The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

# HEALTH AND SPORT COMMITTEE

Tuesday 14 December 2010

Session 3

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## HEALTH AND SPORT COMMITTEE
**37th 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 ALSO ATTENDED:**

Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)

**CLERK TO THE COMMITTEE**

Douglas Wands

**LOCATION**

Committee Room 4

# Scottish Parliament

## Health and Sport Committee

*Tuesday 14 December 2010*

[The Convener *opened the meeting at 15:02*]

## Patient Rights (Scotland) Bill: Stage 2

**The Convener (Christine Grahame):** Welcome to the 37th meeting this session of the Health and Sport Committee. I remind everyone to switch off mobile phones and electronic equipment. Apologies have been received from Rhoda Grant. I welcome Frank McAveety, who is substituting for her today.

We have only one item on the agenda: day 1 of stage 2 of the Patient Rights (Scotland) Bill. Members have before them the marshalled list of amendments and the groupings of amendments for debate. I welcome the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon.

Before we move on to consider the amendments, I state that it is my intention to get through all the groups of amendments and to complete stage 2 today. Brevity and succinct submissions would be welcome; I know that members are all up for that. If we do not complete stage 2 today, we will have to have a double sitting at a later date. That is the stick; you have had the carrot.

### Before section 1

**The Convener:** Amendment 19, in the name of Richard Simpson, is grouped with amendments 21, 24, 26 and 34 to 36.

**Dr Richard Simpson (Mid Scotland and Fife) (Lab):** A paradox that emerged both in the responses to the Government's consultation and in the evidence that was given to the committee was that, although, like the committee, all the respondents concurred in the belief that patient rights are of great importance, many questioned the need for primary legislation. Those who questioned the need for a bill did so from a number of angles. Most of the organisations representing health professionals opposed legislation—or came close to opposing it—on the ground that it is unnecessary. Patient organisations, on the other hand, were more supportive but were concerned that the bill is inflexible and exclusive—for example, the lack of any mention of mental ill health was a particular concern.

Other organisations, such as the Law Society of Scotland and the General Medical Council, expressed concerns about the possibility that omitting many of the rights that patients currently enjoy through existing legislation in statute or common law, or through common practice in the national health service, would mean that the rights that are specified in the bill would, in some way, have primacy. Paragraphs 42 to 44 of the committee's stage 1 report referred to some of the 17 such rights that were evidenced to us by the Law Society.

As my colleague Ross Finnie has quoted at some length, I was frequently critical of the bill in my questioning of witnesses. Indeed, I remain sceptical of the Government's suggestion that primary legislation is needed to raise awareness or, as the Royal National Institute of Blind People Scotland said to us, to change practice. However, I share the Government's desire to attempt to place in law patients' rights, and this first amendment is one of a large number that attempt to build on the Government's initial work in the bill.

Amendments 19, 21, 24, 26, 34, 35 and 36 will, if passed, make it a requirement for the minister to publish a charter of rights. That would parallel the English approach and it would benefit from some read-across to that charter. Such a charter would build on the work that was done initially by the Conservative party and subsequently by the Labour and Lib-Dem Administration in its charter. It would be flexible and should be inclusive of other conferred rights. If it is backed by political leadership, it should help to raise awareness and change the culture.

I move amendment 19.

**Ross Finnie (West of Scotland) (LD):** I made it clear at stage 1 that I was unpersuaded of the need for primary legislation, and I suppose that that remains my view. However, the Parliament has passed the bill to stage 2, so it is incumbent upon us to look constructively at suggestions that are being made. Although I am not sure of the need for primary legislation, if the view remains that we require it, I believe that the lot of patients would be hugely improved by a document that set out their rights clearly and concisely. I therefore support amendment 19.

**Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing):** The way patients are treated when they receive health care—being involved in decisions about their care and receiving appropriate support—is extremely important. That is why we introduced the bill and why it sets out how patients should be treated when they receive health care. As Richard Simpson has outlined, amendment 19 would introduce the power for ministers to issue an order putting into statute a patient charter, which would

set out all existing statutory rights and responsibilities that apply to patients.

I listened carefully to the stage 1 debates at committee and in the chamber, and I accept that some members feel that setting out rights and responsibilities in a patient charter would have benefit for patients and for staff. For those reasons I am happy to agree with amendment 19 in principle. However, the Scottish Government is not able to accept the group of amendments as they are currently drafted. I ask Richard Simpson to consider not pressing them today, with an assurance that we will work with him to produce amendments that will have the desired effect without the difficulties that I believe the amendments would lead to as currently drafted.

The difficulties include, for example, the stipulation that the charter would be contained in an order that was subject to affirmative procedure. That could make the process of updating the charter—which may need to be done regularly and often—cumbersome and time consuming, because its altered form would always have to come back to the Parliament to be approved. In addition, if the charter is to be contained in an order and is to list reserved as well as devolved legislation, as would be the case if all existing statutory rights were to be listed in it, then there may be some legislative competence issues. There are also issues about the length and usability of the charter as proposed.

All in all, although I support the amendments in principle, I think that they require further detailed consideration and development. An alternative could be the bill making provision for ministers to publish a patient charter, which could be updated quickly and easily without its taking up parliamentary time every time updating was necessary, and could be more flexible in the information that it contained—I note that Richard Simpson rightly used the word "flexibility" in connection with the proposed patient charter. It would therefore be more useful for patients and for staff.

Although I agree with the introduction of a patient charter in principle, the detail of how it would work in practice needs to be given further consideration. I ask Richard Simpson to withdraw amendment 19 and not to press the others in the group, and I commit to working with him on mutually acceptable amendments on a patient charter for him to lodge at stage 3.

**Dr Simpson:** I think that we will have the same discussion about several of my amendments.

On amendment 19, I do not acknowledge that the argument about regular updating and members having the opportunity to debate the charter has any validity. The matter is so important that it is crucial that members have the opportunity to debate rights, and that they are seen by the public to be debating them. If we have to do so regularly, members should not consider their time doing so to be ill spent.

I understand the need to list reserved legislation—it is clear that an order would have to be drawn up in a way that would address the reservations that the cabinet secretary has expressed. I accept that there is an additional problem in that reserved legislation may from time to time require to be updated, but the strength of the arguments that were put to us on ensuring that all patient rights be included in a single charter leads me to say that I want to press amendment 19, although I am happy to look at any further amendments that the Government might want to lodge to increase flexibility. The cabinet secretary's argument on that is the one argument she made that I would accept.

