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Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 24 November 2010

Session 3

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HEALTH AND SPORT COMMITTEE
34th 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:

Jacqueline Campbell (Scottish Government Chief Medical Officer and Public Health Directorate)
Mike Palmer (Scottish Government Chief Medical Officer and Public Health Directorate)
Frauke Sinclair (Scottish Government Chief Medical Officer and Public Health Directorate)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 3

Scottish Parliament

Health and Sport Committee

Wednesday 24 November 2010

[The Convener *opened the meeting at 10:01*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. I welcome everyone to the 34th meeting of the Health and Sport Committee in 2010. I remind everyone to switch off their mobile phones and other electronic equipment. No apologies have been received.

Agenda item 1 is a decision on taking business in private. The committee is invited to agree to take in private item 3, which is consideration of the committee's approach to scrutiny of the Scottish Government's draft budget, and also to agree to take in private at future meetings consideration of its draft report to the Finance Committee on the draft budget. Is that agreed?

Members *indicated agreement.*

The Convener: Thank you.

Certification of Death (Scotland) Bill: Stage 1

10:01

The Convener: Item 2 is our first oral evidence-taking session on the Certification of Death (Scotland) Bill. We begin by taking evidence from the Scottish Government bill team. I welcome Mike Palmer, deputy director for public health; Frauke Sinclair, bill team leader; Jacqueline Campbell, head of the health protection team; and Edythe Murie from the Scottish Government legal directorate.

I invite committee members to ask questions.

Helen Eadie (Dunfermline East) (Lab): Good morning. I do not know whether the witnesses have had time to read the British Medical Association Scotland's submission to the committee, which states:

"We believe the medical reviewer system is less robust and not as comprehensive as the current system or the scheme being introduced in England and Wales. Indeed, there will in fact be a two tier system in the UK, and it is doubtful that this would reassure the Scottish public."

It also states that it would be better not to

"implement inadequate and unsafe changes to save money."

Would the witnesses like to comment on that accusation?

Mike Palmer (Scottish Government Chief Medical Officer and Public Health Directorate): Certainly. We are proposing to go in a different direction from the proposals in England and Wales. The rationale for our proposals is the implementation of a set of arrangements that we believe are proportionate and provide the necessary level of robustness for the purpose that they are designed to achieve.

We decided to propose the implementation of a set of arrangements for a sample of scrutiny on a random basis. As part of a broader package of measures, we would also implement a system whereby any interested person who was connected to the death would be able to request scrutiny by the team of medical reviewers. We also propose that the medical reviewers would be at liberty to scrutinise up to 100 per cent of cases in any geographical area or any practice where there might be a concern and they believed it was appropriate to go in and implement more intensive scrutiny.

I know that the BMA Scotland has raised concerns that random scrutiny is proposed for only about 500 cases a year, which appears to be significantly lower than the scrutiny in 100 per cent

of cases that is proposed in England and Wales. However, we believe that it is important to look more broadly at the whole package of measures that we are proposing, of which random scrutiny is only one small element.

We have deliberately not fixed the numbers for random scrutiny in the bill. Therefore, we are looking at a system that is potentially flexible and could be adjusted so that if after evaluating the early operation of the system we thought that it would be wise to increase the number of death certificates that are scrutinised, we would be at liberty to do that via secondary legislation. We believe that our proposals have in-built flexibility and responsiveness to changing circumstances, which are desirable.

On the ethos that underpins our proposals, we are seeking to drive up the standard of completion of death certificates at source. In England and Wales, the proposal is to institute a check on every single certifying doctor's medical certificates. Essentially, the assumption that lies behind that is that it is necessary to check every single doctor's work, and that that is the only way to institute an effective and robust system around death certification.

We approach the issue from a different perspective. The goal that we are aiming at is to drive up standards at source so that we do not need to worry about having to check every single doctor's completion of a death certificate. We aim to drive up the attention and priority that are given to that particular function, which we feel is a Cinderella function to an extent in some parts of the national health service. We also aim to drive up the priority and attention that are given to the standards of completion of the certificate, and to change the culture and practice so that certifying doctors complete certificates to a much higher level of accuracy at source. We do not believe that the heavy education and training element in our proposals is as prominent in the English proposals. Almost half of the remit for the medical reviewers will be to do with education and training to drive up standards at source.

Helen Eadie: The BMA Scotland also has a concern about the very tight timescales involved. Its submission contains quite an extreme comment. It says:

"If an unrealistic timescale is set, or an emergency arises, or due to pressures from staff absence, a doctor will be required to decide"—

to choose, in other words—

"whether to let patient care suffer or to be imprisoned."

That is quite a worrying statement, which I would like you to comment on. Obviously, the BMA Scotland feels under pressure with the proposal, and the possibility that it describes is quite worrying.

Will you also comment on the removal of the requirement for two signatures from around 60 per cent of death certificates, where the deceased is to be cremated? That seems to be quite a worrying aspect as well.

Mike Palmer: On the first point, I believe that the BMA Scotland was commenting on circumstances in which there might be an epidemic or an emergency, and that it is concerned about the pressures that might arise from staff absences during such times. Our proposals include the suspension of the arrangements in epidemic and emergency situations. I do not know whether Jacqueline Campbell wants to comment on that.

Jacqueline Campbell (Scottish Government Chief Medical Officer and Public Health Directorate): Subsection (7) of proposed new section 24A of the Registration of Births, Deaths and Marriages (Scotland) Act 1965, as inserted by section 2 of the bill, sets out that the Scottish ministers may make a statutory instrument to

"suspend the referral of certificates ... during an epidemic ... or to prevent the spread of infectious diseases or contamination."

In the second category, we might be in a situation that is somewhat short of an epidemic but in which, in order to prevent difficulties such as those flagged up by the BMA or delays to funerals, in extreme circumstances we want to suspend the operation of the system.

The Convener: There was another part to the question—the removal of the requirement for two signatures.

