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Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 6 October 2010

Session 3

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HEALTH AND SPORT COMMITTEE

29th Meeting 2010, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

*Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Nanette Milne (North East Scotland) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Melanie Hornett (NHS Lothian)
Jacqueline Richardson (NHS Forth Valley)
Nicola Sturgeon (Cabinet Secretary for Health and Wellbeing)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Wednesday 6 October 2010

[The Convener *opened the meeting at 10:02*]

Subordinate Legislation

Nutrition and Health Claims (Scotland) Amendment Regulations 2010 (SSI 2010/307)

Addition of Vitamins, Minerals and Other Substances (Scotland) Amendment Regulations 2010 (SSI 2010/308)

National Health Service (Travelling Expenses and Remission of Charges) (Scotland) Amendment (No 2) Regulations 2010 (SSI 2010/319)

The Convener (Christine Grahame): I welcome everyone to the 29th meeting in 2010 of the Health and Sport Committee. Here we are again, worthy workers. I remind everyone, including our witnesses and members of the public, to switch off mobile phones and other electronic equipment. Apologies have been received from Michael Matheson and I welcome his substitute, Joe FitzPatrick, to the meeting.

The first item on the agenda is consideration of three negative Scottish statutory instruments. SSI 2010/307 and SSI 2010/308 are technical amendments to existing European nutrition, vitamin and mineral regulations that are in force in Scotland and SSI 2010/319 updates various allowances and travel expenses for national health service students. Members have received a copy of each instrument and a cover note from the clerk summarising its purpose. I can tell members that the Subordinate Legislation Committee had no comments to make on any of them. If members have no comments, is the committee content not to make any recommendations on these instruments?

Members *indicated agreement.*

The Convener: I should also say that this is the last time that members will receive hard copies of subordinate legislation. From now on, instruments will be made available online, which is only sensible.

Patient Rights (Scotland) Bill: Stage 1

10:03

The Convener: The next item is our final oral evidence-taking session on the Patient Rights (Scotland) Bill. We will hear evidence from two panels of witnesses, the first of which comprises representatives from the health boards that responded with written submissions to the committee’s call for evidence. I welcome to the meeting Jacqueline Richardson, patient focus and relations manager with the NHS Forth Valley PFPI steering group, and Melanie Hornett, nurse director at NHS Lothian.

We will move straight to members’ questions.

Ross Finnie (West of Scotland) (LD): Good morning. I thank the witnesses for their written submissions. In the second paragraph of its submission, NHS Forth Valley welcomes the bill, saying that it

> “was thought to be ‘sensible and achievable’”,

while NHS Lothian, in generally welcoming the bill, notes however that it “is not enforceable”. None of the witnesses who have given evidence on the bill to the committee over the past few weeks has thought that patients should not have rights. Why do you think that it is better to put such rights in an act of Parliament when, as one of you has expressly noted, the legislation “is not enforceable”? What difference will the bill make? It is, of course, good to set out the rights in a single format that every patient can access and understand, but what in your opinion is the benefit of putting them into an act of Parliament that will not be enforceable?

Jacqueline Richardson (NHS Forth Valley): We on the PFPI steering group feel that the bill goes beyond and builds upon existing legislation. The issue is not just complaints or waiting time targets but the fundamental delivery of care. Much as we talk about being patient centred and providing patient-focused care—on which, I should say, we have made huge leaps—we still have a long way to go. In any case, it is important to underpin the fundamental principles of care in legislation.

Ross Finnie: But how does that affect the patient if the legislation cannot be enforced? I am not suggesting that it would not be helpful to have these rights written down or clearly articulated on a single piece of paper, but what is the advantage of their being set out in law when you cannot enforce that law?

Jacqueline Richardson: The focus group members found the issue challenging, but in our conversations we made it clear that we did not want a lawyer at every bedside. This is not about being adversarial in getting feedback but about giving boards the direction that being patient focused and patient centred is a need-to-do rather than a nice-to-do.

Ross Finnie: Could you not do that in other ways?

Jacqueline Richardson: You could do it through guidance, but that would be about saying what you would like to do or what you could do. For me, the bill enforces patient-centredness as the fundamental principle of care.

Melanie Hornett (NHS Lothian): I recognise the importance of patients' rights, and putting them into legislation might have the benefit of allowing patients and the public to understand a little more the seriousness with which the Government and health boards take them. However, the rights that are set out in the bill are, by and large, already in place as a result of Government direction, guidance and strategies. For example, patient-centredness is an element of the new quality strategy that boards are all enthusiastic about implementing and using. Because of the lack of enforcement, I am not certain about the bill's absolute benefit.

Ross Finnie: That is helpful.

The Convener: Before we move on, I said that Ms Richardson was representing the PFPI steering group. We get that PF means patient focus, but we are a bit bemused by the PI bit. What does that mean?

Jacqueline Richardson: Public involvement.

The Convener: Now we are all happy.

Mary Scanlon (Highlands and Islands) (Con): NHS Forth Valley's submission refers to "positive" comments and says that the bill is "sensible and achievable". I want to explore the treatment time guarantee, which, given that it takes up almost a third of the bill, must be seen as its central focus. I should also add that the guarantee does not apply to patients with mental health issues, so it appears that we have a bill on patient rights in which certain patients have more rights and others have none.

Having had that rant, I point out that under the bill a health board that breaches the treatment time guarantee

> "must ... ensure that the agreed treatment starts at the next available opportunity, ... provide an explanation to the patient as to why the treatment did not start "

and

> "give the patient details of ... advice and support"

including

> "how to complain."

Are those provisions not already in place? Why do we need a bill that does something that is already being done, or is it actually doing more than I think it is doing?

Melanie Hornett: Those measures are in place already. We work hard to meet the 18-week referral-to-treatment time and the stretch target under that of treating patients within nine weeks. Should we fail to achieve those targets—we fail for a small number of patients—we do exactly what you described. We offer such patients alternative dates as soon as possible, apologise and explain how they could seek further information or complain. That is nothing new.

Different waiting times for different matters and different targets could create confusion. As you say, the important point is that the focus is on acute and elective in-patient day-case care, which leaves large sections of patients and their treatments uncovered by the bill.

Mary Scanlon: I will move on to exclusions. Mental health services and diagnostic tests are not included in the treatment time guarantee. Until a person has a diagnostic test, they do not have a diagnosis, so they cannot be referred for treatment. Could a longer time be taken for the diagnostic test to manipulate the treatment time guarantee? If the time for the test was extended, that would allow more time for treatment. Are you concerned that diagnostic tests are excluded? The treatment time guarantee is fairly meaningless until a test has been conducted. Should tests such as X-rays be excluded?

Melanie Hornett: All the work that has been done for the 18-week referral-to-treatment time means that considerable work has been done on examining the times that people wait for diagnostic tests. To be able to refer and treat someone within 18 weeks, diagnostic tests must have been undertaken. Of course, people do not need diagnostic tests just because they will have an operation; general practitioners might refer people for tests. For all patients, a short waiting time for diagnostic tests is important. The work that has been done means that the timescales are much shorter than they used to be. I am sorry that I cannot cite an example of that, but the point is important.

Mary Scanlon: The point is very important. When a GP refers a patient for a diagnostic test, it could take 20 weeks, after which the patient could suddenly have a treatment time guarantee for treatment of one week. That is a serious point.

The Scottish Public Services Ombudsman knows a wee bit more than most of us about patients' rights and responsibilities. His submission says:

> "With the exception of the treatment time guarantee, the Bill does not appear to provide any significant extension to existing rights and expectations in relation to the quality of NHS services provided in Scotland. Instead, it confirms and makes explicit rights and expectations that currently exist."

I do not understand why we are scrutinising a bill that gives patients not one additional iota of rights. Has the ombudsman got that wrong? Does the bill contain anything that will enhance patients' rights?

Jacqueline Richardson: I would not say that the ombudsman is wrong.

The Convener: Do not be frightened to say that, although I am not tempting you to do so.

Jacqueline Richardson: The bill is subtle. As I tried to say, it is not just about patients' rights to complain and to have treatment at a certain time. I am aware of no other legislation that defines the principles and puts patients at the heart of care delivery. That is the most important part of the bill.