**The Convener:** The question is, that amendment 19 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 19 agreed to.*

### Section 1—Patient rights

**The Convener:** Amendment 20, in the name of Richard Simpson, is the only amendment in the group.

**Dr Simpson:** I will be very interested to hear what the cabinet secretary has to say about amendment 20.

Amendment 20 reflects one of the main concerns that people have expressed to me over a number of years, particularly people with a disability that might impair their ability to deal with information on a number of different matters that they are presented with. I accept that it appears that considerable progress has been made over the past decade in providing information in forms that meet patients' needs, and that that information should be made available to people in a form in which they can use it under existing

reserved legislation, but progress is still patchy, and I believe that including the provision in the bill will indicate that the right in question is as important as the other rights that may be contained in the charter.

I move amendment 20.

**Nicola Sturgeon:** Amendment 20 is a logical extension of many provisions that are already in the bill. Evidence from the consultation on the bill and the equality impact assessment as well as evidence that the committee has received suggest that the form in which information is provided is of real importance to patients, particularly groups of patients with particular needs. I hope that Richard Simpson is not too surprised that I am happy to support amendment 20.

*Amendment 20 agreed to.*

*Amendment 21 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 21 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 21 agreed to.*

**The Convener:** Amendment 22, in the name of Richard Simpson, is grouped with amendments 47, 59 to 63, 2, 64 to 70 and 76.

**Dr Simpson:** The Government and the Parliament have made an important commitment to the development of the mutuality aspect of the NHS. The days in which any form of autocracy or paternalism in the delivery of care was seen as acceptable should be past. In parallel with that growing mutuality, a robust and modern complaints system is needed. It is not a matter of there having been no complaints system, but it has been under the direction of the minister under the National Health Service (Scotland) Act 1978 and not in statute. I understand that that is the reason for the Government's including the matter in the bill.

15:15

There are multiple deficiencies in the current system and there is no opportunity for genuine partnership. There is, really, only a complaints system and many patients do not want to complain. That may be because the issue is not of great moment, or because to start a complaint is too formal, or because it is felt by patients, families or carers that to do so would risk the relationship with health professionals during treatment. For the health team, a complaint implies blame, fault or even negligence and—again—smacks of there being little mutuality.

In its evidence to the committee, the Scottish Human Rights Commission referred to a system that has been developed at the state hospital at Carstairs. It arose in part from a whole-systems approach to care and management in the hospital, based on a human rights approach. When I visited Carstairs, I was impressed by the benefits of the system, which is referred to as the four Cs. They are: compliments, or positive feedback when good practice is appreciated by patients or families, which might help to spread such practice; comments, which would apply to minor observations, such as on a clinician wearing regulation short sleeves but still wearing a wrist watch or bracelet; and concerns, which would be more serious or might be on a frequent minor example of good practice not being followed or a comment not being acted upon. From looking at health care environment inspectorate reports, there must be many occasions when a comment or concern that has been expressed by a patient, visitor or carer could have led to action. The last of the four Cs is complaints.

The effect of introducing the four Cs system was to increase mutuality and improve practice in what I think members would accept is the fairly difficult setting of the state hospital. The system there reduced the number of complaints and significantly improved the ethos and atmosphere in the hospital. The committee, along with the Scottish Human Rights Commission, commended the approach.

Amendments 22, 47, 59 and 63 would introduce that approach in the bill. Amendment 64 would move a positive feedback section ahead of the complaints section, and so is a simple reordering of the bill. Amendments 66 and 69 would tackle a concern of Consumer Focus Scotland, patients and the independent advice and support service by ensuring that there was feedback on any action that was taken by a national health service body. Such feedback would go beyond a simple report to the patient; I have often found in dealing with such issues as an MSP that patients get a fairly full report of their cases, but it does not say what action the board has taken to amend the

underlying problems. Most of us want to know when we complain, comment or have concerns, that our action has resulted in changes in practice.

Amendment 70 would introduce a power to require feedback to the health department so that it may, in turn, relay to other boards actions that may be pertinent to the NHS in Scotland as a whole, just as alerts on patient safety are currently disseminated.

In conclusion, I say that I also support the Government's amendment 2, which will introduce mediation and conciliation.

I move amendment 22.

**Nicola Sturgeon:** I am happy to speak to amendment 2 and other amendments in the group. In its report, the committee recommended that a remedy such as alternative dispute resolution be explored further at stage 2. As I confirmed in the stage 1 debate, I asked my officials to do that, so amendment 2 will specifically enable Scottish ministers to issue directions to a relevant NHS body about the use of conciliation or mediation as part of the complaints process. I am committed to ensuring that patients have access to a complaints system that is easy to navigate, that is responsive to their concerns and which—crucially—results in improvements in how care is delivered. I urge members to support amendment 2.

I turn to the other amendments in the group. I support amendments 60, 64 and 70 and I welcome the references to

"feedback, comments, concerns or complaints"

in other amendments. I intend at stage 3 to lodge a few tidy-up amendments to ensure consistency of language throughout the bill. Nevertheless, I support the amendments.

I have a concern that amendment 76, which would insert a definition of feedback, does not recognise, in using the word "appreciation", that feedback can be negative as well as positive. I therefore ask Richard Simpson to reflect on that point and perhaps not press the amendment so that we can find more appropriate wording before stage 3.

The purpose behind amendments 66, 67 and 69 is not crystal clear. For example, amendment 66 refers to

"a member of the relevant NHS body".

It is unclear whether that means a member of staff of the relevant NHS body. Even if it means that, it is unclear why we would make a distinction between the body and its staff. It is also unclear what relationship any such nominated member of staff would have with an NHS complaints officer.

I ask Richard Simpson not to move amendments 66, 67, 69 and 76 so that we can see whether we can work together before stage 3 to find better wording that would allow us to implement the intentions behind the amendments without the difficulties to which I have referred.

**Ross Finnie:** When the bill was introduced, the cabinet secretary pointed out that we do not have a statutory right to complain. I am bound to say that I have never come across anyone who has had a letter of complaint returned to them in an envelope with a covering note that said, "You don't have a right to complain, so we're sending your complaint back." However, I have had a host of complaints that have demonstrated beyond peradventure that the system for dealing with complaints in the health service is unsatisfactory in many cases.

