The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

# HEALTH AND SPORT COMMITTEE

Tuesday 12 June 2012

Session 4

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## HEALTH AND SPORT COMMITTEE
**19th Meeting 2012, Session 4**

**CONVENER**

*Duncan McNeil (Greenock and Inverclyde) (Lab)

**DEPUTY CONVENER**

*Bob Doris (Glasgow) (SNP)

**COMMITTEE MEMBERS**

*Jim Eadie (Edinburgh Southern) (SNP)
Richard Lyle (Central Scotland) (SNP)
*Fiona McLeod (Strathkelvin and Bearsden) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Adam Ingram (Carrick, Cumnock and Doon Valley) (SNP) (Committee Substitute)
Michael Matheson (Minister for Public Health)

**CLERK TO THE COMMITTEE**

Douglas Wands

**LOCATION**

Committee Room 6

# Scottish Parliament

## Health and Sport Committee

*Tuesday 12 June 2012*

[The Convener *opened the meeting at 10:00*]

## Decisions on Taking Business in Private

**The Convener (Duncan McNeil):** Welcome to the 19th meeting of the Health and Sport Committee in 2012. I remind everyone that mobile phones and BlackBerrys should be turned off, as they can interfere with the sound system.

We have an apology from Richard Lyle, and Adam Ingram is attending in his place.

I ask the committee to agree to take in private agenda item 6, which concerns consideration of the committee's draft report on national health service boards budget scrutiny. Do we agree to do so?

**Members** *indicated agreement.*

**The Convener:** Also, do we agree, at future meetings, to deal in private with our draft stage 1 report on the Social Care (Self-directed Support) (Scotland) Bill?

**Members** *indicated agreement.*

## Subordinate Legislation

### Mental Health (Safety and Security) (Scotland) Amendment Regulations 2012 [Draft]

10:01

**The Convener:** The next item of business concerns consideration of an affirmative instrument. The Subordinate Legislation Committee has raised no issues on the regulations.

I welcome the Minister for Public Health, Michael Matheson, to the meeting. He is accompanied by Simon Cuthbert-Kerr, the head of the Scottish Government's mental health legislation and adult protection policy team. I invite the minister to make a brief opening statement.

**The Minister for Public Health (Michael Matheson):** The regulations amend regulation 2(2)(a) of the Mental Health (Safety and Security) (Scotland) Regulations 2005. The purpose of that is to include the new medium secure service at the Rohallion clinic in Perth in the list of hospitals where the 2005 regulations apply. That will bring Rohallion into line with the other medium secure units in Scotland. Rohallion is due to open in August.

The effect of the amendment is to include patients in the medium secure service of the Rohallion clinic in the definition of "specified persons" in the 2005 regulations. Various actions may be taken in respect of specified persons as required, including searching them, taking samples of bodily fluids, restricting their possession of certain items, such as mobile phones, and restricting their visitors.

The medium secure service at the Rohallion clinic will be Scotland's third medium secure unit, after the Orchard clinic in Edinburgh and the Rowanbank unit in Glasgow. The amendment will provide that all patients in the medium secure service at the Rohallion clinic may come within the restrictions that are set out in the Mental Health (Safety and Security) (Scotland) Regulations 2005.

I am happy to respond to any questions that members might have.

**Dr Richard Simpson (Mid Scotland and Fife) (Lab):** Will this be the last medium secure unit development? I know that the programme has been to reduce the state hospital numbers by almost half over the past few years, with the substantial refurbishment of the state hospital, and that the clinics in Glasgow, Edinburgh and Perth have been created, in part, to absorb the effects of

that shift to a lower level of security for people for whom that is appropriate. Have we got the balance right between the state hospital, the medium secure unit and locked units or light secure units—I cannot remember the modern term for them.

**Michael Matheson:** Low secure.

**Dr Simpson:** Low secure; thank you. Those have also been substantially redeveloped. Will this be the conclusion of the situation for the foreseeable future?

**Michael Matheson:** The move is part of the programme that was concerned with the flow of patients from the state hospital into medium secure units and low secure units, and then into a community setting. The planning for that is being taken forward on a regional basis, given that a relatively small number of beds are required—the new Rohallion medium secure unit will have 32 beds. We need an approach that is sustainable in geographical terms.