Mary Scanlon: Do we really need legislation for that? Is that not part of what health professionals do every day?

Jacqueline Richardson: What is described is what health professionals would like to think that they do every day, and it is what they endeavour to do every day, but I am not convinced that we have gone far enough to make that happen and that we have truly achieved mutuality in all aspects of health care.

Mary Scanlon: I am struggling to understand and find a justification for the bill. If the bill is passed, what will the average nurse in the average ward, who perhaps does not do as much as she should to meet patients' rights, do that she does not do now?

10:15

Jacqueline Richardson: I am not sure that the bill alone will change the culture of the health service, but it definitely sets the tone that this must happen. Of course, it would have to be underpinned by staff training and by information that was readily available and easy for the public to understand.

Mary Scanlon: Sorry, convener—I ask you to bear with me. Jacqueline Richardson said "this must happen". What must happen?

Jacqueline Richardson: It is about changing the culture to a certain extent and the understanding of patients' involvement in their care and their decision making about their care. We can say that that happens, but we know from complaints and from patient feedback that we do not achieve 100 per cent success.

Melanie Hornett: I agree with the SPSO. It is not about legislation; it is about quality of care. As I said, the quality strategy has been favourably received. It is about achieving a culture change, education, training and things that you cannot legislate for. In NHS Lothian, we have found that work that we are doing around compassionate care with Edinburgh Napier University has been significant in changing the way that staff work together with patients. It is about putting the patient at the centre of all aspects of their care and treatment. That programme, which is much more in depth and in some ways much more sophisticated, is bringing about change, whereas the legislation will give us a legal position on the matter but it will not necessarily make people think about their own practice and how they interact with patients day to day.

The Convener: I will let Rhoda Grant in with a supplementary before Mary Scanlon asks another question.

Rhoda Grant (Highlands and Islands) (Lab): It is okay. The matter has been dealt with.

Mary Scanlon: My final point is that we have quite a few student nurses in the audience today, and I imagine that they are attracted to the profession because they are committed to looking after patients. I do not imagine that when they graduate any of them will seek out the Patient Rights (Scotland) Bill to gain an understanding of how to care; I imagine that every one of them wants to care already.

The Convener: That was not a question.

Mary Scanlon: No, it was not, but it was worth saying.

The Convener: It was evidence.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): We seem to have made significant advances in the past 10 years. Melanie Hornett described what is going on in Lothian, where I worked for four years and was certainly conscious of the efforts that were being made.

One of my concerns about the bill is not that it is not worthy—it is extremely worthy—but that it is damaging to patients' rights, because it changes, for example, the right of the patient to consent to or refuse treatment to

> "allow and encourage the patient to participate as fully as possible".

That change in the language is understandable in the sense that we are trying to encourage mutuality, but it is not helpful.

On equality and respect for their needs, patients have a right not to be discriminated against on the grounds of race or other equality issues, but the bill just refers to having regard to

> "The patient's abilities, characteristics and circumstances".

Human rights legislation is not mentioned in the bill, which just says that it is necessary to "have regard to" the need to treat a patient with dignity and respect and to "have regard to" the need to respect privacy and confidentiality. Apart from the bill not mentioning human rights, except in that way, it reduces those rights. There is a right under NHS legislation to be supported by a family member, friend or carer, but the bill simply says that it is necessary to "have regard to" the need to provide support, and so on.

My concern is not only that the bill does not help, but that it does not encompass all the rights that patients have. The Law Society's supplementary submission lists nine or 10 rights that are not even mentioned in the bill. Jacqueline Richardson referred to the bill being "sensible and achievable" and Melanie Hornett also made some comments. Would they like to comment on that aspect of the bill?

The Convener: My only point by way of observation on what you said on human rights, Richard, is that all bills that are lodged in the Parliament must, according to the Presiding Officer, be compliant with the European convention on human rights. I accept your phraseology, but—

Dr Simpson: You are absolutely right, convener. I was saying not that the bill is not compliant but that, if the purpose is—as the witnesses said—to enshrine, enforce and promote patient rights, the fact is that substantial numbers of rights are not referred to in the bill. The implication is therefore that the rights in the bill are greater than other rights. When I was drawing up legislation as a minister, the matter was referred to constantly—

The Convener: I was just correcting you from the point of view of—

Dr Simpson: I accept that the legal position is not altered, but we are not talking about that. The witnesses have said that the bill is worthy and will improve rights that they promote already. My point is that that is being done in a discriminatory way, as Mary Scanlon described—I will come to that in a minute—and that, by neither emphasising nor listing the other rights in the bill, the effect is not to promote but to demote them.

The Convener: I wish that I had not said what I said; we are getting more evidence. I simply wanted to make it plain that while your point is perfectly valid, all bills need to be ECHR compliant.

Now I have lost the question. Do we remember what it was?

Ian McKee (Lothians) (SNP): It was: do the witnesses agree with him?

Dr Simpson: No, it was not that. The question is whether the bill promotes all patient rights or whether it discriminates between different types of rights.

Melanie Hornett: I agree that the bill does not demonstrate all the rights that patients have at the moment. The information from the Law Society of Scotland was helpful in that regard. In our submission, in thinking of education and development, we said that, if the bill were to go ahead, we would welcome investment for the totality of patient rights as that would be helpful to the public and patients. We also said that it would not be so helpful to focus only on the rights that are enshrined in the bill, as people might think that those rights excluded other rights. We know how difficult it is to share with people some of the complex messages that are in the bill. We need to be very clear on the matter.

Dr Simpson: My second question is on the patient rights officer, the patient advice and support service and the existing independent advice and support service. I have read your submissions. Do you think that IASS should be strengthened and improved—even given the new set-up—or should the new set-up be a complete substitute for IASS? In other words, is the money totally new? Will the new set-up do the job that IASS does? What problems might arise from close association with health boards, which contrasts with the present independent citizens advice bureau-run service?

Jacqueline Richardson: Having worked closely with IASS and having had feedback from patients and the public on it, I can say that IASS has been a very positive service, although I am not sure that it has been consistent nationally. Some boards have had a very positive experience, whereas the experience of other boards has not been quite so positive. Having a national system with a national framework, agreed standards for practice and agreed outcomes would benefit the service. From discussions with our public members, I understand that patient rights officers will build on the existing service and the good practice that has been achieved.

Melanie Hornett: Citizens advice bureaux are well-known institutions; people understand what they do and how they can help them. It has been helpful to have IASS working in the CAB network. When people go to a CAB to seek help, they can solve more than one problem at a time. Individual experience of the IASS is largely positive, albeit that the number of people who have accessed it has been small. That brings into question IASS's value for money. There would be benefit from evaluating and enhancing that, as opposed to trying to start up something completely new from scratch. There must be things that we could learn from the work of IASS that we could use to strengthen the service.

Dr Simpson: I understand your argument for consistency, but could that be achieved just as easily and without the cost of all the new officers by taking IASS into a national contract? A service-level agreement with Citizens Advice Scotland that was delivered locally would retain the independence, allow for national audit and ensure consistency, but not rip things up. I ask that in light of the fact—I wonder whether the witnesses are aware of it—that funding for at least half the services that are provided by IASS has been cut this year. Will the witnesses comment on that?

The Convener: The role of patient rights officers differs from that of IASS, does it not? I ask you to clarify that, because I might have got that wrong.

Jacqueline Richardson: I understand that we are talking about an enhanced role and that patient rights officers will support patients to exercise their rights and responsibilities, whereas IASS focuses mainly on supporting people who wish to raise concerns with the health service. However, as IASS sits in citizens advice bureaux, our patient panel members feel strongly that it is almost a one-stop shop, such that people who have concerns about not only their health care but their housing or other benefits can go to one point of contact and be signposted quickly.

The Convener: That is what I want to be made clear. Is one a signposting service whereas the other gives people advice and advocacy? I am not clear about that.

Dr Simpson: That description is not right.

The Convener: That is why I am asking for clarification from the witnesses. The jobs are not the same—or are they? I understand that one job involves signposting. Patient rights officers will say, “You go here for your advice.” Is IASS exactly the same?