I welcome the cabinet secretary's support for the principles behind Richard Simpson's amendments. Those principles are not exclusively but are certainly more often used in Carstairs than anywhere else. I, too, have looked at the system there, which appears to bring substantive changes. If it can improve for patients' benefit the way in which complaints are dealt with, that is very much in patients' interests. We will support Richard Simpson's amendments.

**Dr Simpson:** I will press amendment 22 and I will move the other amendments in the group. I intend to move amendment 76 on feedback because, in the system that I propose, "feedback" means only positive feedback. Comments, concerns and complaints are the other three areas, which we deal with in other amendments on the looped feedback system that we suggest. I am happy to work with the Government on what amendments 66, 67 and 69 propose, although I will move them—I would rather have them in the bill before stage 3 and then work with the Government to develop further amendments and seek clarification.

*Amendment 22 agreed to.*

*Section 1, as amended, agreed to.*

*Section 2 agreed to.*

### Section 3—Duty to have regard to certain rights and principles

**The Convener:** Amendment 23, in Mary Scanlon's name, is grouped with amendments 25, 27 and 52.

**Mary Scanlon (Highlands and Islands) (Con):** The bill says that health boards and other relevant NHS bodies must

"have regard to the health care principles"

and the treatment time guarantee. The intention behind the amendments in the group is to strengthen the bill and to ensure that health boards place patients' rights firmly at the heart of patient care rather than simply consider them by having regard to them. Several committee members have raised that issue, because the exact meaning of "have regard to" is uncertain and ambiguous.

The bill does not place a specific duty on NHS Scotland to comply with patients' rights. The duty of having regard to the rights and principles extends to any person with whom a relevant NHS body

"enters into a contract, agreement or arrangements to provide health care",

in so far as those rights and principles

"are relevant to the service being provided."

I understand that contractors who deliver services, such as general practitioner practices or cleaning and catering services in a hospital, will be covered by the bill—in so far as those services are covered by the bill. Given that the bill sets out patients' rights, it seems reasonable to give those rights priority and to uphold them.

Another criticism of the current wording is the lack of accountability: it would be impossible to verify whether a health board or other NHS body had actually regarded the patient's rights. It might be demonstrable that the patient's rights had been disregarded, but the opposite would not necessarily be the case. To change the wording of the bill to "uphold" would send a message to the NHS body and to Health Scotland and the Scottish Government, which will, I presume, hold NHS bodies to account.

As the Health and Sport Committee confirms in its report, there is an inherent contradiction between setting out patient rights in primary legislation—that has, perhaps, changed, as of today—and there being no legal enforceability in terms of those rights. I certainly do not want a lawyer's charter, but I want something that promotes the rights of patients. Perhaps "uphold" is too strong a word, however. I am interested in hearing what the cabinet secretary has to say on the matter. I should also say that the matter has been raised with the Scottish Association for Mental Health, which believes that people with mental health issues are particularly vulnerable in relation to bodies having regard to their rights.

I move amendment 23.

**Nicola Sturgeon:** The Government is happy to support amendments 23 and 25. Amendment 27 is technically incompetent, because it refers to the wrong section, so I invite Mary Scanlon not to press it. She might want to lodge a replacement at stage 3.

Although I understand what Mary Scanlon is trying to do with amendment 52, I suggest that it is not technically appropriate. Mary Scanlon might want to reflect on it in advance of moving it. The treatment time guarantee is contained in statute and the intention is to issue guidance to health boards on how they can implement and abide by the treatment time guarantee. However, guidance is just that—it is guidelines that set out best practice but which are not, in themselves, statutory obligations. To use the term "comply with" in statute would not be technically appropriate.

The reason for setting out in guidance how the treatment time guarantee is to be met is to provide health boards with the flexibility that members have said in previous discussions is important. For example, the health board might have regard to the guidance, but decide—because of the individual circumstances of the patient—not to comply in exact terms with that guidance in meeting its statutory obligations.

The wording of amendment 52 is not technically appropriate. I would be happy to have further discussions with Mary Scanlon after stage 2, but I ask her not to move it today.

**Mary Scanlon:** I am delighted with that response. I think that I will press amendments 23 and 25 and withdraw amendments 27 and 52.

**The Convener:** You cannot withdraw those amendments yet. Are you pressing amendment 23?

**Mary Scanlon:** Yes.

*Amendment 23 agreed to.*

*Amendment 24 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 24 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 24 agreed to.*

*Amendment 25 moved—[Mary Scanlon]—and agreed to.*

*Amendment 26 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 26 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 26 agreed to.*

*Amendment 27 not moved.*

*Section 3, as amended, agreed to.*

*Section 4 agreed to.*

**Schedule**

15:30

**The Convener:** Amendment 28, in the name of Richard Simpson, is grouped with amendments 29 to 33.

**Dr Simpson:** These amendments to the schedule contain some of the principles on which any charter should be based. The principles are intended not to be fully inclusive but to provide a basis for the charter. The amendments build on the schedule and endeavour to include a number of items that the Royal College of Nursing and the British Medical Association regard as important. Amendments 28 and 29 were suggested by the Royal College of Nursing. Amendments 30 to 32 are about responsibility as well as rights. Amendment 31, in particular, strengthens respect for staff by substituting "expected" for the somewhat weaker word "encouraged" in the bill as drafted. Amendment 33 inserts in the schedule a reference to the new complaints system.

I move amendment 28.

**Nicola Sturgeon:** I support the principle and intention behind amendment 28, which seeks to address an issue that everyone accepts has been a top priority for the Government: namely, the reduction of health care associated infection and the promotion and enhancement of patient safety.

However, there are issues with the amendment as drafted. For example, it talks about patients having to be treated

"in an appropriate, clean and safe environment at all times."

When reading the amendment for the first time, most people would think that there was nothing wrong with it. However, if someone is in a road traffic accident and requires to be treated at the roadside, it is not immediately clear whether that would satisfy the definition of a "clean and safe environment", although it is the most appropriate environment in which to treat the person at the time. I am slightly concerned that the scope of the amendment is a bit too wide. The amendment needs some work to ensure that the intention behind it can be fulfilled without unintended consequences. I invite the member to work with us on that.

