OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 31 January 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 31 January 2017

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HEALTH AND SPORT COMMITTEE
3rd Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dame Denise Coia (Healthcare Improvement Scotland)
Ruth Glassborow (Healthcare Improvement Scotland)
Mark Griffin (Central Scotland) (Lab)
Robbie Pearson (Healthcare Improvement Scotland)
Dr Brian Robson (Healthcare Improvement Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 31 January 2017

[The Convener opened the meeting at 10:00]

Healthcare Improvement Scotland

The Convener (Neil Findlay): Good morning, everyone, and welcome to the third meeting of the Health and Sport Committee in 2017. I ask everyone to ensure that their mobile phones are switched off. It is okay to use mobile devices for social media but not for filming or photographs.

Agenda item 1 is an evidence session with Healthcare Improvement Scotland. I welcome to the committee Denise Coia, the chair of Healthcare Improvement Scotland; Robbie Pearson, chief executive; Ruth Glassborow, director of safety and improvement; and Dr Brian Robson, medical director. Denise Coia has an opening statement.

Dame Denise Coia (Healthcare Improvement Scotland): I have a dreadful cold, so if I splutter at you a bit, my apologies.

Thank you for allowing me to make some opening remarks on the work of Healthcare Improvement Scotland. This is a welcome opportunity to demonstrate how our organisation is making a difference and we welcome your scrutiny of our organisation.

When we begin a piece of work, we ask a fundamental question—how can we best help our partners, from health boards to the new integration authorities, provide the very best care possible, each and every time, for each and every person they support, and by doing this work in HIS, how can we best help patients or people who are receiving care to have a good experience of care?

To fulfil that role, HIS is uniquely positioned as a provider of three things—improvement support, which can be tailored to our partners' circumstances; evidence for improvement, including clinical guidelines and advice on best practice; and public assurance on the quality of services that are provided. I cannot emphasise enough the value of having improvement, evidence and assurance, along with the public voice, all in one organisation. It is a simpler and more effective organisational structure for improving the quality of care in Scotland and we should be proud of it. Many other countries are now seeking to adopt our way of working.

I want to bring to life the breadth, variety and scope of our work because in the complex and changing environment that we work in, there is no single, easy solution and I think that we all have to remember that. Our role in HIS ranges from supporting people to have their say on the design and delivery of services to approving new medicines for routine use in the national health service. We inspect hospitals and other services to drive improvement and we help our partners to design solutions to the challenges that they face.

As an organisation, we work with a wide range of partners and other organisations, so we get to see and understand the full picture of health and social care delivery. That has helped us to support improvement in a range of areas. It is our knowledge and understanding of the overall picture that gives us value.

However, you do not want to hear about the processes behind what we do—you want to hear about their impact and how we measure the value of our work. For example, the first phase of our patient safety programme has helped to deliver a 17 per cent reduction in hospital mortality, supporting the staff in our hospitals to save more lives. What I am most proud of is that the safety programme has helped to drive a 21 per cent reduction in 30-day mortality for sepsis—blood poisoning—again saving lives, especially young lives, across Scotland.

In mental health, the safety programme has supported improvements at ward level, where there have been examples of reductions of up to 70 per cent in the number of patients who self-harm; 57 per cent in the number of incidents in which physical restraint has to be used; and 78 per cent in the number of incidents of physical violence on the wards. Those figures come from some of our most disturbed wards in Scotland, where staff have been working with mental health patient groups and patients from the wards to deliver those outcomes. When you start fixing mental health you know that you live in a civilised society.

We are also expanding into new areas to reflect the integration of health and social care, which puts people right at the heart of delivery of services. Our new improvement hub is a key part of that and we are forming new partnerships across the public sector with organisations such as the Scottish Federation of Housing Associations.

An example of the impact of focusing on housing can be found in work that was originally led by the joint improvement team and which is now part of Healthcare Improvement Scotland's improvement hub. Support was provided to the Western Isles to improve the service that provides equipment and adaptations to individuals' homes.

That service keeps people in the community as well as enabling timely discharge from hospital. In addition to enabling people to live independently, the work has delivered efficiency savings by significantly increasing the level of recycled equipment. In 2012, less than £10,000-worth of housing equipment to help people live at home was recycled, whereas in 2015 the value of such equipment had risen to more than £400,000.