Jacqueline Richardson: IASS is a signposting service; it does not have an advocacy role. Its role is to provide advice and support.

The Convener: Is that correct, Ms Hornett?

Melanie Hornett: Yes, as far as I understand it. The support depends on the case—it is different for different individuals—but a support function is present.

The Convener: I am sorry—I interrupted Richard Simpson’s question about funding.

Dr Simpson: Implementing the bill will cost £6 million in the first three years. In the current climate, will that money be well spent? Apart from signposting, what additional services will the bill give us?

Melanie Hornett: I am not certain about that in many respects, given the financial climate and given that existing services could be enhanced and that boards could work to improve their structures to enhance signposting functions for people.

Most of the time, patients who have concerns or complaints want the situation to be fixed there and then by the people who are present. If that cannot be done, patients want to be told that, to have an apology and to have the problem fixed as soon as possible. When issues become complicated, patients want an objective view, for which the ombudsman provides excellent services.

I am not certain that all the extra infrastructure will help patients or members of the public. The bill will establish a layer of administrative services for the NHS to deal with—we will need to consider how we work with patient rights officers and how we ensure that there is communication, which will be needed if we are to help with issues that arise.

The Convener: I am sorry to return to the distinction between patient rights officers and IASS—I am nibbling away at that. NHS Forth Valley’s submission says that patients

> “suggested that IASS is able to act as a ‘one stop shop’ for those needing advice with benefits and housing as well as health issues.”

So IASS gives out advice, whereas

> “people would have to speak to the PRO for health issues but still have to go to the Citizens Advice Bureaux for other advice.”

That means that the roles are different—I was trying to get at that. The issue is not just that IASS is lumpy or inconsistent throughout the nation, as we have heard in evidence; it is that a distinction exists between the two roles.

Dr Simpson: Convener, I am sorry to interrupt you, but the second function of PASS and its PROs in paragraph 45 of the policy memorandum is to

> “provide advice and support for patients”.

PASS will signpost services and provide advice, so it will duplicate IASS.

10:30

The Convener: I accept what you say about the policy memorandum, Richard. Notwithstanding that, the witness agreed with you that they did the same thing and, given that her written evidence does not say that, I am simply asking whether she still stands by her submission. Do you agree that there is a distinction between your written submission and the oral evidence that you are giving this morning?

Jacqueline Richardson: Our written evidence probably reflects the fact that the public are not clear about the patient rights officer's role. I do not think that any of us is. We are confident that we know what IASS does, but we are not quite sure what the difference will be.

The Convener: I am sure that in her evidence the cabinet secretary will clarify things for Dr Simpson and me.

Ian McKee: You might be relieved to learn that I am not going to rehearse my stage 1 speech, convener.

This is not a trick question—I am simply not familiar with her role—but I wonder whether Jacqueline Richardson will explain the mechanism for selecting and electing the people on her group. How are you and your colleagues chosen to represent the public voice?

Jacqueline Richardson: There was no election. My role as an operational lead for patient focus and public involvement in NHS Forth Valley is a paid post, but I have a number of other jobs and other issues on which I take the lead. Because this was a bill on patient rights, we chose not just to respond as a board but to involve our network of patient and public partners in developing our response to your call for evidence.

Ian McKee: So you are an arm of the board.

Jacqueline Richardson: I am employed by the board.

Ian McKee: That is helpful.

I suppose that my next question, on the treatment time guarantee, is more for Melanie Hornett. It has been suggested in evidence that there could be a risk of managerial imperatives altering clinical imperatives slightly. For example, if a load of people needed ingrowing toenail operations and the 12-week deadline was coming up, you might have a whole list of those treatments and put back someone with a more serious condition who had been on the waiting list for only three weeks. Is such a worry realistic or simply hypothetical?

Melanie Hornett: Patients and clinical staff might well have such a worry, and the health board would want to ensure that patients were dealt with according to clinical need and prioritised according to their illness or the treatment required. That is not to say that a significant amount of work does not go into managing waiting lists and ensuring that people keep moving through in a timely way.

In reality, there is not a huge risk that all the ingrowing toenails would suddenly be operated on and that all the aneurysms and cancers would be put back. Most of our current waiting time targets—for accident and emergency and cancer, for example—have a degree of flexibility; we are not expected to hit 100 per cent all the time in recognition of the fact that with certain clinical conditions the target will not be met and the patient will have to be dealt with differently. In other words, there are opportunities within the targets to manage things. On the ground, the clinical priorities take the overriding position.

Ian McKee: And management accepts that.

Melanie Hornett: Yes. Although we are managers, we also care for and look after patients. Indeed, many of us have clinical backgrounds. One of the other submissions referred to gaming, but we would not want to do that.

Ian McKee: I am not exactly certain what gaming is, I have to say.

Melanie Hornett: I think that it goes back to your point about manipulating the waiting list in some way to achieve the target by not treating patients according to their clinical requirements. I certainly would not want that to happen.

Ian McKee: When certain targets were set for people to be seen at A and E, some areas developed the welcome nurse function. Someone would simply see the patient and say hello, which not only allowed the target for the time between someone entering the hospital building and seeing a professional to be met but meant that treatment could be delayed. It has been suggested that the treatment time guarantee, which I believe starts from the moment the clinician and the patient agree on a form of treatment, could be slightly manipulated if clinical staff were instructed not to agree at a certain point that a certain treatment was necessary. Is that a possible risk?

Melanie Hornett: Your colleague mentioned that earlier, but I do not know who you think is going to instruct clinicians to manipulate things in that way. I am sure that if we tried to do so we would get very short shrift. No matter what professional group they belong to, our clinical staff adhere to their own codes of conduct and regulations and I am sure that they see those as overriding any such instruction that a manager might give.

Ian McKee: That is reassuring.

How do health boards intend the provision to apply in primary care, where more and more procedures are taking place? For example, I know of primary care practices that carry out vasectomies; indeed, with the skill that is available in primary care, many more operations that were done in hospitals are now being carried out in such settings. However, most primary care practitioners are agents for rather than employees of the board. Does the bill contain any mechanism that would allow what is going on in primary care to be supervised on your behalf?

Melanie Hornett: As yet there is no such mechanism. As I said earlier, one of our concerns about the bill is that it focuses on acute in-patient elective care and does not cover the huge area that you have described or the area of mental health. NHS Lothian has its own mental health targets, for example, and is managing to deliver them in line with the current targets for other forms of care. Such a mechanism could be put in place, but we have yet to try it with primary care. However, a huge issue for patients and the public is waiting times that are not seen.

Ian McKee: Although I accept that the bill does not cover mental health issues—and that that will be a matter for discussion—it is my understanding that it covers the other operations that I have mentioned. Although they are done on your behalf, if they were carried out in secondary care they would certainly be covered by the waiting time target.

Melanie Hornett: That would depend on who was carrying out the operation, where it was being carried out and how things were working. As you know, different circumstances apply. Although the bill would cover day-case surgery carried out in community hospitals, for example, it would not cover other treatments such as physiotherapy that people might need. That is a concern.

Ian McKee: But, in NHS Lothian’s opinion, if a GP offered to remove a sebaceous cyst, carry out a vasectomy or whatever, would the procedure be covered by the bill?

Melanie Hornett: To be honest, I cannot answer that. I am simply not certain how we would deal with that situation. However, I am happy to consider it and come back to you.

The Convener: I realise how difficult it is to give evidence before a committee, so if you have any information to add on that or any other question, you can send it to us in writing and we will look at it in considering our stage 1 report.

I suspend briefly to allow a change of witnesses.

10:38

Meeting suspended.

10:39

On resuming—

The Convener: I welcome to the meeting Nicola Sturgeon, the Cabinet Secretary for Health and Wellbeing; Lauren Murdoch, bill team leader, and Kathleen Preston, health and community care solicitor with the Scottish Government legal directorate. So little time has elapsed since we last met, cabinet secretary, that I am tempted to talk about déjà vu or to say welcome back. I understand that you wish to make a brief opening statement.

The Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): Thank you, convener. I am very pleased to be giving evidence on the Patient Rights (Scotland) Bill, which I believe to be an important piece of legislation that gives life and meaning to the principle of a patient-focused mutual NHS. It is about raising the status and profile of patients’ rights and clarifying both those rights and health boards’ duties with regard to the manner in which patients are treated—by which I mean, of course, treatment in its broadest sense, not just clinical treatment. In short, the bill seeks to change the health service’s culture and dynamics and, if you like, to level the playing field in the relationship between the patient and the NHS.

I know that we will go into more detail about these matters, but at this point I wish to address a number of concerns that have been raised, the first of which is that the bill does not create any new rights. That is not the case: the bill creates the right to complain and establishes the treatment time guarantee. However, it is true that a variety of rights already exist and that we already expect health boards to treat patients in line with certain key principles. In many cases, that is what happens, and I know that boards work very hard at providing patient-centred care.

That said, the existing rights come from disparate sources, are not clearly understood and often relate to very specific matters, such as access to records, rather than to the very essence of the relationship between the patient and the health service. Of course, expecting or hoping that health boards will treat patients in a particular manner is not the same as putting them under a clear duty to do so.

The second concern that has been raised is that the bill contains no right of redress. I admit that it does not give patients an additional right to go to court, but it does not remove patients’ existing rights in that or any other regard. Of course, that is not the same as saying that there is no right of redress. The bill provides, for the first time, a legal right to complain, which is very important for reasons that we will no doubt discuss later, and to give feedback and—crucially, in my view—it puts boards under a duty to learn lessons from complaints. It also lays out the steps that boards are required to take in relation to the treatment time guarantee.

In some respects, the debate about redress misses the bill’s point. Fundamentally, the bill is not about adding to existing methods of redress to deal with situations that go wrong or do not go as patients might expect—although I point out that it does strengthen them—but is about changing the health service's culture and dynamics and the way in which patients are treated in order to raise satisfaction levels and minimise the chances of things going wrong.

My passion—I use that word deliberately—for the bill comes directly from my three and a half years' experience as health secretary. Like everyone else around the table, I am a big advocate of the health service and know how hard it works to deliver patient-centred care, but I have been struck by the fact that—ironically and perversely—patients' loyalty to and high regard for the health service mean that sometimes they accept things that should not be accepted. I often speak to patients who feel that making a complaint is somehow disloyal to the health service and those who work in it, or that it might affect their future care or might not make a difference. I have spoken to patients who, because they receive very good clinical care, feel that they should not raise issues about not being listened to or not being treated with the dignity that they deserve.

Although the bill provides immediate legal rights, it is also concerned with changing the health service's culture in the longer term—indeed, with continuing the culture change that I believe is already under way—and ensuring a more level playing field between the patient and the bureaucracy and big organisation that is the health service.

That is all I wish to say by way of introduction. I am, of course, happy to answer members' questions.

10:45

Ross Finnie: Thank you, cabinet secretary. That was helpful. In taking all that you said at face value, I say that you nevertheless raise an important matter of principle—and we are talking about the principles of the bill. I do not doubt in any way your passion for the health service, which has been evident in the way in which you have discharged your duties as a minister, nor do I doubt the need for patients to be clear about their rights.

However, the principle that you are introducing and the inference that I think you allow to be drawn is that, unless a Government measure that needs to be given life and meaning, that needs status and focus and which is going to change the colour of something, is set out in statute rather than by direction or in a policy document, it will be ineffective. If you are right, that has clear ramifications for the future, because we will be entitled to infer that policy documents and directions are to be regarded as being of a much lower order. That is the bit with which I have real difficulty.

You received many responses that suggested that people do not want a lawyer at every bedside. You could have elected to interpret that as meaning that the respondents did not wish primary legislation, but instead you have elected to introduce primary legislation and, at the same time, in section 18, effectively to emasculate the most obvious ways of enforcing it.

I invite you to explain to us the principle that, in the future, measures that are not set out in primary legislation from your Government are not to be regarded as being capable of delivering anything meaningful.

Nicola Sturgeon: I will take on all those points. They are important points of principle and—dare I say it—philosophy.

I do not take the view that no measure is meaningful or effective unless it is in primary legislation. This Government, previous Governments and future Governments have done and will do many things by means other than primary legislation. That is right and proper, but some measures are of such import that they should be in primary legislation. Their being in primary legislation raises their importance and meaning as a matter of fact and law, as well as through the message that it sends. The clarifying of, and the giving of status to, certain key rights that patients have that are highly pertinent to their relationship with the health service falls into that category.

However, that is not all that primary legislation does; there is hard import to it as well. At the end of my answer, I will come back to that point.

On whether people saying that they do not want a lawyer at every bedside means that they do not want primary legislation, I will be as reasonable and as open as possible in my answer. I dare say that for some people—perhaps Ross Finnie is one of them—that is what that comment meant. However, other people, including some who have given oral evidence to the committee, interpret it differently: they do not want additional rights for patients to go to court, but nevertheless agree that putting patients' rights in primary legislation is very important for effecting the change about which I am talking.

Therefore, we cannot say that somebody saying that they do not want the proverbial lawyer by the bedside translates in all cases into meaning that they do not want the rights in primary legislation. It is interesting that those who tend to focus on the lack of enforceability also say that they do not want the lawyer by the bedside.

On the third and final part of Ross Finnie's question, I take issue—not in any confrontational sense—with the suggestion that section 18 emasculates the bill. It does not do that; it says that nothing in the bill gives rise to the ability of patients to sue for damages. I will not quote the section in full, because members have it in front of them.

The point that I was trying to make in my opening remarks is that that is not to say that the rights that are in the bill have no import and no effect. For the first time patients will have a legal right to complain but, more than that, if the bill is passed, boards will be under a legal duty to do certain things in response to complaints to ensure that the complaints process is not just a process that allows patients to let off steam or vent their opinions but that it becomes a dynamic part of the improvement process in the health service. That is a very important consequence of that particular right in the bill, because it means that when health care is being delivered, boards are required to have regard to particular principles. We do not just hope that they do—they are required to do so and, if they do not, patients have that as a basis for complaint and, if the complaint is upheld, change and improvement has to happen. Boards have to take specific steps around the treatment time guarantee to ensure that it is delivered and, in cases when it is not delivered, they have to do certain things in consequence of that. These are hard rights with hard consequences.

I make the point that the bill is, in addition, about something bigger; it is about changing, in a positive way, the culture of the health service and the dynamics between the patient and the health service. More than anything else, that is what, for me, brings to life what I know we all feel strongly about, which is the mutuality principle: the idea of a patient as a partner in, not just a user of, a service.

Ross Finnie: Cabinet secretary, when your bill team was before us I asked Kathleen Preston about the right to complain. She answered by referring to section 1(3), which states that

> "It is the right of every patient to make complaints".

I asked whether that was a new right and she responded by saying that

> "It will be the first time that the right has been set out in primary legislation."

I went on to ask whether the document produced by the health rights information Scotland initiative should have had the caveat that, although it tells patients that they have a right to complain, actually, they do not. Kathleen Preston replied:

> "No, that is not what I am saying."

I asked whether, in that case, we already had the right to complain and Kathleen Preston answered:

> "I am saying that it will be the first time that the right has been put ... in primary legislation."—[*Official Report, Health and Sport Committee,* 8 September 2010; c 3245.]

There seemed to be some confusion about whether we already have a right to complain but have not been able to complain. Your bill team suggests that we already have that right. Can you respond to that point?

Nicola Sturgeon: I can. With the greatest respect to Ross Finnie, I do not think that there is confusion. Patients can complain: complaints systems are set up in health boards and patients can and do complain, but they do not currently have a statutory right to complain. You may say that that will not make much practical difference, but it will make a difference in the case of the anecdotal patient who says either "I don't really like to complain, because I don't think it's fair because the staff work really hard and it's not their fault", or "If I complain, it will not make a difference", or "If I complain, it might mean that in the future my care might not be as good—maybe there will be repercussions." It is important to be able to say that making a complaint is not just something that patients can do, but something that they, as patients, have a right to do.

For me, the more important part of the bill in respect of the right to complain is the duty that it puts on health boards in relation to what they have to do to respond to complaints. You might say to me that good health boards—I think that most health boards, at most times, are good—should do that anyway; they should take complaints and learn from them.