Amendments 29 to 32 seek to use the health care principles to place responsibilities on patients. I agree that patient responsibility is important. It is perennially difficult to define, but we all accept that it is desirable for patients to be encouraged to take on greater responsibility. However, it is not appropriate to use the health care principles to place responsibilities on patients, as the purpose of the principles is to place duties on health boards. It would be better to use the proposed patient charter to confer responsibilities on patients. I invite Richard Simpson to reflect on that point.

Amendment 33 repeats provisions on complaints and feedback that are already set out in section 11. The provisions in section 11 place statutory duties on relevant NHS bodies so, strictly speaking, it is unnecessary to include them in the health care principles. For that reason, I invite the member not to move amendment 33. However, given that the provisions are already included in the bill in principle and in practice, it will not be the end of the world if the amendment is agreed to.

**Dr Simpson:** I hope that the committee will agree to amendment 28. I look forward to working with the Government to correct the phrase

"clean and safe environment at all times",

as I accept the Government's argument that there are occasions when emergency interventions are absolutely necessary. We may be able to include in the provision some wording that covers emergency situations.

If we do not include in the schedule the wording that amendments 29 to 32 would insert, the bill will be left unbalanced. Unless the Government's intention is to introduce the responsibilities elsewhere in the bill, which is not evident from any of the amendments that it has lodged, I am inclined to pursue them. Amendment 31, which

strengthens respect for staff by changing the word "encouraged" to "expected", is especially vital. In my view, it is not sufficient for us only to encourage people to treat staff with respect. I must declare an interest, as I was assaulted by a patient in a clinic. Because of that particularly unpleasant experience, I lean towards the use of rather stronger language to make the point clearly.

All the items will be included in the charter, but there should also be some balance in the schedule. I will press amendment 28 in my name.

**Ross Finnie:** I am not entirely clear whether, in the event that amendments 29 to 32 were either withdrawn or disagreed to, the cabinet secretary intends to lodge amendments to place those obligations in the charter instead of seeking to locate them in the principal legislation.

**Nicola Sturgeon:** Yes, that is the intention.

**The Convener:** The question is, that amendment 28 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 28 agreed to.*

*Amendments 29 and 30 not moved.*

*Amendment 31 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 31 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
McAveety, Frank (Glasgow Shettleston) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Finnie, Ross (West of Scotland) (LD)
Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

**The Convener:** The result of the division is: For 3, Against 5, Abstentions 0.

*Amendment 31 disagreed to.*

*Amendments 32 and 33 not moved.*

*Schedule, as amended, agreed to.*

### Section 5—Health care principles: guidance and directions

*Amendment 34 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 34 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 34 agreed to.*

*Amendment 35 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 35 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 35 agreed to.*

*Amendment 36 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 36 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)

Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 36 agreed to.*

*Section 5, as amended, agreed to.*

### Section 6—Treatment time guarantee

**The Convener:** Amendment 1, in the name of the cabinet secretary, is in a group on its own.

**Nicola Sturgeon:** I will be brief, convener. I listened to members' concerns about the possibility of the treatment time guarantee distorting clinical priorities and, as that is clearly not the intention behind the provision, have lodged amendment 1 to reinforce the importance of boards prioritising the start of patients' treatment according to clinical need. Prioritisation must take place within the delivery of the treatment time guarantee for all eligible patients, which means that patients should not be left to languish on a waiting list. I urge members to support this amendment.

I move amendment 1.

*Amendment 1 agreed to.*

**The Convener:** Amendment 37, in the name of Richard Simpson, is grouped with amendments 38 to 46, 48 to 51, 53 to 58 and 77. I draw members' attention to the fact that if agreed to amendment 51 will pre-empt amendment 52.

**Dr Simpson:** Our objection to the proposed treatment time guarantee is that it is too prescriptive. The cabinet secretary made it clear in evidence that

"where a service is not delivered as planned or elective care on an inpatient or day-case basis, it will not be covered by ... the"

treatment time guarantee. One problem with the current proposal, as I understand it, is that for a single given procedure there would be a guarantee for only in-patient treatment; however, as NHS Lothian set out in evidence, the procedure itself might be carried out as a day-case or even as an out-patient procedure. Indeed, the procedure might be carried out more and more in general practice under a section 17C agreement or local enhanced service contract.

The policy memorandum listed exclusions, some of which were understandable, but others were less so, such as direct access to x-rays, diagnostic tests, out-patient treatment, some national services, and so on.

There are other issues of concern, such as those stated by the Royal National Institute for the Deaf: waiting as a child might be far more damaging than waiting as an adult, because an 18-week wait for a deaf child would result in the loss of half a year's education. Other concerns were expressed by SAMH about talking treatments or possible guarantees for children with mental health problems, who, despite efforts by successive Governments, are unfortunately still being admitted to adult wards.

We must find a way of balancing realistic guarantees, reflecting the finite resources of the NHS and the clinical priorities that are paramount in the Government's determination to ensure as speedy a service as is practicable, and ensuring that any discrimination, other than on the grounds of clinical priority, is minimised.

The amendments seek to allow future ministers to introduce a suite of guarantees that will address some of those concerns and reflect the priority in waiting times that the Government is seeking to emphasise, some with related health improvement, efficiency, access and treatment targets. That is not easy, and this is my first attempt, with a lot of help from the Parliament's bill team. The amendment might not be perfect; indeed, it might still be too prescriptive, but I do not believe that the Government has got it right either. If the cabinet secretary says today that she is prepared to work with us and the committee to find a form of words that will be flexible, provide the clarity that we need and meet the concerns that have been expressed, I will not press my amendments. For the moment, I await the committee's comments and the cabinet secretary's response.

I move amendment 37.

**Mary Scanlon:** Amendment 37 is an amendment after my own heart. Throughout our deliberations on the bill, I have raised mental health treatment issues.

I seek some clarity from the cabinet secretary. I am aware that the Government is proposing a referral-to-treatment target for psychological therapies—I have submitted some written questions on the subject—but I would like to hear something to assure me that the cabinet secretary is taking the matter seriously, given that the largest percentage of mental health patients fall outwith the treatment time guarantee because few have in-patient or elective treatment. Although the cabinet secretary is thinking about psychological therapies, while mental health patients receive less than equal treatment under the bill I would like some clarity on her approach to the waiting time

target. Will it fit in with the treatment time guarantee for psychological therapies?