We have been looking at the flow of patients and we are content that it is adequate, but we will keep the matter under review, to ensure that we strike the right balance in relation to the flow between high-security, medium secure and low secure facilities and the community. We will continue actively to monitor the situation. There are monitoring arrangements in various regions, which will flag up difficulties, so that we can consider what further measures might be necessary.

**Dr Simpson:** That is helpful. Are you aware of problems in relation to movement from the Scottish Prison Service into medium secure units? Are there barriers to movement, or is the system working effectively? That is a potential area of pressure.

**Michael Matheson:** I am not aware that particular problems are presented at the moment. Sometimes there will be moves into a high-security setting, of course.

**Dr Simpson:** There are now no high-security places for women in the state hospital. Have we had to transfer women to high-security facilities in England, or have medium secure units been sufficient?

**Michael Matheson:** Most of the women who require a secure setting are being dealt with in the medium secure setting in Scotland.

**The Convener:** If there are no more questions from members, we move to item 3, which is formal consideration of the motion. I ask the minister to move motion S4M-03154. If no member wants to debate the motion, we will move straight to the question.

*Motion moved,*

That the Health and Sport Committee recommends that the Mental Health (Safety and Security) (Scotland) Amendment Regulations 2012 [draft] be approved.—[*Michael Matheson*.]

*Motion agreed to.*

**The Convener:** Thank you for coming, minister.

# Petitions

## Orphan Diseases (Access to Therapy) (PE1398)

## Pompe Disease (Access to Therapy) (PE1399)

## Paroxysmal Nocturnal Haemoglobinuria (Access to Therapy) (PE1401)

10:07

**The Convener:** Item 4 is consideration of petitions. Members will recall that after we heard evidence from the petitioners we agreed to write to the Scottish Government, the Scottish Medicines Consortium and NHS National Services Scotland. We have replies to our letters and further submissions from two of the petitioners.

I remind members that we have agreed to hold an evidence session in September on access to newly licensed medicines. The committee will confirm its plans for that session when we consider our work programme under the next item. I invite members to comment on the action so far and the correspondence that we have received.

**Bob Doris (Glasgow) (SNP):** The correspondence, particularly from the SMC, was helpful. When we previously discussed the petitions, I remember that one or two committee members thought that we did not have the expertise to enable us to map out the process effectively. As a result of the correspondence, as well as a number of helpful events at the Parliament, which Nanette Milne has been involved in sponsoring, I feel that I am in a stronger position to be able to take forward the petitions. I very much hope that we will return to the issue when we consider our work programme.

**Nanette Milne (North East Scotland) (Con):** I agree with Bob Doris. Our evidence session in September will be interesting in that it will provide us with the detail about SMC procedures. I was a member of the Public Petitions Committee when the petitions were considered prior to their referral to this committee, and I am pleased that the matter is being taken further forward than the PPC was able to take it. I welcome the information that is before us.

**Dr Simpson:** The correspondence is helpful because it begins to define some of the central questions, including, for example, whether the SMC's modifiers are entirely appropriate, particularly with regard to the major issue of palliative care, and whether the new individual patient treatment request system is working well in two respects, the first of which is the criterion for acceptance under IPTR, which is that the patient's characteristics should be significantly different from those of the general population of patients covered by the medicine's licence or the population of patients included in the clinical trials. That almost creates a catch-22 situation for rare and orphan drugs, because the numbers are so small that it becomes very difficult to differentiate one patient from a group.

The second question that has been raised, particularly in the petitioner's correspondence, is whether there is enough expertise in the 14 IPTR panels and each health board to examine these issues in a fair, equitable, transparent and even way across all health boards with regard to particularly rare conditions that only one or two experts in Europe, never mind the UK, might know about. Certain issues are emerging and I am looking forward to the evidence session later in the year, because it will allow us to define things further.

I also ask our support staff to provide us with a list of medicines that have been approved by the National Institute for Health and Clinical Excellence or the new advisory group on national specialist services but have not been approved in Scotland. After all, there will be concerns—at least, as long as we remain in the UK—that patients in Scotland are being treated differently from those in different parts of the UK and it will be helpful to have a list of the drugs that have highlighted discrepancies in approval systems.

Finally, the English NHS has decided to set up a cancer drugs fund. We in Scotland have generally agreed not to do the same, particularly because of the view that it discriminates against other conditions, but that decision has led to a discrepancy that might not be fully addressed under the IPTR system and we need to review the matter at our evidence session.