A high profile element of our work is assurance. We conduct unannounced, in-depth, robust inspections. At its core, that means that people can read our inspection reports and know how well services are performing, from how clean a hospital is to how well it cares for older people. We have processes in place to escalate concerns directly to ministers. However, it is about much more than just inspection. We use the process to drive improvement and to share good practice and areas for improvement.

For example, the number of requirements that are contained in our Healthcare Environment Inspectorate reports has reduced by 50 per cent. That means that our hospitals are being kept cleaner by staff who are better trained and informed. To take a specific example, our initial HEI inspection of St John's hospital in Lothian in 2010 resulted in seven requirements and two recommendations, but our most recent report, from 2016, showed that there were no requirements or recommendations.

So far, I have described the impact of some of our work, but it is through the combination of our roles that we can deliver the most sustained and substantial improvement. To illustrate that, it is worth considering how our combined role works around quality of care for older people. In collaboration with partners, our work ensures that older people can expect to receive better-designed care, based on the latest evidence in our clear set of standards and more reliable care through our support for implementing improvements, for example in frailty and delirium. Older people can also be assured that care is of a high and consistent quality through rigorous independent inspection. For example we have worked with NHS Ayrshire and Arran to reduce from 16.3 per cent to 11.6 per cent the number of older people aged over 65 who need to be readmitted to hospital. That means that more older people are cared for in their own homes, with all the benefits that that brings.

Our wide range of functions puts HIS in a unique position. We are able to work across our powers to support improvement in a comprehensive and strategic way. It might be useful to compare that with other organisations and systems, in which you might be able to see only one part of the jigsaw rather than how it all fits together.

It is clear that there is still much for us all to do and we know that we need to keep on improving and adapting. Health and social care services do remarkable things every minute of the day but, as an organisation that exists to support those services to improve even further, we also acknowledge the pressures that they face. In these very challenging times, with rising demand for services and competing demands between acute and chronic care, HIS has a crucial role in supporting the services to remain sustainable for the future. I look forward to HIS continuing to make a difference for people across Scotland.

The Convener: Thank you. We all commend you for the positive things that you have explained in your statement.

The core aim of Healthcare Improvement Scotland is to improve the quality of healthcare and increase the effectiveness and value derived from it. Given that the NHS in Scotland missed seven out of eight of its key national performance targets, would you say that HIS is succeeding or failing in that core aim?

Dame Denise Coia: We are trying to look at the overall picture and you will be aware that there is a review of the targets at the moment. There are challenging times ahead and we have started to look at that and address it. Perhaps Robbie Pearson would like to pick up on some of that.

Robbie Pearson (Healthcare Improvement Scotland): The Audit Scotland report that set out the performance was quite stark about the challenges facing health and social care in Scotland. One of the key things for HIS is to look at the totality of the quality of care that is provided in Scotland. For instance, we increasingly look at leadership, at the workforce and at how sustainable services are, and HIS has not been in that position before. Increasingly, we will look at the many dimensions that impact on the quality of care, of which the workforce will be a fundamental part. We have an important role to play in shining a bright light on the quality of care in Scotland and, with the openness of our reports, we can demonstrate a very independent and objective approach in our contribution.

Dame Denise Coia: Targets hit acute care. One of the things with which I ended my opening statement is the tension between the pathways of care and the management of chronic conditions in the community. We have to look at the whole picture, and one issue that we must ensure that we look at is how to work upstream a bit more in order to prevent some of the pressures on acute care.

Dr Brian Robson (Healthcare Improvement Scotland): Denise Coia mentioned Sir Harry Burns's review of targets and indicators—Sir Harry has spoken to this committee. We are actively involved in that review. All the work that Healthcare Improvement Scotland is involved in focuses on outcomes, so we have measures and indicators, and we are feeding examples into Sir Harry. I understand that he is now looking at a broad set of indicators and targets, including population health, quality of care and value in healthcare, as well as the staff and patient experience. Our work contributes to the review and we would like much more of our work evidenced in some of the main targets and indicators.

The Convener: If seven out of eight of the main performance standards are not being met, how do we know that what you are doing is having an impact on improvement? Would it be eight out of eight if you were not there?

Dame Denise Coia: I continue to push the principle of improving targets by pushing a lot of work upstream; Ruth Glassborow would probably like to answer about that. The important thing with targets is that, if we keep doing the same things that we are doing at the moment—for example, the way we run acute care and chronic care—we will continue to fail. We have to change the way we run healthcare in Scotland, and that is part of the work that we are beginning to do at the moment.