Mike Palmer: We are proposing to abolish what is actually the system of triple signature for cremation, which will affect more than 60 per cent of cases. I go back to my point that the underlying ethos of our arrangements is to drive up standards of completion at source and to ensure that the certifying doctor is achieving the required level of accuracy through education and training and through a change in the overall culture and practice, to the degree that the environment places attention on the process to a much higher level.

We have also observed and had fed back to us from many stakeholders who have looked at the issue, including the independent burial and cremation review group, that the current system of triple signature in cremation cases is not particularly effective in acting as a check or a balance. A number of people have commented on how, in many cases, the signing is done in a relatively perfunctory manner and does not really deliver a robust check. The broad consensus is

therefore that the current system is not really delivering effectively.

Helen Eadie: One last question—

The Convener: I will let Ian McKee in on that point, and then I will let somebody else in. You have had three good questions, Helen. Perhaps somebody else has a question to ask.

Helen Eadie: Okay.

Ian McKee (Lothians) (SNP): I am interested in the implication of what you are saying, Mr Palmer. I would be the first to agree that the present method of certifying the death of people whose bodies will be cremated has some defects. However, for the 60 per cent of people who are cremated, the doctor who provides a medical certificate has then to fill in another form with more information than the medical certificate. He or she then has to find a completely independent doctor of more than five years' standing to look at the first certificate, interview the relatives and inspect the body.

I appreciate that inspecting the body does not do much good in practice, but the process in which an independent doctor interviews the relatives, casts an eye over the certificate and then gives another signature—and finally the medical referee gives a signature—applies to 60 per cent of people who die in this country. You are going to replace it with a system that will allow 98 per cent of people who die to be cremated or buried solely on the certificate of the doctor who has been looking after them. In what way is that a better and more secure system than the one that it replaces?

Mike Palmer: The current arrangements do not involve any dedicated team of professionals who oversee the function of death certification, and we are proposing to introduce a dedicated team of medical reviewers.

Ian McKee: Sorry, but is the medical referee at the crematorium not a dedicated professional?

10:15

Mike Palmer: Yes, indeed, they dedicate part of their time to that function. However, the feedback that we have received from the stakeholders whom we have spoken to has indicated that that system of checks is not working very effectively and is not thorough and robust in cremation cases.

In moving beyond that, we would prefer a system that drove up standards in the education and training of certifying doctors and put in place arrangements to support them. For example, if, in filling in the medical certificate of cause of death, a certifying doctor has a doubt about the cause of death—or, indeed, about any aspect of that certificate—they should be able to contact the medical reviewer for advice. We are looking to certifying doctors to use their professional clinical judgment in ensuring that the new system supports and helps them in completing certificates accurately.

Jacqueline Campbell: I should emphasise that although the random sample is 1 per cent—and in interested person cases perhaps another 1 per cent, although we are not yet sure—we have added to the original proposals a very significant power for medical reviewers to carry out additional scrutiny of up to 100 per cent in whatever part of the country they want and for however long they decide. We expect the random sample to form part of a baseline picture of evidence but, as I say, the reviewers can consider other evidence and carry out more targeted work in scrutinising cases in particular areas of the country or particular hospitals where they feel that there are issues to pick up.

One issue that has not yet been mentioned and which is perhaps not such a feature down south is the seriousness with which we in Scotland take links to clinical governance and the national health service's clinical governance structures. We have made it very clear that there must be very strong links between medical reviewers and medical directors—and possibly directors of public health—at health board level. That would create an avenue for exchanging information and taking forward any emerging issues that I do not think exists in the same way down south.

Ian McKee: I will return to those points in my later questions but, as far as this particular supplementary point is concerned, I have to point out that everything in the financial memorandum and statements is based on 98 per cent of people being buried or cremated without any intervention other than that of the doctor who has seen them and who provides a certificate. I fail to see how that system is better than a system in which 60 per cent of deaths are certified by three doctors' signatures.

Jacqueline Campbell: All we can do is reiterate that much of the evidence that we have received from fairly extensive discussions with stakeholders, including people from the medical profession, is that the current system does not work; that getting three doctors to sign a certificate is not a robust procedure; and that many of the checks that are made are perfunctory. There is a fair consensus around the need to change the system in some way and we are presenting a package of measures that we think will take things forward.

The Convener: After checking with the clerk, I think that medical professionals will be giving evidence next week, so we can raise those questions then.

If Richard Simpson intends to follow up this issue, I ask him to do so and then move on to his substantial question.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): My substantial question is actually quite a small one, so I am happy to leave it to later.

Following on from the points made by Helen Eadie and Ian McKee, I believe that, initially, the fundamental driver for all this was the Shipman report. Will the proposed Scottish system ensure that any Shipman-type cases are picked up early? If 98 per cent of deaths are going to be certified by a single doctor, I have to wonder, even taking on board your comment that the bill will be able to vary the figure, whether reviewing only 1 per cent of cases will be enough. What statistical advice have you received that has led you to think that this approach would have picked up Shipman in 1980 instead of two thousand and whatever it was?

Mike Palmer: You are right that the Shipman case was the key original driver for examining death certification. However, quite some time ago, we concluded—and our English and Welsh colleagues have reached the same conclusion—that it is not possible to design and construct a death certification system that can guarantee the prevention of another such case. Even if we were to implement comprehensive scrutiny of 100 per cent of cases, it is still unlikely that someone such as Dr Shipman would have been caught.

We have therefore come to the clear view that the arrangements that we are setting out should have, as the key driver, a focus not on preventing another Shipman but on improving the standard of completion in the death certification system and on providing public health information from death data that will drive up clinical standards and make the links with clinical governance.

Within that set of arrangements, we clearly wish to do as much as we can to try to deter the possibility of another Shipman case. We believe that the package of arrangements that we propose provide a deterrent effect, but evidence from stakeholders has indicated to us that it would be folly for us to try to design a system to guarantee the prevention of another Dr Shipman case.

The other point is that we are talking about cases that are not referred to the procurator fiscal, so we are not talking about any cases in which there might be suspicion of malpractice or dubiety about the cause of death. We are talking about cases in which unambiguous and non-suspicious causes of death are being looked at. The clear conclusion that we have come to is that although there was an original driver around Shipman, that is not the key focus of the proposals that we have brought forward.

