper system for assessing the numbers of people that we need in all of the professional groups. We will not start to see the benefits from that process until the new year. We have specifically factored in a requirement that people have regard to MMC in that context.

Obviously, there is a difficult interim phase as we move from the current arrangements for training to the MMC model. We are working hard to ensure that we do all that we can to minimise any disruption from that and that we train and retain all the doctors that we can.

Mr McNeil: I assume that you anticipate that, during that transition, the numbers might fall short and there might be a great risk of an impact on services. How would you deal with that risk? Will you bring in the private sector or doctors from abroad as part of a contingency plan to cover such a dip, or will we await the crisis and then react to it?

15:45

Dr Woods: We are not awaiting or expecting a crisis. We are trying to understand and quantify the problem and take steps now to minimise any effect. For instance, the hospital at night initiative is a way of helping to overcome some difficulties. Some specialties have bigger problems than others, potentially, but it would be premature to say, "We think we've got a problem of this size in this specialty in this board." The situation is variable. We want to get to the bottom of the matter and understand it and, as I said, we will be in a better position to do so in a few weeks' time.

Mr McNeil: I ask the question in a genuine way. Will it impact on one health board more than another, perhaps in areas where there are teaching hospitals or whatever? Is there an even spread? Where will the impact mainly fall? Will it be general and across the board or will there be hot spots?

Dr Woods: It will impact differentially according to the medical staffing that exists in different parts of Scotland. For example, the impact is potentially greater in parts of the country that have small departments so, obviously, we are focusing on some of those.

In general terms, we are trying to understand in detail what the impact will be, but there is quite a lot that we still do not know about it because of the uncertainty about what are called the run-through programmes—they are the programmes that follow on from foundation years one and two. It is at that stage that we get into the specialist training of doctors for orthopaedics, A and E and so on.

Mr McNeil: That is what concerns me. Not all of it is in your control—you mentioned the royal colleges, among others who may have an influence on the pace. I am also anxious that in the smaller hospitals the blip—the short-term problem, as you described it—will be used as an argument for further centralisation or concentration of services. I am concerned that it will be used as yet another piece of evidence to show that we cannot sustain small or medium-sized hospitals.

Mr Kerr: In the discussions that we had with individual boards, they all addressed the matter in similar ways. There was no expectation on my part, or indeed on theirs, that we could not manage the process. I hear what you say about the potential impact on smaller boards or hospitals but they are planning for the process now, so it should not have the effect that you describe.

Dr Woods: Mr McNeil mentioned uncertainty in relation to the royal colleges and organisations other than the Executive and the health boards. Last week, Scotland's new chief medical officer, Harry Burns, and I met with the presidents of the royal colleges here in Scotland and it is fair to say that we had constructive discussions. There is enormous good will and determination to ensure the smooth introduction of the new programme. Everyone is clear that they want to work together and, wherever possible, to find solutions to the problems here in Scotland. There is determination to do that as quickly as we can. As I said, we will take stock in the next few weeks, when we have more information from NHS Education for Scotland, which has been leading the detailed work on our behalf.

The Convener: The point is made, minister, that there is apprehension down the line that there might be an issue that needs to be monitored.

Mr Kerr: I note that.

The Convener: Finally, Shona Robison has a question, which will be the end of the process.

Shona Robison: My question is on the use of the independent sector. In "Fair to All, Personal to Each" the Executive stated that £45 million was going to be spent over the next three years on negotiating contracts with the independent sector. Can you provide more detail on how that funding has been allocated for 2005-06?

Mr Kerr: I cannot give you the detailed figures. We have per-board figures for the distribution of that resource and, from the national waiting times unit, how it is proposed to spend that money, which I am happy to forward to the member.

Shona Robison: I have a supplementary on the outcomes for those contracts. Will they require the independent sector to deliver X or Y? You will be aware that in England there have been difficulties in delivering contracts. In some cases, only 40 or 50 per cent have been delivered. How will you manage that process?

Mr Kerr: By not doing our business in the same way. We are having individual contracts. We will get a commitment from the board about what it requires and then go to market. We will also aggregate the procurement—or get the best value for the taxpayer. My understanding of the situation in England—I emphasise that it is my understanding—is that a certain number of procedures were bought, then boards were asked, "Can you use this capacity?" We start by determining the capacity that is needed, what patients require, and where the pressure points are, then we go to market to address them.

Shona Robison: But independent providers will only be paid for what they deliver?

Mr Kerr: Absolutely correct. The contractual basis will be per procedure, per number of patients and so on, so it is very focused.

The Convener: Minister, you said that you would come back on a couple of issues. As long as I receive information in writing by 20 October, we will be able to incorporate it in our thinking for our report.

Mr Kerr: I will respond to Kate Maclean on targets, Mike Rumbles on dental budgets, Shona Robison on reporting on efficient Government, Janis Hughes on IT investment and Duncan McNeil on MMC. I am sure that not all of that will feed into your report.

Kate Maclean: Just watch.

The Convener: The information should come to me, because it will all need to go to the clerk.

Mr Kerr: Absolutely. We always do that, convener.

The Convener: Thank you, and thank you to your officials.

15:52

Meeting continued in private until 16:08.

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