Ruth Glassborow (Healthcare Improvement Scotland): I will briefly talk the committee through our work on the living well in communities programme, which helps people in the system to make the changes that will reduce admissions into hospital and that will support earlier discharge from hospital. Our approach with our improvement support offering focuses on helping the people in the system to understand their local opportunities for improvement and to design—or redesign—services to address those opportunities. We support them in a practical way with implementation and we support evaluation by collecting local measures to see whether the changes have made a difference.

With the living well in communities programme, using the evidence base and our evidence arm, we identified a number of areas in which there are opportunities to make changes. One of those areas is anticipatory care planning. To take the very practical example of the Glasgow partnership, we have worked with it on the data so that it has been able to understand where its local opportunities for improvement are. On the back of that it has identified a number of areas of work, one of which is anticipatory care planning. Our support includes looking at what we can do practically to help the local system to implement anticipatory care plans. We know that they make a big difference to hospital admissions and that between 5 and 6 per cent of the population have complex needs that would benefit from such plans. Furthermore, the evidence shows that, if the right information is available in the system, admissions can be reduced by between 30 and 50 per cent.

10:15

Across Scotland, there is a big variation in who has an ACP. Some of our practical work has been to support the design of templates to ensure that systems are collecting the right information, and we have done work with the electronic key information summary nationally, so that that information is available electronically when someone presents at accident and emergency. In 2016, we saw a 20 per cent increase in the number of ACPs on that electronic system. We have been raising awareness across Scotland on the importance of ACPs, working with partnerships and boards to produce, for example, videos and toolkits. Our work is all about supporting the system to make practical improvements.

I will take it right down to the patient level, because it is quite important to see how ACPs impact at that level. I have real-life stories to share about two individuals. One was Margaret, who had an anticipatory care plan; the other was Jean, who did not. Their circumstances and conditions were very similar. Margaret spent much less time in hospital and she managed to die at home, because information was available to everyone supporting her about what her needs and wishes were. However, Jean had a number of hospital admissions, with all the costs that that incurred, and she eventually died in hospital.

It is about working through from the national level to the practical impact for patients and individuals using services.

The Convener: How do we find out what you do and what impact it is having?

Ruth Glassborow: Information is available on our website and in our annual report. We are looking to strengthen how we make information much more accessible. We have various communities. We have a practice site where various case studies are open to clinicians, practitioners and the managers doing the improvement work, but we need to get more information out into the public domain about the work.

Dame Denise Coia: There is another way to measure the impact. The bottom line with that practical example is that the new Glasgow city integration joint board had a budget allocated to it. We are responsible for quality assuring its

commissioning plans, and we would expect to see in those plans that it has put the resource into anticipatory care planning. Reducing the number of people coming into the Queen Elizabeth university hospital in Glasgow through the accident and emergency department requires Glasgow City Council and the other integration bodies that have been set up in the west of Scotland to use the resource that they have been given to deliver anticipatory care planning.

Robbie Pearson: I have an important point to make on outcomes and the impact of the £25 million that Healthcare Improvement Scotland spends. We publish measures in our progress report, which is part of our board papers. Those demonstrate the increasing link between our investment through our budget and the impact. I will give you a practical example of that beyond improvement support. In Scotland, there is a high-end technological procedure in cardiac care called a transaortic valve implantation, which is an alternative to cardiac surgery. We provided the evidence base to support its use in Scotland in a way that was more focused than would have otherwise been the case. That has saved the NHS £2.6 million. As a public body, we need to demonstrate our share in the return on that investment.

Colin Smyth (South Scotland) (Lab): I want to touch on the governance arrangements that you have in place. Obviously, it is a complex process, particularly your oversight of HIS's various constituent parts. Last week, we took evidence from the Scottish health council. It is fair to say that members raised a number of concerns, which reflect public concerns, over its performance and role. How independent from Healthcare Improvement Scotland is the operation of the Scottish health council and the other constituent parts? What performance management do you undertake over the various parts?

Dame Denise Coia: The governance arrangements of Healthcare Improvement Scotland are relatively straightforward: we have a board, which I chair, that provides governance. Importantly, we have had to provide governance arrangements recently across local government as well, because we now work right across the public sector—that is a much more complex arrangement.