Dr Simpson: I accept the policy objectives and aims of the bill that are set out in paragraph 16 of the policy memorandum. Nevertheless, as a Parliament and as a committee, we will want to be reassured that any new system will not make it less likely that someone like Shipman will be picked up. The statistical analysis of death certification is obviously important and it might give one some clues. However, it will be possible to cremate 60 per cent of people very rapidly—with, therefore, no recourse, even when one has a suspicion—and the system will do no more than allow the doctor to certify the death. That seems to me substantially to lessen the potential for ascertaining another Shipman.

I accept your basic point that you cannot prevent another Shipman—that can be very difficult because psychopaths are extremely clever. However, we have to have a system that at least reassures the public that it would be more likely, rather than less likely, to pick up such cases.

I have concerns, even given the introduction of the interested person review, which I think is a very important and welcome measure, and the proposal to review 1 per cent of cases. To exercise the additional powers of investigation in a particular geographical area or with regard to specific doctors, you have to be suspicious or to have a reason for doing that. I am not sure that Dr McKee's point has been fully answered.

Mike Palmer: On your point about whether we are in danger of moving to a system that is less robust than the current one, we have talked a lot about cremation cases, but more than 30 per cent of people are buried. There is no check at all in those cases. That points up the anomalies and weaknesses in the current system.

We are proposing that, for the first time, we will have a standardised, uniform system across both burials and cremations and that there will be checks in cases that go to burial in a way that there have not been before. I think that it should not be lost that that is an important enhancement, if you like, to the current system.

The Convener: Ross Finnie has a supplementary on the same issue.

Ross Finnie (West of Scotland) (LD): I share with all my colleagues a little difficulty in following the two aspects of a system that is perceived to be robust. As I understand it, the current system contains a requirement, in a large number of cases, for more than one signature, and you have found that system to be "perfunctory", to use your word. Nevertheless, the principles behind it are the general principles of any system that is designed to obviate fraudulent practice through seeking some third-party corroboration of an action that

has taken place. However, I can do nothing other than accept that, having done the work, you have found that perfunctory.

What I find difficult, however, is that, having concluded that the current system involving a second or third check is not working—and notwithstanding all the other systems that seek to insert some check or balance into a procedure that might be open to exploitation or fraud—you have suddenly decided that the answer is not to make that checking system better but to remove it completely. I confess that I find the philosophy behind that extraordinarily difficult.

This might come as a surprise to some members, but a long time ago I operated in the accounting profession, which went to great lengths to make me a better accountant. However, that did not mean that I would not indulge in fraud. The procedures that were placed around me in any operation that I took part in involved a third party scrutinising what I was doing or indicating what I should do. My technical excellence could get better and better—such that I might even fill in a death certificate, if properly trained. However, that system did not itself obviate any exploitation or fraud.

Why, given that generality of dealing with such situations, have you elected almost to eliminate any third-party check?

Frauke Sinclair (Scottish Government Chief Medical Officer and Public Health Directorate): The matter of the second and third signatures was never about fraud. The purpose of the second and third signatures for cremation certificates derives from a historical reason. The main purpose was to catch criminal activity. At the time, the system was set up because death certification was not performed in the consistent way that it is today. Death certification was not done 100 per cent of the time in some cities.

That situation no longer applies today, however. As we accept, the system that we are introducing is not about catching criminals. As you accept, the current system is not working very well. It is indeed perfunctory, and it is not independent. We no longer wish to continue with those arrangements.

Ross Finnie: So we are not looking for fraud or any criminal activity.

Frauke Sinclair: Correct.

Ross Finnie: In fact, we are not looking for any error at all in the system. I am not going to play with words. You can call it fraud, criminality, inadvertence or whatever you like. We can choose any word in the dictionary—we can bring in a thesaurus and choose one. You are telling us that the proposal has absolutely nothing to do with checking anything that might have gone wrong.

Frauke Sinclair: Not quite—

Ross Finnie: That is what you have said. That is exactly what you have just said.

Mike Palmer: We are making a distinction in relation to detecting possible criminal activity in completing the death certificate—for example, knowingly inserting a totally inaccurate cause of death in order to cover something up. That is a criminal activity, and if there was any suspicion or dubiety about the cause of death, or even if it was simply a sudden death, it would go off to the procurator fiscal immediately and it would be dealt with under a different system.

Ross Finnie: Please do not introduce different factors. We understand perfectly that a sudden death will go to the procurator fiscal. The issue is about the completion of a death certificate by a medical practitioner. You seem to be telling us that, if he has made a spelling error or if there is a grammatical infelicity, that is about the extent to which the system is intended to pursue the matter.

10:30

Mike Palmer: No. The system does not seek to detect fraudulent activity in terms of something being knowingly covered up—we would look to the Procurator Fiscal Service to cover that aspect. We are looking to pick up genuine errors that a clinician might have made in an inaccurate recording of the cause of death. Some of those errors might be simply due to a clinical error of judgment, and some of them might be due to less-than-full attention being paid to the filling out of the death certificate—for example, we know of some cases in which “old age” was recorded as the cause of death, which is not a sufficiently accurate cause of death for a death certificate. It is that type of error—as well as more mundane errors, such as those involving illegibility—that we seek to detect.

The Convener: One of the general practitioners on the committee almost choked on his water when you said that “old age” had been put on a death certificate.

Ross Finnie: Does it matter? What is the purpose? Why have an act of Parliament?

Jacqueline Campbell: Some statistics from the General Register Office for Scotland help to give some perspective to the matter. We know that, in 2009, there were nearly 2,500 medical certificate of cause of death forms in which the cause of death could not be identified and the forms had been incorrectly completed. The GROS employs a consultant who looks at the system of coding deaths and writes letters to doctors in such

circumstances. In about 600 cases, those letters were not responded to in any way. We have had discussions with the GROS about that coding system and have also considered how there could be links with the medical reviewers to make that system more robust as well.