**Nicola Sturgeon:** I will start with a brief response to Mary Scanlon's point about psychological therapies and mental health treatment more generally. I hope that it is obvious that the Government is committed to improving services for mental health patients, including reducing the horrific waiting times that people who are waiting for mental health services traditionally had to endure. We intend, over time, and as long as it is possible and sustainable, to bring groups of patients who are waiting for particular types of treatment that have not traditionally been included in the waiting time guarantee into the ambit of the 18-week referral-to-treatment guarantee. I will talk about that again in a second.

As the bill is framed, people who require in-patient, planned treatment will be covered by the treatment time guarantee, but those who require other types of treatment are, nevertheless, still covered by the 18-week referral-to-treatment guarantee. As I said, we want to bring additional groups of patients within that guarantee.

I turn to Richard Simpson's comments, and assure him that I am happy to work with him and the committee to see whether we can find common ground around the provisions in the bill and his amendments. I ask him not to press his amendments, but to give us the time to work together to come up with a better set of amendments. It would be preferable to get to a set of provisions that are right, rather than amending the bill now and trying to improve the amendments later, which could end up being a bit messy.

15:45

I take Richard Simpson's point about being less prescriptive, although I am not convinced that his amendments achieve that objective in all respects. They appear to be trying to put the whole patient journey, including its different stages, into statute. On the face of it, that might seem a perfectly reasonable thing to do, because, as I have just said to Mary Scanlon, we have the whole-journey, 18-week referral-to-treatment guarantee, and the treatment time guarantee in the bill is intended to sit within that.

However, any whole-journey, referral-to-treatment time target, by its very nature, requires to have what we call tolerances. For example, we would say that 90 or 95 per cent of patients have to be treated within the time. The reason is that, as everybody knows, there is a degree of uncertainty attached to the diagnosis part of the patient journey, which can take a long time. It might take several diagnostic tests to find out what is wrong with the patient before we can determine the treatment that is appropriate for them, and it might not always be possible to do that within the maximum waiting time.

We therefore need flexibility, and it is difficult to provide adequately for tolerances in legislation that confers individual rights. The Government has chosen to put that part of the patient journey about which there can be certainty—that is, the part from diagnosis and the decision to treat, to treatment taking place—into statute. In the vast majority of cases, patients will be treated both within the 12-week treatment guarantee and the overall 18-week referral-to-treatment guarantee but, in a small number of cases where diagnosis may take longer than 18 weeks, the flexibility will still be there.

The approach also means that, if it takes more than 18 weeks to diagnose a patient and they are already out of the guarantee period by the time treatment is agreed, they will not be in no man's land, because they will still have as a long stop the 12-week guarantee for the period between the decision to treat and treatment taking place.

A secondary concern about how the amendments are framed is that specifying in the bill different guarantees for different stages of the journey ignores, to some extent, some substantial redesign work that has already taken place. These days, not all patients will go through all the set stages of the patient journey. One example is the one-stop shop systems that many boards have put in place for cataract treatment, under which patients do not get an out-patient appointment at all. They are pre-assessed on the day of the operation and everything happens on the same day. A patient might be assessed and treated on the same day within the 18-week referral-to-treatment guarantee. Say that happened within 16 weeks. Under the system that is proposed in the amendments, there might have been a breach of the out-patient appointment bit of the patient journey. We must be careful that we do not provide perverse incentives and encourage boards to go back to old ways of delivering treatment.

There is another subsidiary concern. Amendment 77 defines "patient", and that definition is applied to the whole of the bill, but it seems to include only patients who are currently receiving treatment. It excludes those who have had treatment, those who are in recovery, and those who are waiting for treatment.

Those are my key concerns about the amendments. I am happy to see whether we can come to common ground between now and stage 3. If that does not prove possible, Richard Simpson will still be free to lodge amendments at stage 3 and I will be free to argue against them, but there is an opportunity for us to try to design something that suits all our purposes and gets us

something in the bill that is workable and goes with the grain of service redesign rather than counter to it.

**Dr Simpson:** The discussion has been helpful. I thank the cabinet secretary for her comments. I welcome the Government's intention to give patients some clarity on what can and cannot be guaranteed. The conundrum is that, if the Government gives guarantees that are too strict, it might interfere with clinical priorities. That is a concern of clinicians, and of course we do not want that to happen. On the other hand, however, we do not want patients to be left hanging for ever, or for prolonged periods of time.

The amendments were an attempt to give future ministers the flexibility to be able to introduce such guarantees as they believed to be appropriate but, on reflection, I am not sure that they do that. The cabinet secretary has been helpful in setting that out.

I entirely accept her view that there is a considerable need for tolerances in the period from referral to diagnosis. For some conditions—such as prostate cancer, which is an area in which I was very much involved—there is a need for repeated observations and tests. It is crucial not to go ahead with treatment too quickly; if one proceeded with treatment because one was required to do so, it might be inappropriate for that particular patient.

I accept many of the cabinet secretary's arguments, but I am not comfortable with the current treatment time guarantee, although I acknowledge the intention to provide clarity in the text of the bill for that particular aspect of the journey. I welcome her undertaking to work with the committee and with me to see whether we can get something that is a little broader but also flexible and, for that reason, I will not press amendment 37.

*Amendment 37, by agreement, withdrawn.*

*Section 6, as amended, agreed to.*

### Section 7—Treatment time guarantee: further provision

*Amendments 38 to 43 not moved.*

*Section 7 agreed to.*

### Section 8—Breach of the treatment time guarantee

*Amendments 44 to 46 not moved.*

*Amendment 47 moved—[Dr Simpson]—and agreed to.*

*Amendments 48 to 50 not moved.*

*Section 8, as amended, agreed to.*

### Section 9—Treatment time guarantee: guidance and directions

**The Convener:** We are wondering when we might have a little break. Members should let me know when they feel that they could do with one.

*Amendments 51 to 54 not moved.*

*Section 9 agreed to.*

### Section 10—Treatment time guarantee: key terms

*Amendments 55 to 58 not moved.*

*Section 10 agreed to.*

### Section 11—Complaints

*Amendments 59 to 63 moved—[Dr Simpson]—and agreed to.*

*Amendment 2 moved—[Nicola Sturgeon]—and agreed to.*

*Section 11, as amended, agreed to.*

*Amendment 64 moved—[Dr Simpson]—and agreed to.*

### Section 12—Patient feedback

*Amendment 65 moved—[Dr Simpson]—and agreed to.*

*Amendment 66 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 66 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

**The Convener:** The result of the division is: For 4, Against 4, Abstentions 0. I use my casting vote against the amendment.

