HEALTH AND SPORT COMMITTEE

AGENDA

30th Meeting, 2010 (Session 3)

Wednesday 27 October 2010

The Committee will meet at 10.00 am in Committee Room 3.

1. **Subordinate legislation:** The Committee will consider the following negative instruments—

   The Materials and Articles in Contact with Food (Scotland) Regulations 2010 (SSI 2010/327);
   The Food Irradiation (Scotland) Amendment Regulations 2010 (SSI 2010/328); and
   The Contaminants in Food (Scotland) Regulations 2010 (SSI 2010/329).

2. **Palliative Care (Scotland) Bill:** The Committee will take evidence on the Bill at Stage 1 from—

   Dr Richard Scheffer, Board Member, Dignity in Dying;
   David McNiven, Director, MS Society Scotland;
   Jenny Henderson, Development Manager, Alzheimer Scotland;
   Lilian Lawson, Director, Scottish Council on Deafness;

   and then from—

   Dr David Oxenham, Medical Director, Marie Curie Hospice Edinburgh;
   Irene McKie, Hospice Director, Strathcarron Hospice;
   Dr George Gray, Associate Specialist in Palliative Care, Prince and Princess of Wales Hospice;
   Dr Colin Barrett, Associate Medical Director, and Jacquie Lindsay, Nurse Lecturer, St Margaret of Scotland Hospice;
and then from—

Sandra Campbell, Member, Royal College of Nursing Scotland;

Katrina McNamara-Goodger, Head of Policy and Practice, ACT (Association for Children’s Palliative Care);

Professor Scott Murray, St Columba’s Professor of Primary Palliative Care, Association of Palliative Medicine;

Dr Robert Euan Paterson, Royal College of General Practitioners.

3. **Patient Rights (Scotland) Bill (in private):** The Committee will consider a draft Stage 1 report.

Douglas Wands  
Clerk to the Health and Sport Committee  
Room T3.60  
The Scottish Parliament  
Edinburgh  
Tel: 0131 348 5210  
Email: douglas.wands@scottish.parliament.uk
The papers for this meeting are as follows—

**Agenda Item 1**

Paper from the clerk

**Agenda Item 2**

Scottish Government Memorandum on the Palliative Care (Scotland) Bill

Submission from Dignity in Dying

Submission from MS Society Scotland

Submission from Alzheimer Scotland

Submission from the Scottish Council on Deafness

Submission from Marie Curie Hospice Edinburgh

Submission from Strathcarron Hospice

Submission from the Prince and Princess of Wales Hospice

Submission from St Margaret of Scotland Hospice

Submission from the Royal College of Nursing Scotland

Submission from ACT (Association for Children’s Palliative Care

Submission from the Association of Palliative Medicine

Submission from the Royal College of General Practitioners

**Agenda Item 3**

Paper from the clerk

PRIVATE PAPER
Overview

There are three negative instruments for consideration. These relate to the amendments of regulation in Scotland relating to food safety standards in order to comply with the latest Directives of the EU Council on these issues.

A brief explanation of each instrument, along with the comments of the Subordinate Legislation Committee, is set out below. If members have any queries or points of clarification on the instrument which they wish to have raised with the Scottish Government in advance of the meeting, please could these be passed to the Clerk to the Committee as soon as possible.