We have governance committees. One of those committees is related to the improvement hub and must have an advisory board that has representation from local government, social work, housing and the third sector. For our improvement work, we must have governance arrangements that feed up to our board inside Healthcare Improvement Scotland that have participants from the third sector. I have reconfigured my board at the top with members from the third sector and local government to reflect that change to working across the health and social care sector.

The Scottish health council is a governance committee of Healthcare Improvement Scotland and therefore is performance managed by it. The director of the Scottish health council is answerable to the chief executive. We have commissioned a review of the health council because we feel that the work of getting the public voice and public representation cannot be contained in one area; it now must extend right across quality assurance, improvement and evidence. Our public partners work across all those areas. The review of the Scottish health council is due to be published—Robbie Pearson might want to talk you through that.

Robbie Pearson: I will come back to the review in a moment.

On the governance arrangements, the accountability runs to myself as the accountable officer for Healthcare Improvement Scotland. I add into the mix the fact that the Scottish health council has its own identity in legislation in the Public Services Reform (Scotland) Act 2010; there is a bit of history there that needs to be recognised.

The review of the Scottish health council is doing all the things that Denise Coia has referred to. Importantly—I think that the committee touched on this last week—in the context of the integration of health and social care, we need to think more broadly not just about patients but about citizens and how they engage with services. The review will be ready in late February or early March. That will be the opportunity to look at options for the future, and then we will take the recommendations back. This committee has expressed an interest in making sure that its voice is heard in that review.

Colin Smyth: If a member of the public has a complaint about the health council, you deal with that complaint—is that the case? Is that not an example of Healthcare Improvement Scotland marking its own homework, so to speak? If it is part of the same organisation, a complaint about it basically goes to you.

Robbie Pearson: I will tease out the two issues of accountability and independence.

I am obviously accountable for the overall performance of the Scottish health council, but I also have a responsibility to ensure that it has credibility and that it is independent. I am accountable for its performance, and I need to assess and respond to any complaints that come in. That is a very clear governance and accountability line.

Colin Smyth: You are effectively responsible for its performance though, so if somebody complains about its performance, you determine whether the complaint is valid. Is that not a conflict?

Robbie Pearson: No—I do not believe that it is a conflict. It upholds the independence of the Scottish health council, as much as I uphold the independence of our inspections. It is important that, as part of our performance on credibility and independence, I need to be accountable and that should refer to complaints, for instance.

Colin Smyth: If the Scottish health council is independent, what is the point of being part of your wider structure rather than a separate organisation?

Robbie Pearson: Denise Coia has referred to a number of opportunities. Healthcare Improvement Scotland has a unique opportunity to bring together evidence, quality improvement, quality assurance and—increasingly importantly—the citizen's voice. That mix is an important ambition for the organisation; we want to tell the whole story about the experience of care.

The embedding of all those aspects in one organisation allows us to go from the bedside, by taking account of patient opinion and the experience of individuals, all the way up to the board room when it comes to assessing the quality of care that is delivered by the leadership in NHS Scotland.

Colin Smyth: Is HIS content with the voice that patients currently have within the NHS?

Dame Denise Coia: No, we are absolutely not content. We have a long way to go on that. When we carry out inspections, we have patients with us. They talk to members of the public and listen to people's views, then they reflect them and write parts of our inspection reports for us. We are involved in a learning process on how to do that.

The public are involved in new medicines and in all our evidence guidelines. Increasingly, they are driving the selection of guidelines. In the past, there has been a problem with clinicians—no offence to Brian Robson—deciding to write a guideline about their pet subject or the area in which they have had the most evidence, whereas members of the public would have preferred to have evidence on something that mattered to them. A big issue for us at the moment is that the public would genuinely like to know what new services the integrated bodies can develop that will make a substantial difference and stop them having to go into hospital for certain treatment. We do not know what the evidence base for that is, so we have had to ask our colleagues in knowledge and evidence to start to look at some of the evidence on what matters to the public. We will still continue to do really worthwhile things such as the asthma guidelines, but we need to involve the public in discussing what to produce guidelines on.