I make it a practice when I chair the annual reviews of health boards always to ask them, "How do you respond to complaints? How do you ensure that you use them as part of the learning process?" It is good practice that they do that.

The bill makes it clear that the complaints process has a point. Boards must monitor and consider how they learn from complaints and must make improvements as a result. That is important, because it allows people to look a patient in the eye and say, "Not only do you have the right to complain, but you can make a difference by complaining, because your complaint—your raising what did not go right for you—will minimise the chances of that happening to somebody else in the future." For those reasons, an important difference exists.

Ross Finnie: Notwithstanding that, people who believe equally passionately, I suspect, in the delivery of health care—including the witness this morning from NHS Lothian, the British Medical Association, the Royal College of Nursing, the

Royal College of General Practitioners, Unison, which represents some NHS workers, the Scottish Public Services Ombudsman, who has duties in relation to patients' rights, and Consumer Focus Scotland—all expressed the clear view that the bill is unnecessary. I do not wish to miscall the Law Society of Scotland, but it is perhaps not as impassioned about the health service. However, it certainly has an interest in good law, and it suggested not only that the bill is not needed but that it might diminish existing rights. How do you respond to that?

Nicola Sturgeon: Your question had different parts; I will try not to forget any of them. Like you, I will not miscall the Law Society. I suspect that, if there is an organisation in the country that would quite like a lawyer at every bedside, maybe it is—

Ross Finnie: I inadvertently put that point and received a tart response from the Law Society.

Nicola Sturgeon: I am sure that the Law Society would deny the point vigorously. The law is the convener's former profession and mine—it could be our future profession; that depends on the whims of the electorate—so we should probably say no more about that.

It is interesting that, although Ross Finnie has quoted health boards, doctors' organisations and unions, he has not quoted the many patient-focused bodies that are enthusiastic about the bill.

Ross Finnie: I referred to Consumer Focus.

Nicola Sturgeon: I am talking about patient-focused bodies. Consumer Focus has a wider remit and does good work on the whole public service agenda for consumers.

I do not criticise in any way health boards, the BMA, the RCN or Unison—I have nothing but admiration for the way in which NHS staff do their incredibly difficult jobs and for the way in which health boards deliver the health service. However, it is not surprising that those who run and those who use the service might express disparate views about a bill that is directly about changing the balance of the relationship between those who run and those who use the health service and about levelling the playing field.

I have listened carefully to views and I will continue to listen throughout stage 1. I will pay lots of attention to the committee's stage 1 report in considering whether we can improve or strengthen the bill. The bill is unashamedly about strengthening patients' position in the health service. I make no apology for that.

Ross Finnie: I will ask my final question. I do not dissent from your wish to elevate patients' rights. My disagreement is not with that but with the use of primary legislation as a matter of principle.

Your department has produced documentation in developing and setting out patients' rights. Could you achieve the same aim by setting out the rights in a single document and publishing that by way of direction, under the powers that are open to you in the National Health Service (Scotland) Act 1978?

Nicola Sturgeon: I can do many things under the 1978 act. If you ask whether what you propose would be an equally good or better way of achieving not just the immediate change but the longer-term culture change that I want to bring about, the answer is no—that would not be as desirable a way of doing it.

The Convener: Shall I tick you off my list, Richard?

Dr Simpson: No.

The Convener: I see you deleting questions.

Dr Simpson: Perhaps I could ask a supplementary, as Ross Finnie has asked one of my main questions.

The Convener: That would mean going in front of your colleague Helen Eadie, who is next on my list. That can be done only with her consent.

11:00

Helen Eadie (Dunfermline East) (Lab): Okay.

Dr Simpson: One of the concerns that has been raised is that, by emphasising and strengthening certain rights, such as the right to complain—which the cabinet secretary has majored in today—the bill suggests a variation in rights from other rights that are either given by direction or enshrined in law. Examples are discrimination—which is in primary legislation—confidentiality and patient consent, and the right to be supported by family members. The Law Society says that all those rights are already covered, and is concerned that by emphasising some rights over others, there is going to be discrimination. We will come to the areas of health later, which my colleagues have been looking at.

Did you look very carefully at the English "NHS Constitution" as an approach? It lays out 29 rights very clearly in approximately two pages, and it includes the specific right to medicine under the National Institute for Health and Clinical Excellence. We do not have that specific right in Scotland, and it is not included in the bill. In no way do I doubt your good intentions in introducing the bill, but I feel that it will not help patients in the way you expect it to. A constitution or charter for patients that has the force of direction from your office, and the energy behind it to make sure that patient rights are properly promoted, will achieve what you are seeking to achieve.

Nicola Sturgeon: We did look carefully at the "NHS Constitution" and the legal underpinning for that in England. We also considered practice in Australia and other countries. We are not alone in giving a legal underpinning to patient rights; it is an international trend and I happen to think that it is important.

We decided that we want a set of rights in primary legislation that are about the manner in which patients could expect to be treated rather than about specific individual rights. We also decided that we do not want the bill to repeat a plethora of existing individual rights. The bill is clear that it does not affect any existing rights.

I have read carefully some views that the bill should contain something that shows that other rights are given elsewhere. I will listen to all that and make a judgment on it. Of course, it is open to anyone to suggest that particular provisions should be added to the bill. However, to go back to my earlier point about changing the culture and dynamics of the patient relationship and levelling the playing field, we came to the conclusion that the bill should be about the manner in which patients are treated rather than their specific rights.

Dr Simpson made a point about NICE, and one of its principles is that patients should be treated in line with current clinical guidance, which would include, for example, Scottish Medicines Consortium directions. That is the thinking behind our approach.

It is important to clear up two things, although I think that I have already cleared up one of them. The bill will not remove any existing rights. I have heard some people say that it will, but it will not. I am not saying that Richard Simpson has said that, but I have heard others say so. The second point is—I think that I meant to make one point. I have forgotten what my second point was. If it comes back to me, convener, I will be sure to make it later.

The Convener: It has been a long week for all of us.

Dr Simpson: Thank you for allowing me in to ask my question, convener.

The Convener: It was your colleague, Helen Eadie. She has been so gracious and she is coming in now.

Helen Eadie: As Ross Finnie said, and as I know from my time on the Health and Sport Committee, you are very committed, cabinet secretary; I do not demur from that point of view. I admire much of the commitment that your work shows, although I do not always agree with your policy decisions at the end of the day.

Nicola Sturgeon: It is okay; I have noted what you have said.

The Convener: There is a "but" coming.

Helen Eadie: I will try to avoid using the word "but" now that you have said that. However—[*Laughter*.] Among all the submissions that we have received, the points that the Law Society of Scotland raised are compelling.

Cabinet secretary, I heard you say that the outcome of the bill will be to give patients additional rights. I have been an MSP for approaching 12 years and I am lucky to have a fairly sophisticated means of measuring the cases that come into my constituency office. Of all the concerns that I receive, housing is at the top of the tree, followed quickly by health. I have had to deal with some—in fact, probably many—really horrid, nasty, serious cases. We get to the end of the line, which is usually the ombudsman, and yet my constituents still feel that, at the end of the process, not one single iota of good has been done. The bill does nothing to change that.

In your preamble, you spoke of access to records. The Law Society of Scotland's evidence is that the following are not referred to in the bill:

> "Right to access medical records ... Medical reports issued for insurance purposes ... Right to advocacy services (for mental health service users) ... Right to appoint welfare attorney/make advance directive"

and

> "Human rights".

Under the heading "Rights under NHS legislation/government directions and statements", the Law Society says that the rights "To a GP" and "To a second opinion" are not referred to in the bill. Under the heading "Standards of treatment (Government guidance to professionals and health boards)", the Law Society further says that the following are not referred to in the bill:

> "Health professionals must show due care"

and

> "Guidance from government about treatments should be given due consideration (judicial review available)".

The Law Society also lists rights that are referred to in the bill, but highlights wording such as having regard to those rights. Any rights that you are purporting to give patients under the bill are very qualified.