<table>
<thead>
<tr>
<th>Name</th>
<th>Deadline</th>
<th>Motion to Annull</th>
<th>Purpose</th>
<th>Drawn to attention by Subordinate Legislation Committee (SLC)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Materials and Articles in Contact with Food (Scotland) Regulations 2010 (SSI 2010/327)</td>
<td>8 Nov</td>
<td>No</td>
<td>These Regulations revoke the Materials and Articles in Contact with Food (Scotland) Regulations 2007 (S.S.I. 2007/471) (“the 2007 Regulations”) and re-enact, with certain amendments relating to active and intelligent materials and articles, provisions contained in those Regulations. These Regulations provide for the enforcement of Regulation (EC) No. 1935/2004 of the European Parliament and of the Council on materials and articles intended to come into contact with food and repealing Directives 80/590/EEC and 89/109/EEC.</td>
<td>The SLC sought clarification from the Scottish Government regarding the scope of the offence of contravening regulation 8. The SLC was content with the clarification provided by the Scottish Government. The SLC also reports that the reference to the transitional defence in relation to regenerated cellulose film in the explanatory note is an error and welcomes the Scottish Government’s commitment to correct this by correction slip.</td>
</tr>
<tr>
<td>The Food Irradiation (Scotland) Amendment Regulations 2010 (SSI 2010/328)</td>
<td>8 Nov</td>
<td>No</td>
<td>These Regulations amend the Food Irradiation (Scotland) Regulations 2009 to give effect to: (a) Commission Decision 2010/172/EU amending Decision 2002/840/EC as regards the list of approved facilities in third countries for the irradiation of foods (O.J.</td>
<td>The SLC reports that an explanation has been provided by the Scottish Government of how regulation 4 makes the necessary correction to properly transpose the requirements of articles 8 and 9 of Directive 1999/2/EC, on which the</td>
</tr>
<tr>
<td>The Contaminants in Food (Scotland) Regulations 2010 (SSI 2010/329)</td>
<td>8 Nov</td>
<td>No</td>
<td>These Regulations revoke and re-enact with changes the Contaminants in Food (Scotland) Regulations 2009. They make provision for the continuing execution and enforcement of Commission Regulation (EC) No. 1881/2006 setting maximum levels for contaminants in foodstuffs (OJ No. L 364, 20.12.2006, p.5) (“the Commission Regulation”).</td>
<td>The SLC had no comments to make on this instrument</td>
</tr>
</tbody>
</table>
PALLIATIVE CARE (SCOTLAND) BILL

MEMORANDUM BY THE SCOTTISH GOVERNMENT TO THE SCOTTISH PARLIAMENT HEALTH AND SPORT COMMITTEE

Introduction

1. This Memorandum has been prepared by the Scottish Government to assist consideration by the Scottish Parliament Health and Sport Committee of the Palliative Care (Scotland) Bill, which was introduced by Gil Paterson on 1 June 2010.

Background

2. The aim of the Bill is to place a statutory requirement on the Scottish Ministers and through them, NHS Boards to provide palliative care for every person with a condition, illness or disease that is progressive, fatal and cannot be reversed by treatment; for that person’s family members and, also sets up reporting arrangements which requires Scottish Ministers to report annually on the provision of palliative care. The Bill specifies indicators with the aim that the quality of care provided can be monitored.

3. The Bill reflects the Scottish Government’s expectations contained within ‘Living and Dying Well’ Scotland’s first national action plan for the provision of palliative care which aims to ensure that palliative and end of life care is available for patients, their families and carers, however the Bill places a legal duty on the Scottish Ministers to provide such care. ‘Living and Dying Well’ ensures that palliative and end of life care will be available regardless of diagnosis or location and wherever possible, allows for the patient to be treated at the location of their choice. This may also mean that the patient can choose to die at home if this is their wish and is practicable in accordance with their clinical needs.

4. To make this a legal duty, the Bill amends Section 48 of the National Health Service (Scotland) Act 1978 making it an additional requirement of Scottish Ministers to ensure the provision of palliative care to persons with a life-limiting condition and to their families and goes on to make it a further legal duty on the Scottish Ministers to report to the Scottish Parliament providing details of palliative care provision. One of the objectives of the Bill is to raise the priority of palliative care services in line with ‘Living and Dying Well’ by creating a specific duty on Scottish Ministers to provide or secure palliative and end of life care for anyone who needs it.

5. The reporting arrangements require Scottish Ministers to report on the provision of palliative care in relation to a number of key indicators established in the Bill. Scottish Ministers will be required to lay an annual report before the Scottish Parliament which compiles the information submitted by frontline providers to enable the Scottish Parliament to scrutinise, compare and contrast the delivery of palliative care services nationwide.
Consultation

6. The consultation exercise on these proposals was originally undertaken by Roseanna Cunningham MSP and on her appointment to the Scottish Government, Gil Paterson MSP took over the process which ran from 14 November 2009 to 9 March 2010 and considered the consultation responses. A total of 370 copies of consultation document were issued to organisations, MSPs and MPs with an interest in the issue and further copies were provided in response to individual requests. The consultation document was also made available from a link on the proposals for Members’ Bills webpage on the Scottish Parliament website.

7. The consultation exercise resulted in 106 formal responses being received, the breakdown being is as follows, 59 individual responses were received, 23 from health professionals, 9 from hospices and charities, 5 from forums and groups, 4 from church organisations, 3 from societies and 3 from local authorities.