The Convener: To everyone else on the committee, I say that the two GPs on the committee, who have filled out death certificates, will be given more space to ask questions than those members who have not.

Dr Simpson: I welcome the fact that we are modernising our system. However, why are we not moving to an electronic system? That would mean that a death certificate could not be submitted unless it were filled in in a way that was acceptable to the GROS, and it would also remove from the process the need for repeated data entry, which is another source of possible error. It would, for example, stop someone writing "old age" on a death certificate—although, on that point, Ian McKee and I would both agree that, in a case in which, for example, someone was 103 years old and there was no other diagnosis of death, it would be acceptable to say that they had died of old age. Using an electronic system would establish a chain of evidence and would do a lot to clarify matters. It would also introduce some of the other issues that I will raise later.

Mike Palmer: We have not included a proposal for electronic underpinning of death certification.

Dr Simpson: Why not? I do not think that simple training will solve the problem that results in 2,500 death certificates being incorrectly submitted.

Jacqueline Campbell: Obviously, we can see the advantages of doing it electronically, but I do not think that we have a system at the moment that would allow that.

Dr Simpson: It would also allow there to be immediate, almost real-time, analysis. A medical reviewer could use that to pick up very quickly whether something was going wrong. Software packages could be used to analyse series of two or three deaths, which could be statistical blips, so we would not have to wait for the GROS to deal with the matter, which, as you know, it will not do until six months to a year afterwards.

Jacqueline Campbell: As an integral part of the system, we will employ a national statistician, with an assistant, who will produce national and local statistics that we would expect the medical reviewers to be able to use. That might, in part, be the answer.

Dr Simpson: They will have to enter all the data manually or wait for the information from the GROS.

Jacqueline Campbell: Unfortunately, I do not think that we can get around that. Registrars do a brief check on the death certificates that they receive, and they will also be able to refer certificates to medical reviewers.

Dr Simpson: I just think that we are missing a chance. If we are going to modernise the system, we should modernise it. We should be moving to the 20th century before we leave the 21st.

The Convener: I did not understand that.

Helen Eadie: He is talking about e-health.

Dr Simpson: Computers came in in 1990, in primary care at least. It is perfectly feasible to have an electronic system for this, but we are not even proposing it in the 21st century, which is a shocking omission.

The Convener: I follow you. I was just working out which century I was in. It has been a long week so far.

Rhoda Grant has been very patient.

Rhoda Grant (Highlands and Islands) (Lab): I want to talk about some of the concerns of island authorities, and the concerns of ethnic groups—for example the Jewish community—about delays in burial. In its submission, Orkney Islands Council talked about the custom and practice of keeping a body at home until burial. Any delay will cause additional distress and could have health implications.

Frauke Sinclair: We expect that, on average, the scrutiny that we are proposing will take up to half a day of the medical reviewer's time, stretched over one to two days on average, so we do not anticipate that it will usually have any effect on funerals. We appreciate that in circumstances like the ones that you mentioned, there will be an effect on communities in remote and rural areas as well as faith groups. That is why we have proposed in the bill a section on a so-called expedited procedure for which anyone who is chosen for random scrutiny can apply. That will mean that scrutiny will take place in parallel with registration, and when registration is complete the disposal/funeral can take place. That is how we answer the concerns that faith groups have raised. They would certainly be eligible to apply for the expedited procedure. With regard to remote and rural communities, we want to test in the pilots before implementation how long it will take to access medical notes et cetera.

Rhoda Grant: Can I take it that you expect to have a network of medical reviewers throughout the country so that, for example, somebody will be based in Orkney and will be able to carry out the review very quickly? You are nodding, so I assume that that is the case.

Frauke Sinclair: In the financial memorandum we propose having six medical reviewers and the same number of medical assistants. The medical reviewers may be part-time, so there may be up to 12 reviewers. We have not decided exactly where they will be based, but we expect them to be based in different locations around the country and that they will be mobile.

On accessing documents, we expect that some of them will be electronic. You will know that hospital documents are available electronically. As I said, in the test sites, we will pilot accessing and transferring documents as quickly as possible. We will also make use of other means of quick communication. For example, if there is a comprehensive review, health personnel will need to be interviewed, which will be done by telephone to ensure that it is done as quickly as possible so as not to inconvenience anyone.

Rhoda Grant: That sounds great, but the problem is that in remote and rural areas broadband might not be available and it can be difficult to transfer information electronically. I cover the Highlands and Islands, and I have been stranded on islands due to bad weather, which can happen in summer, winter or whenever. There can be fog in Orkney and storms, which can stop people moving about, so the physical transfer of people and information can be difficult, and the wherewithal to transfer information electronically might not be available either.

Is there a way of taking into account those issues when a random review is done? In the middle of winter, if people do not have access to electronic equipment, or if bodies cannot be transferred, could people appeal to have the review suspended because of the distress and delay that it would cause?

Frauke Sinclair: When cases are chosen for random review, people will be able to apply for an expedited procedure. People might well be able to do that in the circumstances that you describe, and we will consult on that in due course. As I said, the test sites will look into that.

As we explain in our policy memorandum, the random review's purpose is not to deal with specific concerns, so the only reason for a hold-up would be the need to access the body, which would be rare. I am confident that we will be able to meet the needs that you mentioned.

Rhoda Grant: So a funeral could proceed without the need to wait for the review to be completed.

Frauke Sinclair: The expedited review would achieve that purpose.

The Convener: Is the expedited procedure to which you refer in section 6?

Frauke Sinclair: Yes.

Rhoda Grant: The Jewish community has pointed out that it would like burials to take place before sundown on the day of death or—at the latest—on the day after death. Given your earlier answer, could people from that community apply for a burial to take place while a review was on-going?

Frauke Sinclair: The circumstances are the same—the expedited procedure could apply.

Rhoda Grant: How long do you estimate that it would take to apply for clearance to use the expedited procedure?

Frauke Sinclair: We would expect that to be done over the phone within an hour or so.