*Amendment 66 disagreed to.*

*Amendment 67 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 67 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

**The Convener:** The result of the division is: For 4, Against 4, Abstentions 0. I use my casting vote against the amendment.

*Amendment 67 disagreed to.*

*Amendment 68 moved—[Dr Simpson]—and agreed to.*

*Amendment 69 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 69 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

**The Convener:** The result of the division is: For 4, Against 4, Abstentions 0. I use my casting vote against the amendment.

*Amendment 69 disagreed to.*

*Amendment 70 moved—[Dr Simpson]—and agreed to.*

*Section 12, as amended, agreed to.*

*Section 13 agreed to.*

**The Convener:** Do members want a little break, or do you want to press on?

**Members:** Press on.

### Section 14—Patient advice and support service: establishment and funding

**The Convener:** Amendment 71, in the name of Richard Simpson, is grouped with amendments 72 and 73.

**Dr Simpson:** The committee was generally of the view that the current system—the independent advice and support service—has been a helpful development. It is a relatively young service, but its association with local citizens advice bureaux is already much appreciated by patients. The ability to manage patients' concerns in an holistic way, addressing concerns beyond those of the immediate NHS problem, is worth while and should not be lost in any new development.

Amendment 71 seeks a change in name and a presumption that any new service, whether it is provided by the citizens advice bureaux or by another organisation, is independent and continues to take a comprehensive approach. We support the name change to PASS and the move to a consistent national contract.

Amendments 72 and 73 remove the development of the new patient rights officers. Having a new group of officers whose function is simply to signpost is not the way to go. The boards will have to designate those who will be responsible for responding, but the route to go down is to use Citizens Advice Scotland, local citizens advice bureaux or similar independent organisations—which one hopes would use trained volunteers and staff—with advice continuing on a number of issues and people acting as much more than signposts. I would prefer any funds to be used to enhance what already exists, rather than to create a new group of officers.

I move amendment 71.

16:00

**Nicola Sturgeon:** We all accept that the association of the service with citizens advice bureaux has been one of its strengths. Many of the comments that were made at an earlier stage of the bill on the holistic nature of the service related not to the design of the service but to the fact that the service is provided by citizens advice bureaux, which can signpost patients on to other services that they provide. I do not take issue with the point about the strength of that service. However, I am advised that, in all likelihood, amendment 71 would breach procurement rules, because it appears that its intention is to specify a preferred provider for the patient advice and support service, which should rightly be awarded by competitive tender.

The amendment also seems slightly odd in that it names citizens advice bureaux but also states that the provider could be

"any other such source of independent advice and information."

That begs the question why mention a specific organisation. However, I am most concerned about procurement rules in relation to the amendment. I therefore ask Richard Simpson to seek to withdraw amendment 71 and, if he presses it, I ask the committee to oppose it.

As Richard Simpson said, if amendments 72 and 73 are agreed to, the bill will no longer specify that the PAS service is to be staffed by patient rights officers. Personally, I think that that would be a retrograde step, as patient rights officers would have a useful function to perform. However, it is important to stress that, if the amendments are agreed to, they would not otherwise affect the delivery of the PAS service, which I believe will be an extremely strong and valuable service, with or without patient rights officers.

**Mary Scanlon:** I have a question for the cabinet secretary. We heard a lot of evidence that the complaints system is inconsistent and patchy across Scotland, but I was impressed by some of the services that are provided by citizens advice bureaux. We were told that it is an holistic service. I am minded to support Richard Simpson's amendments although, obviously, I do not want to support anything that breaches procurement rules. Will the new system be an add-on or a parallel service? What will happen to some of the good practice if we do not pursue amendment 71? What will happen to some of the excellent citizens advice bureaux, such as the one at Raigmore hospital in Inverness, which is highly valued by patients?

**Nicola Sturgeon:** Putting to one side the issue of who provides the services, I point out that the services will continue. The purpose of the bill is not to add to or fundamentally change the service. As we discussed at stage 1, it is about ensuring that there is an obligation to provide the services consistently and that they do not go by the wayside if boards are looking to make savings. It is about entrenching the service firmly in the NHS.

Given my comments on procurement, I need to be careful in what I say about a service that is to be competitively tendered. However, I have heard—and I agree with—many of the comments that have been made about the service that is currently provided. Whether in future that service is provided by CABx or, to use the words in amendment 71,

"any other such source of independent advice and information",

we want to ensure that it has the same qualities and holistic nature as at present, so that patients continue to enjoy those benefits.

I am significantly concerned by the procurement implications of amendment 71 but, if it helps, I am more than happy to provide further advice to the committee, within the constraints relating to legal advice that we have discussed at the committee in other contexts. I can perhaps provide a bit more information to the committee to flesh out the concern before we get to stage 3. However, it would be unfortunate if we agreed to something today that raised significant legal issues.

**Helen Eadie (Dunfermline East) (Lab):** I am very pleased that everyone round the table seems to be in agreement with the fundamental principles. That is good, because all of us have had experience of using patient advice and support services. I had to battle hard to get such services established in Fife.

As regards procurement, what strikes me about amendment 71 is its use of the word "may". It does not say, "The patient advice and support service will be provided by Citizens Advice Bureaux or any other such source of independent advice and information." I think that it provides sufficient wriggle room for anyone to be able to go to tender, should the procurement rules say that, so I query the minister's argument.

**Nicola Sturgeon:** As I said, I would be happy to provide further information to the committee. I take Helen Eadie's point about amendment 71's use of the word "may" rather than "shall" or "must". Nevertheless, it seeks to put one provider in a preferential position by naming it and no other potential provider in the bill. It is that, rather than any stipulation around it, that gives rise to those concerns.

Without prejudicing any final decision that might be taken on the matter, I would be happy to provide some further information that could inform members before we get to stage 3.

**Dr Simpson:** May I ask the convener a question? If we sought to agree to an amendment that was against procurement legislation, would the Presiding Officer not rule that out of order?

**The Convener:** No.

**Dr Simpson:** So we could do it.

**The Convener:** Yes. It would be challengeable in court, once the bill was passed.

**Dr Simpson:** I certainly do not wish to press an amendment that might be in contravention of procurement rules, although we were careful to put in the word "may" and not "must" and to add the rider, which the cabinet secretary saw as rather strange, that, although the service is currently provided by the CABx, it could be provided by

"any other such source of independent advice and information."