Financial Impact

8. The Financial Memorandum to the Bill indicates that the financial implications of the provisions are based on the costs of implementing the recommendations contained within ‘Living and Dying Well’ and also on what information is currently being collected by NHS Boards.

9. The Audit Scotland report into palliative care service in Scotland, which is referred to in the Financial Memorandum, indicated that palliative care associated with primary care and more general acute care was undertaken by generalists and that these costs are more difficult to determine as they are embedded in the existing work of staff working in health and social care. Information on the cost of generalist palliative care provision is not held centrally with this funding included in Board allocations.

10. Additional funding of £3m has been provided for generalist palliative care provision through Action Point 14 of ‘Living and Dying Well’ which stated that additional funding would be provided to support improvements in generalist palliative care through a Direct Enhanced Services (DES) for palliative care which was launched in November 2008. GP Practices were able to add patients with palliative and end of life care needs (irrespective of diagnosis) onto their Quality and Outcomes Framework palliative care register. A further £1.12m over the 2008-09 and 2009-10 financial years was provided for the development and implementation of the actions set out in ‘Living and Dying Well’ individual NHS Board delivery plans across all care settings.

11. Funding for specialist palliative care which relates to care provided through specialist teams by the NHS and specialist care commissioned from hospices is quoted as amounting to £59m in 2006/07 of which £32.8m was met by public donations to individual hospices. The remainder is provided by NHS Boards through the current funding agreement which allows for NHS Boards to fund hospices up to 50% of agreed running costs (HDL(2003)18 Funding of Specialist Palliative Care
Provided by Independent Voluntary Hospices in Scotland) and which is currently under review.

12. The funding details provided in the Financial Memorandum reflect spending by the Department of Health (England) and whilst a figure of £198m for 2010/11 is quoted, a survey conducted by the National Council for Palliative Care found that 35% of Primary Care Trusts who responded were unable to identify how much they spend on end of life care in 2009/10. The assumption that a simple 11% comparison can provide corresponding expenditure in Scotland is potentially not reflective of the true position. It should also be noted that stemming from the requirements of ‘Living and Dying Well’, Delivery Plans were produced by NHS Boards in Scotland. A one-off amount of £25k was provided to each NHS Board to support this work. However, as indicated there will be initial set up and running costs associated with the production performance indicators and reporting systems. It will be necessary for NHS Boards to consider the financial implications of additional statutory requirements which extend beyond the range of services currently provided.

Scottish Government’s Position

13. The Scottish Government is not planning on bringing forward legislation in respect of the provision of palliative and end of life care and the UK Government has no plans to introduce such legislation. We consider there are sufficient existing legal powers and policy arrangements to ensure the development of palliative and end of life care services in common with other NHS services. The Bill recognises and acknowledges the messages and recommendations contained within ‘Living and Dying Well’, the Scottish Government’s action plan for the provision of palliative and end of life care in Scotland.

14. ‘Living and Dying Well’ sets out the Scottish Government’s vision of how this care should be provided and fully commits NHS Boards to the provision of palliative and end of life care, regardless of diagnosis or location and has been accepted by NHS Boards and voluntary sector and local authority stakeholders. The proposal to make this provision a statutory obligation may limit the flexibility of NHS Boards to plan and provide palliative and end of life care services in accordance with local circumstances.

15. Since the publication of ‘Living and Dying Well’ in October 2008, NHSScotland with key stakeholders, has been working to implement the actions set out in the action plan. All NHS territorial and applicable special NHS Boards now have a delivery plan against each of the actions. We are currently preparing an update to ‘Living and Dying Well’ that incorporates the reports from a series short life working groups supporting the implementation of ‘Living and Dying Well’ as well as the various related work programmes. This paper will include a number of additional actions for NHS Boards and key stakeholders to review/implement through their ‘Living and Dying Well’ delivery plans.

16. Alongside this, further examples of the development work continue including an educational care package through NHS Education Scotland. The NHSScotland Do Not Attempt Cardiopulmonary Resuscitation Policy was published in May 2010 and the national roll out of the electronic palliative care summary (ePCS) continues. Linkages have been made to related work programmes including Care Homes,
dementia, reshaping older people’s services and the Healthcare Quality Strategy for
NHSScotland. As we finalise the outputs from the working groups, the key
recommendations, as well as potential measures to demonstrate continuous,
sustainable improvement will be developed and implemented as part of the NHS
Quality Improvement Scotland Implementation and Improvement Programme for
Palliative and End of Life Care.