Those who have been in politics for a long time know that one of the worst things that you can do as a politician is raise public expectations. People expect a magic bullet and, plainly, the bill is not that. I invite you to respond to the criticism that the likely outcome of the bill is that the health service will tend to prioritise minimum legal requirements for patients. As the Law Society of Scotland said, there is a danger that the bill will diminish rights. There is a set of clear rights for all across society. The question is how we use and pursue those rights, which is why the charter approach that Richard Simpson suggested should be considered.

I have a further question, convener.

The Convener: Forgive me, but that was a long speech and not a question.

Helen Eadie: In case you do not let me back in again, I will raise the issue of patient advice and support about which I have had real concerns for a long time. First, there is the issue of cost. I am not against the proposal in the bill—we should have more patient support—but the reality is that health boards will not be able to afford it. I had to battle tooth and nail—

The Convener: Question, please.

Helen Eadie: My question is: how will you fund all these extra services, cabinet secretary? Will you give health boards more money? Will you ensure that the proposed service is truly independent—that it is outwith the control of any NHS body?

The Convener: I think that the questions were on additional rights, the patient rights officers and money.

Nicola Sturgeon: I will take on them all. I am sure that Helen Eadie's intention was not to make the case for the bill, but she did that rather well in a way.

With the greatest respect to my former professional colleagues, the Law Society of Scotland is plain wrong when it says that the bill diminishes existing rights. It does not. The bill does not affect existing rights. Helen Eadie gave a long list of rights from the supplementary paper that the Law Society provided to the committee. None of those rights is affected in any way by the bill. It is really important that that point is well understood.

Helen Eadie's pertinent point—it was this point that made me think that she was making a better case for the bill than perhaps even I had done—was on the constituency cases that we all receive. She spoke of people going through the whole system and getting to the end of it feeling that no difference has been made. That is one thing that the bill is specifically trying to deal with.

Giving patients the right to complain is one issue that the bill tries to deal with. The aim is not just to say that patients can complain, but to make that a specific right and to put a duty on boards, as section 11 does, to monitor complaints with a view to identifying areas of concern and improving performance as a result of those complaints. In other words, the aim is to close the loop in the complaints process so that patients will be assured that going through the process will improve things in future for other people, even if making a complaint will not change things for them. Sometimes nothing can change what has happened for a patient who makes a complaint. That the process will improve things in future for other people is exactly what patients want to hear. For me, that is one important aspect, although not the only important aspect, of the bill.

I assumed that we would come on to the patient advice and support service as a specific topic, but I will answer Helen Eadie's questions about it now. She said that she has concerns about the current operation of the independent advice and support service, but the proposals have been made exactly because those concerns exist. There are concerns about patchiness, lack of consistency, there not always being clear lines of feedback and communication between the service and the health board, and information not always being shared to ensure that patients' experiences are used in the improvement process. The bill seeks to put the service on a national footing, and to make it consistent and statutory so that boards could not cut it even if they wanted to in order to save costs. The service is seen as a core part of what the health service does. We are providing additional funding for it, which is important, and it will be independent. The health service will fund it, as it must be funded by somebody, but the Government will give the health service additional funds. We intend it to be contracted in a way that is similar to how the independent advice and support service is contracted at the moment. That will ensure that the people in question are not directly employed by the health service and are not under its control. Patient rights officers will be independent.

The bill will also strengthen the current system by making it clear what patient rights officers are there to do. Among other things, they will aim to raise the awareness and profile of patient rights, including awareness of the options that are open to patients if they are not satisfied with the treatment that they have received.

Many of the personal constituency cases that Helen Eadie mentioned—we can all recount such cases—strengthen rather than weaken the case for the provisions in the bill. Members have been kind enough to say that they do not doubt my intentions or my passion for the health service. I do not doubt members' commitment to patient rights, but we need to consider how we embed and strengthen the concept of patient rights in the current system.

Helen Eadie: I—

The Convener: I will let Helen Eadie back in later. The cabinet secretary has had quite a long spiel.

Helen Eadie: I just do not know where the magic bullet is. The cabinet secretary has not said where that is.

Nicola Sturgeon: I am beginning to echo my contribution to the minimum pricing for alcohol debate. I am not saying that the bill is a magic bullet. Anybody who—

The Convener: I will just stop you there, cabinet secretary. I do not think that there is any such thing in life as a magic bullet. It is mythical.

Nicola Sturgeon: Exactly.

Helen Eadie: The question is whether the bill will make a difference to my constituents.

Nicola Sturgeon: I think that it will for the reasons that I have outlined.

The Convener: Halt! Helen Eadie can come back in later; I will let Rhoda Grant in first.

Rhoda Grant: I want to ask about patient rights officers, but I have a couple of supplementaries first.

Like everybody else, I welcome moving to change the ethos in the health service to give patients more rights and make them feel more included in their own treatment, but I am not sure that we can legislate for that change; rather, training and how the health service is run need to be considered. The cabinet secretary outlined the process for dealing with complaints. A good health board should deal with complaints at the moment, but she talks about patients getting more satisfaction if they see that their complaint has led to a change in the way that things are handled or done. How will that be monitored? How will health boards be held to account? It seems to me that, at the moment, it is down to the health board to do things, but nobody oversees that and the patient has no sanction available to them if the health board does not act. Will the Government monitor and hold health boards to account if they fail to act?

11:15

Nicola Sturgeon: I agree with most of what Rhoda Grant has just said. I am not suggesting that, just by virtue of passing a piece of legislation, we can change the ethos and culture of the health service. I hope that nobody takes what I am saying to mean that I think, to use Helen Eadie's phrase, that the bill is some kind of magic bullet—I do not.

The Convener: I am going to ban magic bullets, along with scenarios and directions of travel. I hope that you all accept that. On you go, cabinet secretary.

Nicola Sturgeon: I do not think that I have been issued with the list of words that are banned at the Health and Sport Committee.

The Convener: Ah, that list is growing.

Dr Simpson: Coffee cups are banned, too.

Nicola Sturgeon: My train of thought has been completely interrupted.

The Convener: I am so sorry.

Nicola Sturgeon: I do think, however, that putting these rights in legislation helps the process. It focuses the minds and the efforts of those who deliver health care on what they must have regard to in delivering health care.

Rhoda Grant is absolutely right about the importance of monitoring. Assuming that the bill is passed and that we introduce further regulations, monitoring will be a part of the process. The bill deliberately and expressly says that monitoring will be one of a health board's duties, so it will become part of the performance management of the health service to ensure that monitoring is part of the way in which complaints are dealt with. I said earlier that, as a matter of practice at annual reviews, I ask health boards about monitoring. As it becomes a legal duty on health boards, monitoring will become a more formal and systematic part of the process of dealing with complaints.

The Convener: That answers the question that I was going to ask about how the provisions in sections 11(3)(e) and 12(4) would be enforced. You are saying that, if the bill is passed, the review of performance management of NHS boards will cover whether they are compliant. My question was going to be about—

Nicola Sturgeon: Yes—the reviews will be one way of doing that.

Rhoda Grant: I move on to patient rights officers. We have been made aware of the concerns that exist about the system as it stands, but most of those concerns are about how seriously health boards take the service. They each contract individually for the service. Some do not provide it at all and others are very good at providing it, which has created a patchy service. It was put to us that one of the benefits of the bill would be that a national service would be provided; however, I am not sure that we need legislation for that to happen. Would it not be possible for the Government to contract with CAS at a national level to carry out the service in the various health board areas, ensuring that there was consistency nationally? All health boards would have a financial responsibility for that and the service would be paid for.

One of the concerns about the bill is that it would damage the service that is available where it is of a good quality. At the moment, people go to CABx not only to get health service advice and information, but to get housing and benefits advice—they have only to go to one place for the whole spectrum of advice, which is where the current arrangement works well. Is there no way of changing the service that is currently available to ensure that we keep the best parts of it while acknowledging that there are problems and sorting them out through having a national contract rather than local contracts?

Nicola Sturgeon: Of course, we could contract nationally rather than locally. However, it is important to address the matter in the bill, as a future Government might believe that the service was not particularly important and decide not to contract for it any longer. You may argue that a future Government could change the law, but that would be a bit harder to do and would require more scrutiny. We are embedding the service firmly as a core service that is available in the NHS to help patients to exercise their rights. That is the simple answer to your question why we should legislate on the matter rather than simply contract nationally for the service.