**Gil Paterson (Clydebank and Milngavie) (SNP):** If we are to consider differences between Scottish and English operations, we will need a corresponding list of the drugs that are used in Scotland but not in England. We need to find out the rationale for such decisions and why there are positive and negative outcomes north and south of the border.

**The Convener:** If no one else wishes to speak, I will bring Bob Doris back in and then we will move on.

**Bob Doris:** I will make a very brief point, because I hope that we will examine the issue in more detail in the very near future. Richard Simpson has made a number of important and fair points but, for the sake of completeness, I note that in its written correspondence the SMC states that the AGNSS process itself might have some

shortcomings. We cannot state that, just because England has another process, it is necessarily better; what we are looking for is the best process for Scotland.

The SMC also makes the point that England has three different systems running in parallel. One might suggest that such an approach simply fragments the situation and does not provide consistency of judgment; in fact, you might argue that with the cancer drugs fund England has four different systems. I think that we have to approach the issue with an open mind, examine the strengths of the English and Scottish processes and recommend changes if we need to. I know that Dr Simpson was not doing this, but we should not simply assume that just because England has something different it is necessarily better. There might be issues with that system that we should scrutinise before we make any recommendations.

**Dr Simpson:** I entirely agree, convener.

**The Convener:** It was useful to get those comments on the record, as they will help in our preparations for the evidence session. Do members agree to note the additional correspondence that has been received and to consider the petitions again following the evidence session in September?

**Members** *indicated agreement.*

## Work Programme

10:15

**The Convener:** We come to item 5. From the paper, members can see that the main points are two items under inquiry work for September 2012—medicines and community sport. There is also one item at the very end of the paper in which I ask for any suggestions for work that we might undertake in the run up to Christmas.

The committee is invited to agree to the proposal in paragraph 15 of the paper to devote its meeting on 18 September 2012 to consideration of the approval process for newly licensed medicines and the system of IPTRs. Can we agree that approach?

**Members** *indicated agreement.*

**Bob Doris:** I absolutely agree but, for completeness, it would be good to put it on the record that we do not hope to use the session to analyse one particular drug and the approval process for that individual drug. We are talking about futureproofing the system for all new drugs that might emerge, so we want to look at the nuts and bolts of the system to see, irrespective of whether a drug is approved, whether there is a way in which the timeframe of the process would allow us to make speedier decisions and bring more certainty to the process. That would be a useful evidence session.

**Dr Simpson:** I apologise for asking this, but I have forgotten my iPad. Is the meeting on 18 September to be a panel or an evidence session?

**The Convener:** We will now go on to confirm the witnesses for that meeting. The proposal is for a round-table meeting with the Scottish Medicines Consortium, the Association of the British Pharmaceutical Industry, consultants via the Royal College of Physicians, and representatives of up to three NHS boards.

**Nanette Milne:** Are we to specify those NHS boards today?

**The Convener:** This is your opportunity to make suggestions and feed into the process.

**Nanette Milne:** In that case, I suggest NHS Grampian as one of the health boards. The IPTR system was brought in because of a petition from a patient in the Grampian health board area, and it did a lot of detailed work on the issue right at the beginning of the system. It would be useful for the committee to hear about that experience.

**The Convener:** Does the committee agree?

**Jim Eadie (Edinburgh Southern) (SNP):** I fully endorse Nanette Milne's suggestion, and I suggest

that NHS Lothian would be a suitable and appropriate health board to bring before the committee. The rationale for that is that the figures that I have seen as a result of a freedom of information request show that there are some issues worth teasing out about how the IPTR system is operated in that particular health board.

**Dr Simpson:** Do we know which health board refused the paroxysmal nocturnal haemoglobinuria treatment that was recommended by the national services division clinic at Monklands? That seems to me to bring up the question of equity. I think that the patient was in Inverclyde.

**The Convener:** It was NHS Greater Glasgow and Clyde. I have had a couple of constituency cases. It is important to note that we are not necessarily looking at the procedure or the drug that a person applies for, but at the experience of the process that the person has to go through.

Those suggestions would give us Grampian, Lothian and Greater Glasgow and Clyde health boards.

**Dr Simpson:** The problem with those suggestions is that it might be one of the smaller health boards that might face particular financial pressures from IPTR, unless it is backed by a risk sharing system. I wonder whether we should make it four and invite a smaller health board as well.