You asked whether the public voice is heard. It is not heard in that respect, but it is also not heard in genuine adult discussions. In my opening statement, I spoke about the tension between acute care and chronic care. The fact that the NHS and social care in Scotland have a finite budget is problematic. We will have to have a public debate to decide how much to spend on state-of-the-art, techie acute care and how much to spend on chronic care that should be provided in communities rather than in hospital. We need to know how to shift the budgets. For the public to be able to have a truly genuine debate, they must have at their fingertips the facts and knowledge relating to the various decisions that people want to make.

You asked about the Scottish health council. In our review, we would like the voice of the public to be heard far more in all the work that we do in Healthcare Improvement Scotland so that they can genuinely say, "We don't think this is a great idea." The citizens panels that we have set up are beginning to do that, but we can ask them only one question at a time. I would like to see a far more honest debate about whether we want to spend more money on chronic care or whether we want to continue to have the seriously high-tech acute care, which gets more and more expensive. If we are to be the best in the world in the provision of acute care, we will need to spend the money on it. However, that is a public debate.

Sorry for that rant about things.

Colin Smyth: I do not want to separate the two issues, because that is a wider health debate. I want to look specifically at your enforcement of the current role of the health council. It seems to me that you are unhappy with the role that it is performing at the moment, yet you are not forcing it to make changes. You have not made significant improvements to the work of the health council, despite the fact that you have that performance framework role.

Robbie Pearson: As Denise Coia said, we recognise that we are involved in a process of evolution. We need to think about how we strengthen the voices of citizens in making big choices about the future priorities of health and social care in Scotland. The Scottish health council is already doing a number of things, which it should be given credit for. When the Scottish Public Services Ombudsman gave evidence on the complaints process, it was mentioned that the health council had suggested a more robust process involving earlier engagement on the management of complaints. That is a demonstration of the health council's work in

building a more responsive and less defensive complaints system. Some good work is already under way in the health council. We want to build on that and to think about how we strengthen the citizen's voice in decision making and make sure that it is a genuine debate.

10:30

Colin Smyth: Are you the right body to do that? I am highlighting the fact that there is widespread concern about what has already happened on the patient's voice and you have not made significant changes, from what I can tell. Are you the right organisation to enforce those changes?

Robbie Pearson: We are the right organisation to do it because, increasingly, we are considering the totality of the quality of care. If we are to do that in a way that is not just about the clinical experts giving their view, and if we want to hear the citizens' voice, it is fundamental that we have that voice in the process from the start.

Dame Denise Coia: If we did not have the Scottish health council within HIS, we would have to create something else to hear that voice because we cannot start to consider overviews of services and support the redesign of services without having the public's voice involved. We have set up the review of the Scottish health council so that we can consider how we do that better.

Alex Cole-Hamilton (Edinburgh Western) (LD): I thank Denise Coia for a comprehensive explanation of what Healthcare Improvement Scotland does and for coming out to my constituency and meeting me to go through it personally.

I will follow on from Colin Smyth's questions and focus particularly on some of the evidence that we heard last week about the work of the Scottish health council, which sits in the witnesses' stable. I am looking at the health council's website. It sounds like an organisation that we would have to invent if it did not exist, as Denise Coia just said. I am glad that it exists if it is carrying out its role.

The council's website says:

"Our aim is to improve how the NHS

Listens to you

Values your views and experience

Respects you as an individual, and

Involves you in planning and developing health services".

That is good stuff. It also has a big, colourful graphic that says:

"Working together to improve health and social care

OUR VOICE".

It strikes me that that gives the health council a role in two matters: quality, about which we have talked, and eliciting patients' views. We learned last week that, despite having a budget of £2.3 million a year and 14 bases, it has elicited the views of only 1,100 people or thereabouts. That is less than 100 per base, if my maths is right.

We talked about views on major and minor service redesigns, particularly major service redesigns. I am anxious about the fact that the health council is averaging one view a year. It strikes me that the SHC is a conduit for patients to influence change in the NHS, but it is stifled at best. What are the witnesses reflections on those views?

Robbie Pearson: The 1,188 number that was shared and to which you just referred related to a particular initiative by the Scottish health council to engage with communities about how they get a stronger voice. During 2016, the Scottish health council engaged with just short of 13,000 people directly. Tens of thousands more than that engage through its website and social media.

On the wider point of policy versus engagement, one of the things that we teased out last week was the fact that the Scottish health council's role is a lot about informing policy. However, one of the things that has got a bit stuck in the conversation is the threshold between major and non-major service redesigns. That is where some of the debate has got to and one of the big things about the our voice approach is the question of how to ensure that all change is viewed as just as relevant as the major stuff.