I have found the evidence on the need for holistic service provision interesting, and I absolutely agree with the points that have been made about the provision of advice and support to patients. It is not just about health; it is about dealing with other issues and complaints that may impact on people’s health or their ability to access the health service. It is, nevertheless, important to stress that the ability of the current independent advice and support service to do such work comes not from the health boards contracting with the provider but from the fact that it is the CABx that are providing the service. The CABx can give the patients who use the service access to all their other services. If CAS or a similar organisation were to get the contract to deliver the service in the future, the same holistic approach would still be possible and would be very desirable. However, it is important to recognise that, right now, that approach is possible because it is the CABx that are providing the service, not specifically because of the way in which the IASS is contracted for. There is nothing in the bill that will reduce or diminish what is already provided—it will only strengthen and improve the current system.

Rhoda Grant: Would it be possible for the bill to state that whoever ran the contract for the new advice and information officers would have to be able to provide more holistic advice?

Nicola Sturgeon: I am happy to consider that. This is only stage 1. The committee will know, from its consideration of previous bills, that I take on board all the suggestions that it makes. I am not sure what might be possible under procurement rules, so I do not want to give a definitive yes or no answer. However, as with all the suggestions that the committee makes, I am more than happy to consider that suggestion.

Mary Scanlon: As with the scrutiny of all the bills that come before the committee, it is important that people are not given the impression that there are party-political divisions. The Conservatives introduced a patients charter in 1991; 10 years later, the Labour-Lib Dem coalition created health rights information Scotland; and now, 10 years down the line, the SNP has introduced this bill. I hope that, in our deliberations, it is not assumed that one party cares more about patient rights than others. We all have a huge commitment to the subject.

I will ask a couple of questions that I have asked before—you will have heard the arguments and will have read the evidence, cabinet secretary. My first question is on the exclusions from the treatment time guarantee. I struggle to see why diagnostic tests, out-patient treatments and mental health patients should be excluded from the treatment time guarantee. I understand why organ transplants and obstetrics are excluded, but why have you decided on the other exclusions?

Nicola Sturgeon: Mental health services are not excluded—it is important to correct that misapprehension. The treatment time guarantee is intended to relate to planned and elective in-patient services. Where mental health treatment is to be provided in that way, it will be covered by the treatment time guarantee. There is no exclusion of mental health services. As Mary Scanlon takes a close interest in mental health services, she will know that much of mental health hospital care is provided on an emergency, unplanned basis. It would, therefore, not be appropriate to have a 12-week waiting time for that, as it will be provided instantaneously. A lot of mental health care is also provided on an out-patient basis, which is why, along with other out-patient services, it will not be covered by the treatment time guarantee. Nevertheless, I make it absolutely clear that, when mental health treatment is to be provided on a planned, in-patient basis, it will be covered by the treatment time guarantee just like any other service. I want to make that very clear.

Mary Scanlon’s question also referred to diagnostic tests. The 12-week treatment time guarantee that is provided for in the bill sits within the 18-week referral-to-treatment target that we currently have. In order for that target to be met, diagnostic tests require to be done quickly; we already have waiting time targets for key diagnostic tests, which health boards are meeting.

Right now, our waiting time targets are individual stage-of-treatment targets. We have a waiting time target for out-patient treatment, a waiting time target for key diagnostic tests and a separate waiting time target for in-patient treatment. So, although somebody might need several diagnostic tests and it might take weeks or—as can be the case—months to diagnose them, at the point of diagnosis the in-patient target will still have to be met.

When we move to a referral-to-treatment target, because that is a whole-journey waiting time target it requires to have tolerances attached to it, given that sometimes diagnosis takes longer than 18 weeks. The 12-week treatment time guarantee ensures that if, for argument's sake, it takes 18 weeks to diagnose a condition, the patient will have the backstop of the 12-week treatment time guarantee, rather than be left hanging because they are already outside the 18 weeks, fall into one of the tolerance areas and therefore have no guarantee of how long treatment will take. I think that it is important to see the 12-week guarantee within the overall context of the 18-week referral-to-treatment target. There is a hard target and guarantee in the bill: once someone is diagnosed, they will be treated within 12 weeks. We all know how much importance patients attach to waiting times; they are not the only thing that they value, but they value them very strongly.

I hope that my answer both clears up some misapprehension about mental health treatment and explains how the treatment time guarantee sits within the Government's wider waiting times agenda and aspirations.

Mary Scanlon: Paragraph 38 of the policy memorandum specifically states, in relation to mental health, that

> "Through secondary legislation, the Scottish Government intends that the TTG will apply to planned and elective care delivered on an inpatient or day case basis".

The cabinet secretary knows as well as I do—and I appreciate that there is a psychiatrist at the table—that a large number, if not the majority, of mental health patients are not waiting for planned and elective care. When they receive a diagnosis, they might be referred to a psychologist. Two years ago, the wait for an appointment with a psychologist in Easter Ross in the Highlands was four years and seven months. The cabinet secretary might say that there is a 12-week diagnosis-to-treatment guarantee—that is the case for hip operations, for example. However, the wait is not 12 weeks for a mental health patient waiting to see a psychiatrist or waiting for cognitive behavioural therapy; there can be, and has been, a wait of up to four years and seven months to see a psychologist. That is the length of time from diagnosis to treatment; let us get the situation clear and let us try not to be misleading.

One of the ladies in the first panel of witnesses mentioned physiotherapy. I made a freedom of information request across the health boards last year and discovered that more than 26,000 patients in Scotland were on a waiting list for physiotherapy. The diagnosis may be that a patient requires physiotherapy, but their treatment is not delivered within 12 weeks. I could go on about infertility treatment and so on. We must be careful to make it clear that mental health patients who require talking therapies are not included in the bill.

Nicola Sturgeon: I did not, either deliberately or unintentionally, mislead the committee. I was very clear that the treatment time guarantee is about in-patient, elective treatment. Any treatment that is not provided on that basis is not covered by the treatment time guarantee. I have explained why we think that a treatment time guarantee is important within the context of the 18-week referral-to-treatment target. Of course, other treatments that are not required on an in-patient basis are still covered by the 18-week referral-to-treatment target.

Mary Scanlon is right to talk about unacceptably high waiting times in areas such as mental health and physiotherapy. We inherited some of that and we have made it clear that our intention is to get waiting times in such areas down so that we can bring them within the ambit of the 18-week referral-to-treatment target. We have already taken action to do that in audiology. The committee will know, from previous discussions, about the work that we are doing to reduce waiting times in mental health services and in child and adolescent mental health services in particular. In return, let us be careful not to mislead in the other direction. These treatments are covered by the 18-week referral-to-treatment target. Within that, we think that we need a specific in-patient treatment time guarantee to take account of what can be the unintended consequences of a whole-journey waiting time target.

11:30

Mary Scanlon: I will refer to the bill. I am not a lawyer, but I point out that section 1, on "Patient rights", states:

> "Health care is to ... be patient focused: that is to say, anything done in relation to the patient must take into account the patient's needs"

and

> "have regard to the importance of providing the optimum benefit to the patient's health and wellbeing".

Why is it necessary to put that into legislation? Are our trained and experienced health professionals not doing that just now?

Nicola Sturgeon: That is not the case. Most health professionals aspire to that on most occasions, and they deliver care very well. This goes back to the points that I made earlier about changing the culture and levelling the playing field.

The committee received evidence from the Royal National Institute of Blind People last week or the week before about the fact that, although the clinical care that they get might be very good, patients sometimes get appointment letters that they cannot read—they cannot access them. The bill is about putting into print and into action the principle that we believe in, which is not just about the clinical care that a patient gets; it is about taking into account their needs in the widest possible sense. It raises the import and the status of that principle to have it in a bill such as the one before us, which makes a very clear statement of intent in describing how we intend patients to be treated in the health service.

Mary Scanlon: The breach of the treatment time guarantee is undoubtedly the central focus of the bill. If the guarantee is breached, the health board

> "must ... ensure that the agreed treatment starts at the next available opportunity ... provide an explanation to the patient as to why the treatment did not start within the maximum waiting time ... give the patient details of ... advice and support"

and of

> "how to complain."