**The Convener:** We can bring back suggestions and see how things would work. We should bear in mind the number of people at the round-table discussion and consider what can be managed. However, it has been useful to hear members' comments to see how we can do things best.

**Jim Eadie:** Can we have a bit of flexibility on the consultants who will be in front of us? We should not simply ask the Royal College of Physicians to recommend people. If members have suggestions, they should be able to input them to the clerks for consideration. There are consultants who have to take difficult decisions at the coalface on whether to request medicines under the IPTR system. I would like to hear from people who take those decisions, rather than people who are at a more strategic decision-making level in boards.

**The Convener:** It is useful to make that point. We can have discussions about that.

**Dr Simpson:** We can ask the RCP to nominate consultants it is aware of who have had particular problems. That is a very helpful suggestion.

**Bob Doris:** It is. If I remember rightly—again, I am drawing on knowledge from one of the events that Nanette Milne sponsored in the Parliament—irrespective of the outcomes of IPTRs, some areas use far more than other areas. That information was available to us, Nanette. We may not be able to do this today, but I wonder whether we can work out two areas that we can contrast. We can consider why IPTRs are used fairly regularly in some parts of the country, but seldom in other parts. It might be quite useful to try to tease out the differences and the reasons for them.

**The Convener:** Do members agree that we can consider the matter and that the clerks should work with those comments?

**Members** *indicated agreement.*

**The Convener:** Do members agree to publicise the session and invite written submissions from interested individuals and organisations?

**Members** *indicated agreement.*

**The Convener:** That leaves us with community sport, which is the other issue in the paper. Do any questions arise from the work programme paper or the meeting that we had?

**Bob Doris:** I am sure that the inquiry will allow this to happen, but I want to consider how we quantify the health, social and community benefits from public money that is invested in community sport. I am not talking about anecdotal benefits, but outcomes that can be measured.

I have previously told the committee that I have been to look at the football fans in training project at Celtic Park, and I believe that the University of Glasgow is monitoring how successful that project has been. I am not talking about a bid for one club over another—I think that Inverness Caledonian Thistle has just been given an award for its football fans in training programme. More important are the academic data that have been produced on what the benefits are. If public investment is involved, we want to be able to quantify the positive outcomes. I make the appeal that, when we finalise our witness panels, we should scratch beneath the surface of the anecdotal benefits of community sports. We all know that there are benefits, but quantifying them can be difficult. We should consider getting witnesses to the committee who have done work to quantify what those benefits are.

**The Convener:** We can take some of that thinking on board.

**Drew Smith (Glasgow) (Lab):** I agree with Bob Doris and understand where he is coming from, but there are slightly different issues around health-enhancing physical activity. That is a wider area than sport for sport's sake. We should not completely lose sight of the fact that we deal with health and sport and not just the health benefits of sport. We have a role in looking at communities, and part of the focus in relation to a community sport inquiry should be on sporting opportunities, regardless of whether they lead to improved health outcomes, because sport in and of itself is

important. There is a distinction between sport and physical activity.

**The Convener:** Are there any other comments on the themes of the inquiry?

**Dr Simpson:** I wonder whether, in calling for evidence, we should draw people's attention to our pathways into sport inquiry, which could be a linked starting point.

**The Convener:** I presume that, like the medicines stuff, we will be able to finalise the issue before the recess. We can take the discussion on board and see where it all fits and what we can do within the short period available to us. However, we can broadly agree the themes, taking the additional comments into account.

We have agreed that the session on newly licensed medicines will be on 18 September. We have still to confirm the witnesses for that session—we will do that before the recess. We have agreed to publicise the session and invite submissions.

On community sport, we have broadly agreed the themes of the inquiry. We can confirm the questions for the call for written evidence, a programme of oral evidence and up to two fact-finding visits, as outlined in the paper.

There is an opportunity to have some chamber time on the issue. Rather than taking a completed report to the chamber, it would be a case of the committee opening up the issue and encouraging wider debate to inform its inquiry. There is a particularly active cross-party group on sport. Members who are interested in the issue would be allowed to participate in the debate. The debate would inform the inquiry, which is an approach that has already been used by other committees to some useful purpose.

**Bob Doris:** It sounds like a good idea. If we do not go for that chamber slot—although I think that we should—would there be an opportunity to debate the completed report at a later date? If we put recommendations in the report, we will want to debate them in the chamber and bring more focus to the Government's response to them.