Alex Cole-Hamilton: I am gratified to hear that. Thank you for the clarification on the numbers.

The distinction between major and minor service redesign is crucial because what the SHC decides is minor—for example, the closure of the centre for integrative care—is major to some people. I will ask about the quality assurance role that you have on that because I understand that you do not quality assure minor service change. In fact, I have a quotation from a letter by Healthcare Improvement Scotland to healthcare campaigner Catherine Hughes, who I think wrote about the decision-making process on the closure of the CIC, which the SHC decided was a minor service change. The letter says:

"However the Scottish Health Council does not have a formal quality assurance role in this process and it would not be the Scottish Health Council's role to halt the process of NHS Board engagement once a need for change has been identified."

Why does not the SHC have a quality assurance role in the process of minor service redesign?

Robbie Pearson: That position has historically been the case, as it was outlined in the guidance

on major service change that came out five or six years ago and which set out the SHC's role in two respects. The first aspect related to the quality of individual boards' engagement across the totality of service change. In that guidance, the role of the SHC became linked to the quality assurance process for major service change; an important part was the minimum three-month consultation period. At present, however, the SHC's role is not expressed beyond what the guidance sets out with regard to its role in the quality assurance process for major change.

I will not pre-empt the outcome of the SHC review, but it may wish to address the council's broader role to give people confidence that every bit of change in health and social care in Scotland is as consistent and good quality as the stuff that reaches the threshold for major service change.

Alex Cole-Hamilton: Again, that is gratifying to hear, and I think that we would all endorse what you have said. However, it follows that the critical point in the journey is the SHC's decision about whether a particular piece of service redesign is major or minor. That process is subjective; many people would not see the closure of the CIC, to use a great example, as a minor service redesign. Can you explain how the process happens?

Robbie Pearson: For clarity, I confirm that the SHC's role is not to decide whether a change is major or minor; that is ultimately a decision for ministers. The SHC offers a view, which is the right thing to do according to the current process. The designation of something as a major service change rests with ministers.

Dame Denise Coia: I want to stand back from all that for a moment, because Alex Cole-Hamilton raises an important point with regard to the CIC, although I will not go too far into that specific case. It goes back to what I said in my statement about the tension that exists. People who have chronic illnesses are concerned that the health service responds simply by dealing with the acute part of their illness. Lyme disease is a classic example in which someone gets a month's worth of treatment with antibiotics and is then sent off with no treatment whatsoever to cope with their headaches, fatigue and everything else. Centres such as CIC provide some support and care for people in that situation.

The debate in Scotland must address that issue. Some people who have certain disorders go past the first month of acute treatment and are disabled for the rest of their lives. I picked Lyme disease because it is a hidden problem in Scotland at present. The prevalence of Lyme disease is growing, and it is appalling that we are not doing more for those people.

Where do those people go? Some of them see the CIC as a place to go. My argument is that, surely, in the whole NHS across Scotland, we could provide far more support for and recognition of chronic illness. We should be offering that support as part of our routine service. For me, that is the big anxiety, because at present I do not hear that conversation going on anywhere.

The Convener: I am really keen that the discussion is not dominated by the Scottish health council, as there are other issues. However, I am surprised that it has taken a week for us to find out that the SHC had in fact contacted 13,000 rather than 1,000 people; I wonder why no one was able to correct that figure last week. I will leave that point sitting there.

Donald Cameron (Highlands and Islands) (Con): I thank the panel for coming today. To pick up on the point about Lyme disease, I am very glad, as a member for the Highlands and Islands, to hear that it is on your radar, because it is a very significant issue.

I want to ask about the independence of HIS from Government. I think that we all accept that HIS is a non-territorial board that reports to ministers. I also want to ask about its role in inspecting hospitals. You can be called in by Government, as you were to Crosshouse hospital last November, to carry out an inquiry or an inspection. Leaving aside HIS's role on infection control, to what extent does it instigate, of its own accord, inquiries into or inspections of NHS hospitals?

Dame Denise Coia: I will respond on the broader issue of independence and then Robbie Pearson can respond on the other points. It is really important to ask who we have to be independent of. It is really important that we are independent of central Government, but we also have to be independent of, and have a new relationship with, local government. In addition, we need to be independent of the many vested interests that can come knocking on our door.