The Convener: I thank Rhoda Grant for that interesting line of questioning.

Mary Scanlon (Highlands and Islands) (Con): I apologise for being late—

The Convener: It was a delight—everybody else got to ask questions first.

Mary Scanlon: I came down on the train from Inverness just this morning, which gave me an opportunity to read the submissions.

Ian McKee: Unlike the rest of us.

The Convener: Stop digging—just ask your questions.

Mary Scanlon: If my question has been asked—

The Convener: I will stop you.

Mary Scanlon: In that case, I will read the *Official Report*.

The 36 submissions do not seem to show anything like unanimous or even majority support for the bill. I was surprised that many say that the bill is "a retrograde step", that 32,000 bodies will be cremated with no scrutiny and that the system will be "less robust" than what is in place and considerably

"less robust than the system in England & Wales".

The Convener: We have covered that.

Mary Scanlon: I appreciate that. We have talked about Shipman. Many respondents have said that GPs will be checked every eight to 10 years.

If that has all been covered, I will move on. Concern has been expressed about a conflict of interest or loyalties, because medical reviewers will not be independent—they will be NHS employees. How can someone whom the NHS employs be an independent person? That is my

question, as the rest of my questions have been covered.

Mike Palmer: Medical reviewers will be employed by healthcare improvement Scotland—

Mary Scanlon: Which is in the NHS.

Mike Palmer: Yes—it is part of the NHS. However, healthcare improvement Scotland is not a territorial NHS board that delivers services with patient contact, so medical reviewers will not be employed by the same territorial NHS boards as employ doctors.

Mary Scanlon: The respondents know that. I did not say that medical reviewers would be employed by territorial boards. I have the submission from the Royal College of Pathologists, for example, which knows about the arrangement and is concerned that medical reviewers will be employed under the NHS's umbrella and will not be impartial.

Mike Palmer: The fact that they are employed by a totally different organisation—albeit within the NHS—from the employing organisation of the doctors that they are reviewing gives them sufficient impartiality. There is sufficient separation and independence. We do not believe that there will be a conflict of interest, because they will not be employed by the same employer.

10:45

Jacqueline Campbell: HIS, which is the body that we are talking about, will replace the existing NHS Quality Improvement Scotland. One of the reasons why we think that it is worth while locating the medical reviewers there is that they already perform a range of similar functions for the NHS. There is a similar model for the healthcare environment inspectorate, which will be part of the same body, and performs a similar function in a different field. We have discussed with HIS the importance of the independence of the medical reviewers. They will be able to work independently within that framework while having accountability to the board of HIS.

Mary Scanlon: I still have significant concerns, but I will move on to my second question.

The Convention of Scottish Local Authorities and others refer to what they call the £30 death tax. Local authorities do not want that statutory requirement to be imposed on people who are registering a death. People who come straight from the hospital might not have the money with them. It is not clear who will collect the fee, or death tax. Are you assuming that it will be the registrar?

Mike Palmer: Our preference is for the registrar to collect the fee. The fee will be significantly lower than the fee that bereaved families currently pay to doctors to countersign cremation certificates. More than 60 per cent choose cremation as their method of funeral, so there will be a significant lessening of the financial burden on the majority of families.

We are still discussing the collection of the fee with the registrars. The other candidate for collecting the fee is the funeral director. The registrars, as a body, and the funeral directors have raised concerns about collecting the fee, therefore we have not yet resolved the matter with them.

Mary Scanlon: To be fair, I did not ask about cremation or disposal of the body; I asked about the registration of the death. Would I be right in saying that, at present, if you register a death at the registrar's, you pay no fee, but if you wish an additional copy of the certificate, you pay £9?

Mike Palmer: Yes. If you register a death, you pay no fee to get a summary of the extract from the death register. If you want the full extract, you pay a fee. It is our understanding that almost 100 per cent of people who register a death pay for the full extract.

Mary Scanlon: But am I right in saying that if the bill is passed, everyone who registers a death will have to pay the £30 death tax? It is nothing to do with whether the body is buried or cremated; I am talking about when they register the death.

Mike Palmer: Yes, that is correct. Under our proposals, when they register the death, they will be liable to pay the fee.

Mary Scanlon: Councils see that as a death tax.

The Convener: To clarify the money business, while there is a lot that one might not like about the bill, I take it that the £147 that is currently paid for cremation disappears.

Mike Palmer: Yes.

Frauke Sinclair: In addition, there is a fee to be paid for the services of the medical referee, which can be up to £70.

The Convener: That is under the current arrangements.

Frauke Sinclair: Yes.

The Convener: What effect will the bill have on the fee to the medical referee?

Frauke Sinclair: It will be abolished.

The Convener: That disappears as well. I wanted to clarify how the money would work out for people in hard times and difficult circumstances.

Mary Scanlon: My concern is the registration of the death.

The Convener: In fairness to the bill team, people who do not have a lot of money will not pay an additional amount; they will, in fact, be better off.

Ian McKee: Not if they are being buried.

Mike Palmer: They will in cremation cases.

The Convener: What is the difference in terms of money?

Mike Palmer: There is no fee at present in burial cases, so it will be an additional charge for those who are buried.

The Convener: So there is an additional charge for burial, but for cremation will pay considerably less. I just wanted to clarify the money issue.

Mary Scanlon: My final question—which you may have been asked by our doctors already—concerns the death certificate itself, and relates to contributory, underlying or risk factors. For example, someone may have died from cardiovascular disease, but the main underlying risk for many years could have been diabetes. Another issue that has been raised with me as an MSP concerns cases in which hospital infections have been a contributory, underlying or risk factor—whichever term you want to use. How much more accurate will death certificates be with regard to such factors? Will more of them be mentioned? Will the information be more extensive? Will families and the health service have a better understanding of the main risk of death than they do at present?

Jacqueline Campbell: A couple of issues are relevant to that. The bill provides for a system in which families as interested parties can take a case to the medical reviewer, for example where there has been a hospital-related infection and the family are not content with what is stated on the death certificate. Under the bill, they will be able to bring forward an interested person review.