**The Convener:** The debate would inform our report, and because we had encouraged people to take an interest in the issue, it might support or strengthen our recommendations. When we have debates in the chamber we are usually sent briefings and so on by various organisations that are interested in the issue being debated. Such a debate should generate information but would not preclude a debate on any report or recommendations that we may wish to make in future.

Are members content with that?

**Members** *indicated agreement.*

**The Convener:** Thank you for your comments and co-operation.

**Drew Smith:** I want to make a general point on the work programme rather than a specific point on medicines or sport. Is it okay to do that?

**The Convener:** Yes, of course.

**Drew Smith:** I want to put it on the public record, since we are discussing the work programme in public, that we need to return to the issue of health and safety after we have received the report from the Scottish Affairs Committee. However, perhaps the planning day would be the appropriate time to do that.

Would it be appropriate for us to take evidence on the legionella outbreak? The cabinet secretary has made a statement to Parliament, and the committee would be expected to have discussions with officials and people locally about the response. I understand that the situation is on-going, but I think that people would expect the committee to take an interest, and we seem to have some time before the recess to do that.

10:30

**The Convener:** The deputy convener and I have discussed the issue in private along with the clerk. Although time could be found this week, it would not have been sensible to take people off the job at the height of the activity. However, the situation has plateaued and, thankfully, the number of reported cases is diminishing. Following the cabinet secretary's statement last week, members are beginning to focus on what happened and on discussing preventive measures with the practitioners who have been involved in this serious incident. I would welcome a decision by the committee. We should have an evidence session as quickly as possible.

**Fiona McLeod (Strathkelvin and Bearsden) (SNP):** I echo those sentiments. We should not take people off the job in the middle of a crisis to write reports and give evidence. The right procedure is to wait until after the crisis. I would like to hear from people about the lessons that they have learned from the outbreak. I would just put a wee caveat on your point that we should have people in as quickly as possible. I would like people to come when they think that they can describe to us clearly how the situation unfolded, how it was dealt with and what lessons they have learned for the future.

**Bob Doris:** I agree with Fiona McLeod. It would be reasonable to slot in a focused session, perhaps before the parliamentary recess. The issue is just about timing. It would be good to find out what lessons have been learned. In any crisis,

lessons will be learned. We need to disseminate best practice on resilience across health boards in case something similar happens again—heaven forfend. I agree with Fiona McLeod that we should contact NHS Lothian, or whomever we agree should come in, and say that we would like them to come before recess, but then wait to see what they say. I believe that they will be keen to come. Drew Smith has done the committee a service by raising the issue.

**Nanette Milne:** I do not disagree with anything that has been said. However, it might be a little too soon to have such a meeting before recess. Obviously, that depends on the response, but we should make it clear that we are not asking people to come before recess if that would be inappropriate. A meeting soon after recess would perhaps be better. However, we should probably leave it to the clinicians or the people in charge of the response to decide that.

**The Convener:** That is correct. We can offer a meeting as early as next week or 26 June, but we should consult NHS Lothian and the other agencies. There is no wish to command people to come here, but I am sure that they will welcome the opportunity to come. We should discuss with the practitioners when they can come before the committee.

**Dr Simpson:** I do not disagree with anything that has been said. The meeting might well take place on 26 June rather than 19 June, depending on the response from NHS Lothian. We should also consider inviting the health and safety and environmental health people and Health Protection Scotland, because those are the three other agencies that are involved.

**The Convener:** We can leave it to the clerks to make the appropriate arrangements, given the committee's discussion. Do members agree to let the clerks make the contacts and find a date that is suitable to us all for the meeting?

**Members** *indicated agreement.*

**The Convener:** I thank Drew Smith for that suggestion.

We also have an issue about our work after mid-November. Drew Smith suggested an inquiry on the Health and Safety Executive for the period from mid-November to the end of the year. He mentioned that it would be appropriate to discuss that at our planning meeting, which would leave us plenty of time to arrange an inquiry. Do we agree to discuss at the planning day in August what to do on the dates from mid-November to December, which we did not foresee would be available?

**Members** *indicated agreement.*

**The Convener:** We now move to agenda item 6, which we have agreed to take in private.

10:35

*Meeting continued in private until 11:05.*

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