17. The Bill reflects the existing policy agenda established in the Better Health,
Better Care Action Plan and the NHSScotland Healthcare Quality Strategy which will
be delivered through Scotland’s national action plan for the provision of palliative and
end of life care (‘Living and Dying Well’). Palliative care has moved rapidly to
become a substantive area of development; and an issue which has received
significant attention from the Scottish Parliament Audit Committee, Audit Scotland
and the media.

18. Current legislation and administrative arrangements have been used as the
basis for the implementation of the action plan. From a policy perspective we are
confident that the proposals underpinning the Bill are already accommodated within
‘Living and Dying Well’, our existing strategic plans and implementation
arrangements.

Conclusion

19. In summary, current legislation already imposes duties to secure the care and
treatment of illness and enables a range of facilities and the finance for these to be
provided. This applies to palliative and end of life care as it applies to other
treatment. The proposed Bill goes a step further however and would make it an
express statutory obligation for Boards to provide this care. Existing work in relation
to the implementation of ‘Living and Dying Well’ is expected to lead to a more
equitable and improved service being provided and which will be maintained through
NHS Board lead officials and palliative care delivery plans.

20. This Bill will place special duties, both in relation to service provision and
reporting, on Ministers/Health Boards in relation to palliative care which is just one of
many types of care provided by NHSScotland. The Bill could initiate the situation
where advocates of particular types of care seek to get a corresponding duty placed
on Ministers/Boards as a means of securing priority for their favoured service
resulting in a small number of services being marginalised.

Quality Division
Healthcare Policy and Strategy Directorate
Scottish Government
11 June 2010
Health and Sport Committee

30th Meeting, 2010 (Session 3), Wednesday, 27 October 2010

Patient Rights (Scotland) Bill

The following supplementary written evidence has been received by the Committee in relation to its Stage 1 consideration of the Patient Rights (Scotland) Bill:

- From **Citizens Advice Scotland**, an email, with attached spreadsheet, containing information about Health Board funding extensions for 2010/11, for the Independent Advice and Support Service provided to patients by Citizens Advice Bureaux. This evidence is supplementary to the oral evidence given to the Committee, by Citizens Advice Scotland, on 8 September 2010, [Annexe A]

- From the **Patient Rights (Scotland) Bill Team Leader**, Scottish Government, a letter, clarifying various points raised during the Committee’s oral evidence taking on the Bill. [Annexe B]

Seán Wixted
Assistant Clerk
October 2010
Further to CAS’s oral evidence session with the Health and Sport Committee, please find attached information about Health Board funding extensions for IASS for 2010/2011.

In cases where there have been reductions, these were carried out after negotiation, and the bureaux in the consortium were willing to operate IASS on reduced funding. These reductions were not based on any problems encountered with the service provided but instead looked at funding levels in general. For example, in one health board, cuts made were in line with cuts made throughout the NHS.

Kind regards

Alizeh

Alizeh Hussain
Social Policy and Parliamentary Officer
Policy and Public Affairs Team
Citizens Advice Scotland

<table>
<thead>
<tr>
<th>NHS Board Area</th>
<th>Funding in 2009/10</th>
<th>Funding in 2010/11</th>
<th>Increase, decrease, or the same as 2009/10?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revenue</td>
<td>Revenue</td>
<td></td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>59,804</td>
<td>59,804</td>
<td>Same</td>
</tr>
<tr>
<td>Borders</td>
<td>24,504</td>
<td>23,926</td>
<td>Decrease of 2.3%</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>49,456</td>
<td>49,456</td>
<td>Same</td>
</tr>
<tr>
<td>Fife</td>
<td>50,850</td>
<td>51,359</td>
<td>Increase</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>68,590</td>
<td>68,590</td>
<td>Same</td>
</tr>
<tr>
<td>Grampian</td>
<td>55,096</td>
<td>50,854</td>
<td>Decrease of 8.2%</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>146,476</td>
<td>139,152</td>
<td>Decrease of 5%</td>
</tr>
<tr>
<td>Highland</td>
<td>110,097</td>
<td>110,097</td>
<td>Same</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>71,540</td>
<td>71,540</td>
<td>Same</td>
</tr>
<tr>
<td>Lothian</td>
<td>80,115</td>
<td>78,702</td>
<td>Decrease of 1.76%</td>
</tr>
<tr>
<td>Orkney</td>
<td>8,000</td>
<td>7,500</td>
<td>Decrease of 6.25%</td>
</tr>
<tr>
<td>Shetland</td>
<td>6,000</td>
<td>7,500</td>
<td>Increase</td>
</tr>
<tr>
<td>Tayside</td>
<td>79,593</td>
<td>53,034*</td>
<td>Decrease of 33.4%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>21,328</td>
<td>21,754</td>
<td>Increase</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>831,449</strong></td>
<td><strong>740,234</strong></td>
<td></td>
</tr>
</tbody>
</table>