The intention was partly to ensure that we have an organisation that can provide an holistic approach, because it was quite clear from evidence to us that that was highly valued by the people who use the present service. Therefore, if the Government is prepared to work with us on the basis that we will come back at stage 3 with an amendment that

spells out those principles, as opposed to specifying the CABx, I am prepared to seek leave to withdraw amendment 71.

**Nicola Sturgeon:** I am prepared to do that. Richard Simpson may be right—maybe we should try to enunciate the principles rather than name a particular organisation. That might be a better way to go about it.

*Amendment 71, by agreement, withdrawn.*

*Section 14 agreed to.*

### Section 15—Patient advice and support service

*Amendment 72 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 72 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 72 agreed to.*

*Section 15, as amended, agreed to.*

### Section 16—Patient Rights Officers

*Amendment 73 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 73 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

**The Convener:** The result of the division is: For 5, Against 3, Abstentions 0.

*Amendment 73 agreed to.*

### Section 17—Duties to share information

**The Convener:** Amendment 3, in the name of the minister, is grouped with amendments 4 to 6.

**Nicola Sturgeon:** Amendments 3 to 6 are entirely technical in nature. They seek to amend the bill so that duties are placed on the Common Services Agency rather than being placed directly on the provider of the PASS. That will make section 17 consistent with the rest of the bill.

I move amendment 3.

*Amendment 3 agreed to.*

*Amendments 4 to 6 moved—[Nicola Sturgeon]—and agreed to.*

*Section 17, as amended, agreed to.*

### After section 17

**The Convener:** Amendment 74, in the name of Richard Simpson, is grouped with amendments 75 and 15A.

**Dr Simpson:** Some parties have had significant objections to the bill and its overall necessity. We will see at stage 3 where we have managed to get to. One of the problems with the bill is that, although it seeks to create rights, it specifically excludes individuals from seeking redress. We have all acknowledged that the Government has listened. Parliament said clearly that it did not want to create a situation where there would be lawyers at the bedside. However, without some redress, the rights are—it is said at least by some people—meaningless.

One of my regrets about the bill is that it has been introduced before the Government could conclude its consideration of a general, no-fault compensation system. I realise that such a scheme and consideration of it will deal primarily with clinical matters, but a system of no-fault compensation could equally be applied to some of the rights and guarantees that the bill will underpin.

Combined with conciliation and mediation provisions, which the Government has itself added today, we could avoid lawyers, while acknowledging when rights are infringed. Amendment 74 seeks to introduce such a system for non-clinical issues.

I await with interest the cabinet secretary's comments.

I move amendment 74.

**Ross Finnie:** I have some sympathy with Richard Simpson on this matter, although I appreciate that the Government had been considering it separately—and we have not had any response on that. I am in no doubt that, if we

are to make a fundamental change in addition to the changes that have now been suggested to the provisions on how complaints are dealt with and how boards respond to them, the need for a no-fault compensation scheme is very important.

I have one reservation, to which Richard Simpson could respond when he winds up. In subsection (3) of the new section that amendment 74 would insert, he seeks to restrict the application of such a scheme to the matters that are covered by the bill. That seems to be a recipe for serious confusion. As a matter of principle, I support the introduction of no-fault compensation into the national health service—although one would like to see the detail—but I am very nervous about the idea of simply moving an amendment to effect such provisions under this bill. Given how the bill is constructed, it is difficult to be precise as to where the scheme might or might not apply. We have now helpfully moved towards including a charter within the bill. If that charter makes specific reference to the various rights that patients have and patients are led to believe that they might benefit from no-fault compensation only to find that the way in which subsection (3) is expressed restricts patients to matters under the principal part of the bill rather than those that come under the schedule, that could cause confusion. I would be grateful if Richard Simpson could address that point when winding up.

**Mary Scanlon:** I have a couple of questions for the member. No-fault compensation is a highly complex issue, and I am aware that we have not taken any evidence on the subject. What sort of consultation has Richard Simpson carried out? What organisations support the amendments in this group? Does he have concerns, as I do, that we have not had an opportunity to discuss the issue at stage 1?

16:15

**Nicola Sturgeon:** As Richard Simpson has said, amendment 74 proposes the establishment of a no-fault compensation scheme to cover patients' rights under the bill. Under the proposal, a patient could claim compensation even if they had not suffered any injury, harm, damage or loss.

As members will be aware, I have expressed sympathy with the idea of moving to a no-fault compensation scheme, although Mary Scanlon is correct to point out that the area is highly complex. Because of those complexities, I asked Sheila McLean of the University of Glasgow to convene an expert group to examine no-fault compensation, to look at systems in other parts of the world and to consider all the complexities and costs that would inevitably be associated with the introduction of such a scheme. I have now received Sheila McLean's report; the Government is considering it and will publish it and our response as soon as possible. Because of the complexities and potential cost implications, we are taking a wee bit of time to consider it, but that is the proper way of proceeding.

Although no-fault compensation has a great deal to commend it, it would, as I have said, inevitably have cost implications. Moreover, my view even since before the bill's introduction is that the move would represent such a fundamental legal change that it would require separate legislation; I have never been of the view that it was appropriate to make provision for it in this bill, although if we move to the system in future, it could be made to apply to the rights in the bill. Given that such a system would have wider application than to those rights alone, we have to consider the issue in its totality instead of tagging it on to the bill. That is particularly important given that, as Mary Scanlon has rightly pointed out, the committee has taken no evidence on the matter.

I might be wrong, but I suspect that Richard Simpson has lodged these amendments partly as a probing exercise to find out where we are with no-fault compensation. I appreciate members' interest in the matter, but it is important that we proceed carefully and with due consideration. The publication of Sheila McLean's report and the Government's response—which, as I say, will happen as soon as possible—will provide the right environment for a full debate on the pros and cons of such a system and on the way forward, if Parliament thinks that we should move on the issue.

**Dr Simpson:** I agree with much of what the cabinet secretary said but, instead of the bill as it stands, I still would have preferred to have been presented with a package that was partly on patient rights and partly on a no-fault compensation scheme and which covered clinical and patient rights issues. I make it clear that the point of lodging the amendment was not to address the clinical issues. However, although it was not our intention to make it overly restrictive, I accept Ross Finnie's point that it might well be, given that it might not cover some of the elements that would be in the charter but not in the bill.