As a chair, I firmly believe that it is necessary to build independence; I do not think that it just happens. An organisation can appoint who it likes and think that it has an independent board, but having the right people in post does not make it independent; it is necessary to work at being independent. For me, that is about two things. One is personal—I as chair and we as a board have to maintain our principles. We have to be apolitical, fair and truthful, and we have to be compassionate, because the best care is not always the best treatment. I am sure that Dr Robson would say that as well. Importantly, we have to be free from financial incentives.

We have to grow a board that is based on principles, but then we have to demonstrate our independence; I think that we are beginning to do that through our reviews, which Robbie Pearson will talk about in a minute. We are also demonstrating our independence by making what can sometimes be difficult decisions and saying difficult things, and by highlighting the challenges to Government. Robbie will pick up on the quality assurance side of how that works.

Robbie Pearson: On the specifics of our ability to carry out inspections, we are entirely independent. Our care of older people inspections are informed by intelligence; we decide where to carry out unannounced inspections. It is the same for our HEI inspections. One of the key—

Donald Cameron: Sorry to press you on that, but if, for example, there is an issue with a maternity unit or with any unit in any hospital in Scotland and you get intelligence on that, are you—of your own accord—able to go in and inspect, inquire and report back?

Robbie Pearson: Absolutely. We have evolved as an organisation—our ability to exercise our independence has increased and it is increasingly informed by intelligence. For instance, we went to the Beatson west of Scotland cancer centre in 2015 because of concerns about the quality of cancer care there. We were at the Beatson for a number of reasons, but our visit was prompted by specific concerns that were raised by the General Medical Council. We did not wait for permission to go there—we went and we produced a report within a matter of months.

Donald Cameron: You do not deal with complaints and you have limited enforcement powers. All that being true, along with the fact that you ultimately report to Government, do you agree with what is a wide body of opinion that we need a truly independent health regulator in Scotland that is comparable with the Care Quality Commission in England?

Robbie Pearson: I would be very cautious about introducing a regulatory regime to the NHS in Scotland. If we look at the accountability of the NHS at present, the accountable officers for NHS boards are personally accountable to Parliament, and the accountable officer for the NHS in Scotland—Paul Gray—is accountable to Parliament and comes to this committee.

If we were to introduce a regulatory regime, we would introduce a different set of relationships and accountabilities and a different set of sanctions. I would be cautious about that. Healthcare Improvement Scotland exists because we recognise that inspection alone will not drive improvement. There is a mix of approaches, from evidence and improvement support through to—increasingly—getting the voices of citizens heard.

I believe that in having one organisation—HIS—we have something unique. The issue is about how we exercise our independence and our existing powers. Our powers have increased. We are now able to sanction the closure of wards—that power did not exist before. We believe that we have sufficient powers. We will keep them under review, but I would be extremely cautious about going down the regulatory route in Scotland.

10:45

Dr Robson: This is an international discussion. All over the world, healthcare systems are considering whether regulation helps and how it fits in. One of the things that Healthcare Improvement Scotland does is connect in with and take advice from across the world. Don Berwick, an international expert in quality improvement, made his views on regulation clear in his review of patient safety in England following the incidents at Mid Staffordshire. He made it clear that regulation has a role, if it is done correctly, but said that regulation from the outside does not improve care sustainably.

That is the evidence that we are seeing across England, and the Care Quality Commission and others have been to meet us in Scotland to see how we combine the improvement and external inspection roles in one organisation. Indeed, this afternoon we will meet Health Quality Ontario, which is interested in how we work. There is no perfect approach, but the stronger the regulation from the outside, the more concerning the results.

Dame Denise Coia: We have a strong relationship with NHS Improvement in England. We are doing quite a lot of work with NHS Improvement and a number of other organisations. NHS Improvement struggles, because the CQC is a separate organisation, and although it meets the CQC, it does not have direct access to data. Ruth Glassborow can give examples of areas where that is important.

The Convener: I would like to ask about the procedures. If there is an inspection and a report is written, what happens next? Are the findings shared with the hospital or care home, or with the Government, before the report is published? How does that work?

Robbie Pearson: A draft inspection report is issued to the board ahead of publication, for the purposes of factual accuracy. The Scottish Government sees the final version of the draft report a few days before publication, so there is a robust—

The Convener: Does it request changes?