* The bureaux involved felt this figure was sufficient for the service, given the number of enquiries
PATIENT RIGHTS (SCOTLAND) BILL

I am writing to clarify a number of points raised in the Scottish Parliament Health and Sport Committee stage 1 oral evidence sessions held on 29 September and 6 October 2010.

In relation to the treatment time guarantee (TTG), on 29 September questions were raised about whether the prohibition in the Bill that would affect legal action in respect of failure to meet the 12 week TTG would compromise the right to take legal action in respect of the 18 week referral-to-treatment target. I can confirm that the current waiting time targets are not legal rights, but targets which are set and measured by the Scottish Government. Patients do not, therefore, have any legal basis for going to court if these rights are not met. The inclusion of the 12 week treatment time guarantee does not therefore remove any rights in this respect.

A number of comments and questions were raised, at the session on 6 October, around the exclusion from the Bill of patients with mental health needs. Patients with mental health needs are not excluded in the Patient Rights (Scotland) Bill; the Bill applies to all patients. There was also a misconception that mental health treatments are excluded from the TTG, or that only child and adolescent mental health services are included. It is proposed that the TTG will apply to all planned and elective care delivered on an inpatient or day-case basis, unless the treatment or service is in the list of proposed exclusions. The proposed exclusions for the TTG are in paragraph 36 of the Policy Memorandum, summarised here:
• Assisted conception;
• Obstetrics;
• Complementary and alternative medicines, including homeopathy, provided on the NHS;
• Organ/tissue transplants;
• Direct access services;
• Diagnostic tests;
• Treatments undertaken in a hospital outpatient department;
• Certain designated national specialist services (scoliosis);
• Services on the Department of Health’s specialised service definitions list, where no equivalent clinical services are offered in Scotland; and
• Alcohol and drug misuse services.

With reference to comments made on the exclusion of cognitive behavioural therapy (CBT), this is not specifically excluded from the TTG. However, 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 eligibility criteria for the TTG: this is the same for all services. It is my understanding that CBT is not usually delivered in this way. (Some aspects of child and adolescent mental health services are delivered as planned or elective care on an inpatient or day case basis and these were therefore given in the Policy Memorandum as an example of a mental health service covered by the eligibility criteria).

In relation to the Patient Advice and Support Service (PASS) and Patient Rights Officers (PROs), it was commented, at the session on 29 September, that there was a potential loss of the holistic service currently provided to patients by multi-disciplinary Citizens Advice teams under the Independent Advice and Support Service (IASS). However, the current IASS is commissioned to provide advice about health issues only. The location of IASS, within the Citizens Advice Bureaux (CAB), means that patients are able to access other advice that CAB provide, but IASS itself is not commissioned to provide this service.

Comments were also made by the CAB, during their oral evidence session, about funding cuts for the IASS, made over the last year. I wish to add that, in cases where there have been reductions in funding, these were carried out after negotiation with CAB. The reductions were not because of any problems with the service, but to do with looking at appropriate funding levels.

Regarding the role of PROs and whether they would become involved in advocacy and resolution of complaints for patients or whether they would simply act as signposts, I would like to clarify that PROs will not act as advocates; the current IASS is also not commissioned to provide advocacy services. Advocacy services speak on behalf of people who are unable to speak up for themselves. PROs will provide advice and support; assist with complaints; and signpost people to other services, such as advocacy.
Lastly, with reference to the oral evidence given by CAB on 29 September, the point was made that very few of the complaints cases handled by CAB involved the use of no-fault compensation. At the moment there is actually no system of no-fault compensation operating in Scotland. This is something that is being discussed separately by the No-fault Compensation Working Group, who are due to publish a report shortly.

I am aware that one further issue, around the delivery of the TTG in the primary care sector, still needs to be addressed and I am in the process of clarifying this with colleagues, but will endeavour to get back to you shortly with a response on this.

I hope that you find the above information helpful.

Yours sincerely

Lauren Murdoch
Patient Rights Bill Team Leader