Nevertheless, one of the fundamental criticisms of the bill is that, if a right is to be a right, there must be redress. That conundrum has not yet been solved without the kind of massive participation of lawyers that none of us wants. As the cabinet secretary has suggested, this is undoubtedly a probing amendment, but I have also lodged it to put on record my view that, even if we are able to pass it, the bill will remain fundamentally flawed in its failure to provide redress.

However, I am heartened by the cabinet secretary's comments. I believe that we should introduce a no-fault compensation system for all sorts of reasons, especially the fact that, in the past financial year, £31 million was paid out on negligence claims. Those settlements might well be totally appropriate, but some of those claims go back seven, eight or nine years and the people in question and their families have suffered as a result. Even though the situation has improved substantially, major clinical issues still need to be addressed.

That said, I seek the committee's permission to withdraw amendment 74.

*Amendment 74, by agreement, withdrawn.*

### Section 18—Protections and limitations

**The Convener:** Amendment 7, in the name of the minister, is grouped with amendments 8 and 9.

**Nicola Sturgeon:** Amendments 7 and 8 are technical amendments to ensure that the original policy intention of the rights that are set out in the bill do not give rise to additional rights to sue health boards, thereby avoiding the lawyer-by-the-bedside concern that was expressed earlier. Patients' rights to sue under other legislation, such as in cases of medical negligence, continue to be unaffected, as is the option of pursuing a declaratory judicial review with the remedy of reduction; all that is still available.

Amendment 9 seeks to address a specific point that was made at an earlier stage, which is that the bill does not exhaustively narrate all the rights that patients have. The amendment simply intends to draw attention to the fact that the rights in the bill are additional to those that already exist and do not undermine them or suggest that they might no longer exist. Of course, we have moved some way this afternoon in the discussion of a patients charter but, nevertheless, amendment 9 is still important.

I move amendment 7.

*Amendment 7 agreed to.*

*Amendment 75 not moved.*

*Amendments 8 and 9 moved—[Nicola Sturgeon]—and agreed to.*

*Section 18, as amended, agreed to.*

### After section 18

**The Convener:** Amendment 10, in the name of the minister, is in a group on its own.

**Nicola Sturgeon:** Amendment 10 is a technical amendment to ensure consistency with the National Health Service (Scotland) Act 1978. It means that the powers that Scottish ministers have under the 1978 act to hold inquiries, to declare a health board or special health board to be in default, to use emergency powers, and to use powers to ensure that services are delivered to a standard that they consider to be acceptable will also apply in the context of the Patient Rights (Scotland) Bill. Of course, as with the 1978 act, those are considered to be powers of last resort.

I move amendment 10.

*Amendment 10 agreed to.*

### Section 19—Interpretation

*Amendment 76 moved—[Dr Simpson].*

**The Convener:** The question is, that amendment 76 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Frank (Glasgow Shettleston) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**Against**

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

**The Convener:** The result of the division is: For 4, Against 4, Abstentions 0. I use my casting vote against the amendment.

*Amendment 76 disagreed to.*

*Amendment 77 not moved.*

*Section 19 agreed to.*

*Section 20 agreed to.*

### Section 21—Orders, regulations and directions

**The Convener:** Amendment 11, in the name of the minister, is grouped with amendments 12, 13, 78, and 14 to 18.

**Nicola Sturgeon:** I will move amendment 11 and speak to amendments 11 to 18. The amendments are entirely technical in nature and, with the exception of amendment 18, were all recommended by the Subordinate Legislation Committee. Amendment 18 simply removes a power to appoint different days on which provisions in the act will come into force for different purposes. That will now be covered by section 8 of the Interpretation and Legislative Reform (Scotland) Act 2010.

I will just say a brief word about Richard Simpson's amendment 78.

**The Convener:** I was just going to point that out to you. I like to point things out occasionally, just to give myself some meaning.

**Nicola Sturgeon:** You have lots of meaning as far as I am concerned, but I will not butter you up any more.

Amendment 78 intends to apply affirmative procedure to the patients charter and the patient guarantee. The amendment is technically deficient because it refers to the wrong section of the bill, so I invite Richard Simpson not to move that amendment and to rectify it for stage 3.

I move amendment 11.

**The Convener:** Richard Simpson will speak to that technically wrong amendment.

**Dr Simpson:** Notwithstanding the technical deficiency, which would have led me not to move the amendment, the patient guarantee sections of the bill have not been passed, so I will not move the amendment for that reason.

**Nicola Sturgeon:** Well spotted.

**Ross Finnie:** That was a trick question.

**Nicola Sturgeon:** It was just a test.

**The Convener:** I feel as if it is all beginning to fall apart. Let us keep going, as the end is in sight. No other members have indicated that they wish to speak, so the minister will wind up.

**Nicola Sturgeon:** Richard Simpson is right. Saying that the amendment that I was describing is technically deficient showed my own technical deficiencies in not spotting that the sections to which it refers were not agreed to.

**The Convener:** I am sure that there is meaning in that answer, but I cannot for the life of me think of it at the moment.

*Amendment 11 agreed to.*

*Amendments 12 and 13 moved—[Nicola Sturgeon]—and agreed to.*

*Amendment 78 not moved.*

*Amendment 14 moved—[Nicola Sturgeon]—and agreed to.*

*Amendment 15 moved—[Nicola Sturgeon].*

*Amendment 15A not moved.*

*Amendment 15 agreed to.*

*Amendments 16 and 17 moved—[Nicola Sturgeon]—and agreed to.*

*Section 21, as amended, agreed to.*

**Section 22—Short title and commencement**

*Amendment 18 moved—[Nicola Sturgeon]—and agreed to.*

*Section 22, as amended, agreed to.*

*Long title agreed to.*

**The Convener:** That concludes stage 2 consideration of the Patient Rights (Scotland) Bill an hour earlier than anticipated. We did it at breakneck speed.

I thank the cabinet secretary for her attendance. I remind members that the committee meets again—I know that you are longing for this—tomorrow in committee room 4. We could really stay put.

**Michael Matheson (Falkirk West) (SNP):** You can, convener.

**The Convener:** No, I will not.

*Meeting closed at 16:27.*

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