We examined those issues in considering the importance of training and education, and the culture change aspects of the bill. We know that training and education for doctors in death certification could be far better, and we would like the medical reviewers to tackle that issue. We expect to see an improvement in the recording of cause of death over time.

Mary Scanlon: So no change is planned; a review would take place only if a family appealed. One or two examples have been given in which dementia was not the main cause of death; it was due to other factors. You are saying that no changes are proposed, and we will not have any more extensive and thorough information. We will get that only if a family member is unhappy and appeals.

Jacqueline Campbell: No. I have mentioned the two areas that are most pertinent to your question. It comes back to the robustness of the whole process, which we discussed earlier. We do not feel that the current system, in which the checks are performed by three doctors for cremation only, is sufficient; the evidence that we have received is that it does not work. We suggest that we should implement a system with several different layers. The issue is the whole system and its robustness. Interested person reviews are an important part of that, where a family has concerns about what was recorded as the cause of death, but such issues will also be picked up through the random sampling, and in particular through the additional—up to 100 per cent—sampling that the bill will put in place.

Mary Scanlon: I am not clear about what you are proposing. If a GP is to be randomly sampled once every 10 years, he is hardly likely to put more information on a death certificate.

Putting aside the appeals to the medical reviewer, you say that there will be more training and education. If the bill is passed, what can people in Scotland expect in terms of additional information—where it is appropriate—on death certificates that they do not have now? Without appeals or anything else, will they be able to register underlying, contributory and risk factors as well as the main cause of death?

Jacqueline Campbell: One of our aims in putting the system in place is to improve the quality of information on death certificates, so the answer is yes. Over time, that information will improve, so the family will have access to better information on the death certificate.

Mary Scanlon: So that is an aim over a period of time, but it has nothing to do with the bill. There is nothing in the bill that will make this clearer.

Jacqueline Campbell: I am not entirely following you, but I think that the point that I have made—

Mary Scanlon: You said it is an aim over a period of time. One thing that I did not have on the train was the bill itself. I am not sure what is going to happen over a period of time.

Jacqueline Campbell: The intention is that the national statistician will be put in place before the legislation comes into force, so part of the new process will come in then. When the legislation takes full effect, all the scrutiny will be in place, which will improve the quality of the current system, plus medical reviewers will be conducting scrutiny and taking a lead in the culture change, training and education aspects.

Mary Scanlon: Is there anything in the policy memorandum, explanatory notes or the bill that will reassure me that people in Scotland will have the appropriate causes and information on the death certificate? Where can I get that reassurance?

Mike Palmer: I do not think that we have written specifically on that point about contributory causes, because the policy memorandum is at a higher level than that level of detail. We could write to you on that specific point if you wish, but the key point is that we definitely expect the accuracy and quality of the information on the cause of death on the medical certificate to be significantly improved under the arrangements, because the dedicated team of medical reviewers will be in place and they will be doing education and training. An annual report will be produced and put in the public domain, and that will make the team of medical reviewers accountable to the Government, the Parliament and the public. There will be an opportunity to direct the work of the medical reviewers into areas where it is felt that there is a need to direct that work.

The arrangements will absolutely create a platform for improving the accuracy and quality of the information on the certificate, including on the cause of death.

The Convener: Forgive me—I am treading dangerously in telling the bill team where something is—but is it not in section 19(2)(b)? It states that the medical reviewer is to

"provide training, guidance and support to persons who are required to complete medical certificates of cause of death".

Is that not what Mary Scanlon is trying to get at, so that we have the information—

Dr Simpson: No, it is in section 25(2). That is what she is getting at.

The Convener: I understand that bit. I am saying that there is a duty to improve the people who fill in the forms. If they do not comply with section 25(2), part of the medical reviewer's job is to do what is described in section 19(2)(b). I think that I understand this. We are trying to get at what is going wrong with health in Scotland. As Mary Scanlon says, it may be that the underlying cause of a death was diabetes, but we have something else on the death certificate, so we perhaps do not have the right information for health prevention. Is that correct? Is section 19(2)(b) the relevant bit?

Mike Palmer: Yes. The bill contains a duty on health boards and the clinical governance arrangements within them to collaborate and co-operate with medical reviewers in improving the quality of death certificates.

The Convener: So there is stuff in the bill—to use a technical word. There is a duty to educate so that we have more conformity and more relevant information.

Mike Palmer: Absolutely.

The Convener: Okay.

Dr Simpson: My main question is now a supplementary to Mary Scanlon's point. Your second and third policy objectives are

"To improve the quality and accuracy of the medical certificate of cause of death form"

and

"To provide improved public health information and strengthened clinical governance".

However, the only section that looks at giving augmented information, which is what my colleague Mary Scanlon has been going on about, is section 25(2). We have no clarity from the explanatory notes as to whether, for example, health care acquired infection will be included, or ethnicity. There is a growing concern as to whether there are higher death rates or lower death rates in certain black and minority ethnic communities, and we need to know about that from the public health point of view, but there is no indication that that will be included.

We have been debating the Palliative Care (Scotland) Bill and collecting information on whether palliative care assessment has been carried out, which is not indicated. I understand that all of that can be included in

"such other medical information as may be prescribed",

but once again we are faced with a bill that does not modernise the system. As Ross Finnie said, the bill simply changes the review system to a less restrictive approach; it does not do what it says on the tin. Unless we get a much clearer explanation during the bill process of what additional information you will seek, what evidence you have taken and what consultation you have undertaken, so that we end up with a modern system, the bill will have difficulties.

11:00

Mary Scanlon: I agree.

Jacqueline Campbell: The bill establishes a framework and does not go into detail. We need to consult on what additional medical information should be provided. We are happy to take your views on that, because it sounds like you have concerns about one or two issues. We have already had a couple of discussions with medical directors. They have not yet come back to us, but we have asked them to inform us of the kind of additional information that they would find helpful

through the clinical governance process. Things are not yet set in stone, which we hope will be an advantage in some ways, because we are happy to take your advice on the matter.