Does that not all happen at the moment? Is that not just basic good practice?

Nicola Sturgeon: Again, that goes back to my earlier point. We can have a set of patient rights whereby we hope that that all happens as part of good practice, or we can ensure that it happens as a matter of rights that patients have in law. I prefer the latter course. That is, of course, a matter of judgment for everybody.

It is important for patients to have certainty and clarity. Health boards have done a fantastic job in bringing down waiting times, and my expectation is that the treatment time guarantee in the bill will be delivered in the vast majority of cases. Where it cannot be delivered, for whatever reason, it is important for patients to have clarity about what then has to happen, and for them to be given support and advice in exercising their rights.

Mary Scanlon: That is the point. Helen Eadie spoke about the bill raising expectations. We are all in favour of patient rights, but under the bill patients just have a right to an explanation and a right to details about how to complain.

Nicola Sturgeon: If Mary Scanlon is suggesting—

Mary Scanlon: Those rights do not seem to be any greater than those that are contained in the patients charter and the HRIS publications, which Labour and the Lib Dems introduced. I am struggling to see why those rights have to be in the bill, as I have no doubt that when a patient anywhere in Scotland asks why they have not been treated within 18 weeks, what the bill covers is exactly what already happens.

Nicola Sturgeon: Sometimes it does, but there will be occasions when that does not happen to the patient's satisfaction. I reiterate that either we just hope that patient rights will happen, or we ensure that they happen. I think that the latter approach is better.

The Convener: I think that we have exhausted that line of questioning—if the committee forgives me for saying so.

Joe FitzPatrick (Dundee West) (SNP): People have raised concerns that the bill would place additional financial pressures on the health service just when money is getting tighter and tighter. I invite the cabinet secretary to respond to that, and to say how the bill fits into the tightening fiscal situation that we are moving into.

Nicola Sturgeon: There are direct and specific costs resulting from the bill, which are all detailed in the financial memorandum. However, I guess that your question is a bit broader than that—should we solidify and embed patient rights at a time when the health service is strapped for cash? There is a view that says we should not put health boards under any more pressure to deliver good, patient-centred, high-quality care. I actually think that times such as this, when money is tight, are exactly when we should be increasing our focus on putting patients at the centre and ensuring that, as boards work through financial pressures and difficulties, they do not lose focus on what the health service is all about, which is delivering high-quality care.

I am asked the same question about our quality strategy—is it the wrong thing to do at a time of financial difficulty? I take completely the opposite view. It is exactly the right time to put a focus on quality and, in this context, on patient-centredness, patient focus and the rights of patients in their interaction with the health service.

The Convener: The final set of questions is from Ian McKee. [*Interruption.*] I should never say that, as a hand always goes up. Ian McKee will be followed by Richard Simpson.

Helen Eadie: You promised me a question, convener.

The Convener: I was hoping that you had forgotten.

Helen Eadie: You were hoping that I had gone to sleep.

The Convener: I was going to shoot you with my magic bullet. Ian McKee will be followed by Richard Simpson and a tiny smidgen of a question from Helen Eadie.

Ian McKee: The cabinet secretary has said several times today that the treatment time guarantee applies to elective in-patient services. Does it also apply to day surgery, which is not an in-patient service?

Nicola Sturgeon: Yes. The treatment time guarantee applies to elective planned treatment, whether that be in-patient treatment or day-case treatment. That is an important clarification. When I say that things apply only to elective planned treatment, I am talking only about the provisions of the bill relating to the treatment time guarantee. The rest of the bill applies not only to planned treatment but across the board.

Ian McKee: Is it your intention that the treatment time guarantee should apply to the same procedures if they are carried out in primary rather than secondary care settings?

Nicola Sturgeon: Yes. If I had long enough, I could cite the relevant section, but the bill makes it clear that boards will have to ensure that the same principles and rights apply to services for which they contract with other organisations.

Ian McKee: I am sorry, but your use of the term “in-patient services” confused me slightly.

I turn to section 8, on breach of the treatment time guarantee. Section 8(3)(a) states that the board

> “must not give priority to the start of any treatment where such prioritisation would, in the Health Board’s opinion, be detrimental to another patient with a greater clinical need for treatment”.

That seems sensible, but can you explain why the provision is included only in the section on breach of the treatment time guarantee? Is it not important to include it in the section on the treatment time guarantee? Rightly or wrongly, there have been concerns that there may be pressure on clinicians to alter their priorities to fit in with treatment time guarantees.

Nicola Sturgeon: I am happy to look at the issue and to consider whether an amendment should be made. Section 2 states that, when applying all the rights for which the bill provides, account must be taken of the rights of other patients.

Ian McKee: I appreciate that. However, given that you include a specific provision in the section on breach of the treatment time guarantee, I should have thought that one might be included in the section on the treatment time guarantee.

Nicola Sturgeon: I am happy to consider whether the section should be amended at stage 2. I am often asked whether targets skew clinical priorities; I am sure that the same question was put to previous Governments. Targets are intended not to skew clinical priorities but to ensure that patients are treated timeously; everyone recognises that point. Ultimately, decisions about treatment should be clinical decisions. Section 8(3)(a) seeks to make that clear, although I take the point that the same provision should be included elsewhere in the bill.

Ian McKee: That would be helpful.

Dr Simpson: I know that you have been doing a lot of work on no-fault compensation, which has been discussed for a considerable period. Do you agree that the ethos of no-fault compensation might move things forward more quickly than many of the provisions in the bill? One reason that patients do not get the rapid response that they seek when something goes wrong, or when they feel that things are not working, is that clinicians think that they might get into a litigious situation. Defence unions used to advise clinicians not to give out any information if they thought that they would be the subject of litigation. How does that point relate to the timing of the bill? I am seeking to understand your general approach.

Nicola Sturgeon: Changes along the lines of no-fault compensation could well be complementary to what the bill is trying to do. I do not think that it is an either/or situation. I am hesitant about saying too much about what our approach to no-fault compensation might be, as I am mindful of the fact that Sheila McLean’s expert group is due to report soon. I would not want to pre-empt that report.

My estimation and my judgment at the outset of the process around the consideration of no-fault compensation was that, should the process result in legal changes, those legal changes would be quite substantial and would probably merit primary legislation in their own right, rather than being dealt with as part of the broader Patient Rights (Scotland) Bill. Should we end up going down that road—I emphasise the word “should”, as we do not know yet what will happen—that would in many respects be complementary to the changes that we are seeking to make with this bill.

The Convener: Helen, is your question on subordinate legislation?

Helen Eadie: It is not on subordinate legislation, nor will I use the dreaded words. Instead, I will refer to a fix-all solution. We will not have a fix-all solution in this bill.

I gather that NHS Lothian is in the process of upgrading and modernising its complaints procedures and services to ensure that complaints are handled in a way that we would all like. That is absolutely right, as we all want there to be change and improvement. Would it not have been better to work with NHS Lothian, which is one of the biggest health boards in Scotland, to find the absolute best practice that is out there and then, once that had been piloted, to come back to Parliament with all the lessons that had been learned from that exercise and propose that we go ahead with all the changes for all the reasons that you could set out? Work has been done in England and in Wales, and there is also the no-fault compensation scheme that you have just talked about with Richard Simpson. I feel that you are, quite rightly, trying to bring a solution to Parliament but that, at the end of the process, people will not be any better off than they are today.

The Convener: The question is, will people be any better off?

Nicola Sturgeon: I think that I have already disputed the point of view that people will not be any better off.

In a sense, Helen Eadie makes a valid point. However, I do not think that anything she has said undermines what we are trying to do in the bill. Of course we work with health boards on a range of issues to improve their practice and procedure. The bill gives a right to complain and it puts a duty on health boards to do certain things in response to complaints. Underneath that, there is the question of what we can do practically to improve the process of complaints handling to give best effect to all that. We will consider anything that any board does in that regard, and see whether we can learn from that and apply it more widely.

The Convener: That brings this evidence-taking session to an end. I thank the cabinet secretary and her team for their attendance.

11:43

Meeting continued in private until 12:37.

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