The Convener: I will take a question from Ian McKee.

Helen Eadie: You cut me off earlier.

The Convener: I did, but I was hoping that the question that is burning inside you had been answered.

Helen Eadie: I have more than one.

The Convener: I am looking at the clock.

Ian McKee: I will ask about two issues. First, how many doctors in Scotland do you estimate are eligible to sign death certificates?

Jacqueline Campbell: I doubt that we have the figure with us, but I am sure that we can find out what it is. A doctor can sign death certificates once they have been certified. Under the Scottish Government's new proposals on revalidation, doctors who have gone through the revalidation scheme will be able, as part of their functions, to sign death certificates.

Ian McKee: We know that there are 5,000 GPs, but there are also many hospital doctors. You do not know the figure. You say that medical reviewers will have an important training function—that they will drive up standards of service and place a heavy emphasis on training doctors. According to the bill, there will be about six medical reviewers. If we take into account holidays, continuing professional development days and sickness absences, we will probably be left with five. The medical reviewers will both carry out investigations into random and reported causes of death and be responsible for the heavy emphasis on training a number of people. You do not seem to know what that number is, but it will be in the thousands.

Jacqueline Campbell: It will, because it will cover most doctors. As you know, there are procedures in place in Scotland for the training of doctors. We have already had discussions with the royal colleges and postgraduate deans about how the system will link into the existing system of training for medical professionals in Scotland. We need to do more work on that. Clearly, medical reviewers will not be in a position to undertake all the training themselves, but they will not need to do that, as we already have a system that will allow the training to be rolled out. However, they will have a role to play in directing that.

Ian McKee: What will that role be?

Jacqueline Campbell: We have just started to discuss the detail of that with the royal colleges. We are happy to keep you posted about it.

Ian McKee: So you do not know at the moment.

At present, the charge for a cremation certificate is quite high because the body is burned, which means that less evidence is left. The principle is that if someone wants a cremation, you need to make a bit more certain that there is nothing that will need to be investigated later, whereas if someone is buried, the body can be exhumed and investigated. I am concerned about what will happen if that distinction is not made and the cost is spread over everyone in the system. I suspect that looking into individual certificates and getting notes together will be much more time consuming than you think, especially given geographical issues. I have a feeling that costs will rise rapidly, given the large number of people who need training, and that, in effect, the measure will be a cost on registration of death that everyone will have to bear. I understand that you cannot answer my question, but I want to put my concern on the record.

Jacqueline Campbell: I understand.

People have quite a wide range of views on the timings that we have proposed for the medical reviewer to conduct a review. We have allowed half a day, which we think is fairly generous. Some people agree with that, but others think that it is far too long a period and that a review could be conducted far more quickly. We will have to test that. Our view is that there is some built-in flexibility, because we wanted to allow for the additional training role and the additional 100 per cent scrutiny that we have discussed.

Ian McKee: Yes.

My other question is about Mr Palmer's statement that most causes of death are unambiguous and the desire for death certificates to be accurate. I am not 100 per cent certain that most causes of death are unambiguous; it is certainly true that many are not.

I will give an example. Let us suppose that an elderly person who has been active injures their foot in a fall and goes into hospital. They have been treated for high blood pressure and have had a few other problems. Three weeks after being in hospital, they are found dead. They were in their 90s—people die in their 90s. It is not possible to know whether it was a heart attack or a stroke, or whether they had a pulmonary embolism as a result of their visit to hospital. There is only one way of being unambiguous, which is to conduct a post mortem. If I were a GP who was a certifier of death and you were to say to me, "You must be accurate on the cause of death," I would insist on a post mortem for just about every death certificate that I issued.

We have been told that in Dundee post mortems cost £500 each. I doubt that we have enough

pathologists to do the large number of post mortems that would be required to give an unambiguous cause of death in every case. I suspect that we get a lot of doubtful certificates not because of poor training but as a result of clinicians making practical judgments with a view to speeding up and easing the practicalities of the funeral process and putting a cause of death on the certificate that allows the funeral to take place and which no one has any doubt about, even if they do not know exactly what the cause of death was. That is my problem with the idea that somehow training will sort everything out. If you want to have a high level of accuracy on cause of death, a great deal of money will have to be spent and a lot more pathologists will have to be provided.

Frauke Sinclair: The chief medical officer has issued guidelines on how to complete medical certificates of cause of death. The aim of the new system is to achieve consistency in the filling in of certificates. That is what we mean when we talk about improving the quality of the certificates that are issued.

I agree that some people think that a post mortem is one way of achieving greater accuracy, but other people have said that even a post mortem does not necessarily provide an accurate cause of death. That is not how we would define quality. It is about implementing guidelines consistently. With six medical reviewers—or perhaps 12 part-time reviewers—who will be managed by a senior medical reviewer, we expect to achieve consistency in the certification of death.

Ian McKee: What do you mean by consistency? It is possible to be consistently wrong. In the example that I gave, if you were the doctor, which cause of death would you choose? Would it be right? If you put "pulmonary embolism", that would have implications for how elderly people are looked after in hospital; maybe it should. If you put "heart attack", you would add one more to Britain's heart attack statistics, which could lead to a change in policy on managing cardiovascular disease. If you put "stroke", the incidence of strokes would increase, which could mean altering all the public policies on strokes. If you always put "stroke", "heart attack" or "pulmonary embolism", that would provide the desired consistency, but it would result in huge alterations in public policy based on lack of knowledge.

Mike Palmer: I think that we are talking about consistency within certain standards. We are simply acting on the evidence that we have been given by stakeholders—that there is considerable scope for improving the accuracy of MCCDs. Clearly, Dr McKee is speaking on the basis of his professional experience of providing such certificates himself. Professionals and clinicians have told us that there is quite some scope for improving the accuracy, although there will be a number of cases in which it is genuinely difficult to do so.

Ian McKee: A procurator fiscal has told me that he felt that "old age" was an acceptable diagnosis in the circumstances that I presented to him.

The Convener: You rest your case—thank you. We can put many of these points to the stakeholders when they come before the committee.

Helen, your time has come.

Helen Eadie: My question is in three pairts, as your friend Alex Neil would say, convener. If you would like to take a note of them as I run through them, we will all know exactly what they are.

My first question is on equal opportunities impact assessments. How did you approach that issue, and what stakeholders were involved? I ask that question in light of the point that my colleague Rhoda Grant raised in relation to the Jewish community, from whom we have received quite a powerful submission.

My second question relates to your engagement with local authorities and COSLA, and in particular to your engagement with the City of Edinburgh Council. The submissions from the council and COSLA repeatedly refer to this proposal as a "death tax". The council is unambiguous in its comment that the proposal will simply require the general public to pay up front, and that the proposal will vastly increase the cost. The cost would not be just £9; there would be a big increase to £30 for the certification fee for an extract. The council says that it would be obligatory—and not only for an extract—for every member of the public to pay that £30. That is causing concern.

The council is worried about the moving of responsibility from local health boards to local authorities. At a time of huge economic cuts across the public sector, the council fears that it will be required to find additional capacity in order to take on additional work. COSLA wonders, clearly and unambiguously, why the public should be required to pay for a scrutiny system, for which the misleading name "certification system" will be used. What you will be putting in place is a scrutiny system; you are not really changing the certification. Certification is provided to everyone.

The Convener: Let me just say that there were questions on equal opportunities impact assessments, engagement with COSLA, and—

Helen Eadie: My third question got a bit lost in transit. The BMA—

The Convener: I have written down three questions. Is this number 4, or is it part B of number 3?

Helen Eadie: It is a very quick question, about the BMA's concerns over confidentiality. The BMA wants guarantees that, when documents are in transit, patient confidentiality will be taken very seriously.

The Convener: To some extent, the points about costs and charges were dealt with in the answers given to Mary Scanlon. The witnesses may therefore be brief if dealing with those points again.

Another question was on the transfer of responsibility from health boards to local authorities and on financial constraints. The question relating to the BMA and confidentiality has not been asked before.

The witnesses should feel free to address those questions as a group or individually. I leave the choice to you. It is very exciting.

11:15

Frauke Sinclair: I can answer the first question, on equal opportunities impact assessments. As our statement says, our main focus has been on dealing with religious and faith groups, and we have used various forms of stakeholder engagement, including public consultation and subsequent meetings. We held face-to-face meetings with the Muslim Council of Scotland, the Scottish Council of Jewish Communities, and representatives of other groups. We have received submissions from them, and they have been very supportive of the general principles of our model. They have raised concerns with regard to delays, which I addressed in my reply to the question on the expedited procedure.

The Scottish Council of Jewish Communities was not sure whether the expedited procedure applied to registration as well as disposal—that is, a funeral. I should just confirm that it applies to both those circumstances. When registration is complete, disposal—the funeral—can take place. They are, actually, the same thing. The council also raised concerns about medical reviewers exercising discretion in the implementation of the expedited procedure. We feel that, because there are only a few medical reviewers, and there are guidelines on which stakeholders will be consulted, discretion will not be a concern in the application of the procedures. We can reassure the council on that point.

Helen Eadie: Concerns were also expressed about out-of-hours services, in relation to the fact that there are no contact details.

Frauke Sinclair: That related to something that was outwith the scope of the bill. It involves registration services that are run by local authorities, which the bill does not cover. The bill does not say anything about the availability of registrars, who are provided by local authorities, so I cannot comment on that.

Mike Palmer: On the question of the fee—

Helen Eadie: Is that the death tax question?

Mike Palmer: Indeed.

Helen Eadie: Those are not my words; they are the words of COSLA and the City of Edinburgh Council.

Mike Palmer: That is fine.

The Convener: You should never accept a phrase like that so willingly. You must learn to spin.

Mike Palmer: I note it, no more.

Helen Eadie: They are not my words.

The Convener: I am not saying that they are your words, Helen; I am saying that Mr Palmer need not accept them and could call it something else—a fee, perhaps.

Mike Palmer: We are not calling it a death tax. The fee that would be charged would not be a fee for receiving the extract of the death register. That fee of £9 will remain.

Helen Eadie: According to the City of Edinburgh Council, it will increase from £9 to £30.

Mike Palmer: No, that is a confusion. The fee that we are proposing to charge for the scrutiny process would be around £30. That would be for the scrutiny process, which is a totally separate function from issuing the full extract of the death register, which will remain, and will continue to cost £9. There will be two separate fees: one of £9; and one of £30.

Helen Eadie: But the City of Edinburgh Council presents it differently. It says that £11 will go to the local authority and £9 will go to the certification fee. I do not know where the rest of the money goes, because nobody says. The reality, according to the council, is that the fee will be mandatory and that everyone will be required to pay £30 as a certification fee. The point is that this is not a process fee; it is a scrutiny fee. COSLA argues that scrutiny should be paid for by central Government, not the general public, particularly at a time when we are reducing wages and bonuses and society has big problems.

Mike Palmer: Ministers have decided that the process should be self-funded through a public fee. You might wish to ask the minister about that policy position.

I can absolutely confirm that the scrutiny fee, which we estimate will be about £30, is separate from the registration fee that is paid for the full extract from the death register. Part of that £30 scrutiny fee will be a charge that the local authority will make for the cost of collecting the fee. The City of Edinburgh Council might be breaking down the constituent parts of that fee.

Helen Eadie: Paragraph 14 of COSLA's submission talks about it as well.

The Convener: I want to move on to deal with the BMA and confidentiality, which has not been raised at all.

Mike Palmer: Clearly, we will have to have arrangements that will protect the confidentiality of documentation in transit and throughout the process. As we draw up detailed plans for the operation of the arrangements, we will need to agree with clinicians and the BMA what arrangements will need to be put in place to ensure that that protection is there. We are going to be running test sites to test the administrative processes around the new arrangements, including the transportation of documents.

The Convener: I thank our witnesses for their evidence. We will now move into private session.

11:21

Meeting continued in private until 12:01.

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