Robbie Pearson: The Scottish Government? No, absolutely not. We are talking about an independent inspection. Indeed, when the NHS boards come back to us, it is simply about factual accuracy.

The Convener: If the Government does not request changes, what is the point of sharing the report with it before it is published?

Robbie Pearson: There are a number of reasons for doing that. One is to give the Government advance information about what is coming into the public domain. The Government might want to prepare lines in response. The approach also reflects the accountability relationship between the accountable chief executives and the accountable officer—the director general of the NHS.

The Convener: Would it not be better if you, as an independent body, just published the report, so that everyone got it at the same time?

Dame Denise Coia: That would slow everything up. There is a classic example from NHS Grampian, when there were major issues—this relates to your point about people complaining. We triangulated information with the General Medical Council and the consultants, and we also met patient groups in Grampian. During that time and before the report was published, the report was shared with Government, not so that changes could be made but so that action could be taken on some of the serious problems in Grampian. That was the value of the approach; if we had not taken that approach, we would have added another month and slowed things down.

It is important to talk about the very practical value of having the scrutiny and improvement roles together.

Ruth Glassborow: Yes, because the background to that is our belief that improvement in health and social care is not driven by inspection alone; it is important to provide practical support so that people can act on the issues that have been identified in the inspection.

I can give a practical example. There were issues in our acute hospitals around the management of delirium. We could have kept calling the problem out, but that would have had limited impact, so we pulled together our improvement resources and looked at the issue with the clinical experts. Patients and their families were also involved in the work. We developed practical assessment tools, because one of the issues was that people with delirium were not being identified when they were admitted to an acute hospital. We thought about how to support clinicians and give them the tools to enable them to identify such patients. Another issue was that, once people were identified, they were not getting the appropriate management, so we worked with clinicians and with individuals and their families to put together checklists on what to do if someone is identified as experiencing delirium.

We provided practical support around Scotland for the roll-out of that work, and our staff worked very closely with our clinical communities. We brought individuals together; we do a lot of work on networking across Scotland, so that what works well in one hospital can be shared with another hospital.

On the back of that work, there have been some significant improvements. I will give you a couple of pieces of data to illustrate that. The mean length of hospital stay in Grampian reduced from 22 days to eight days, and there was a 50 per cent decrease in the number of falls in two of the wards for older people in greater Glasgow and Clyde. Unidentified and untreated delirium can often result in people falling and, in some instances, a fall results in a hip fracture, which has a significant impact on the individual and the costs. Therefore, a 50 per cent reduction in falls is quite significant. There was also a reduction in reattendance at emergency departments for patients aged 65 and over—there was a decrease from 26 per cent to 8 per cent in one hospital—through our work on delirium and frailty, which was done around Scotland.

Most—by which I mean 99 per cent—of our clinicians and managers have gone into their roles to do a really good job, and part of our approach is to provide practical support for them to make improvements.

Ivan McKee (Glasgow Provan) (SNP): I thank the panel for coming along to talk to us. I am from a process improvement background rather than a health background, and I would like to explore in a bit more detail how you operate in some of those areas. It was very reassuring to hear you talk about data, which is one of the cardinal rules with process improvement. You mentioned that there is a targets and indicators review going on, so perhaps there is an issue with what you are measuring and what is being measured at the top level and how it all joins up, but we will leave that to one side for the moment.

I am interested in drilling down into the process that you use to decide what areas to focus on. Classically, using the Pareto principle, you would focus on what had the biggest impact financially or on what would have the biggest impact for the prevention agenda. I am interested in how you tackle that and, secondly, how you go through the process improvements. On the back of that, I am interested in exploring the extent to which the health boards play ball and engage with you, and the extent to which you get resistance. Finally, I want to talk about the financials, but we will come

to that. If you could pick up the first two or three issues, I would be very interested to hear what you have to say.

Ruth Glassborow: Perhaps I can again use the living well in communities programme as an example of how we decided which areas to focus on. We looked at the evidence base to see what the key areas to focus on were if we wanted to reduce hospital admissions and to help people to live well at home. We did an extensive piece of work on data, and we also pulled together some expert opinion. It was the combination of those three factors that led us to say that the key issues across the system that we needed to focus on were anticipatory care planning, palliative care, and intermediate care and reablement.

Translating that to a local level, we have a piece of work on high resource users, who are the 2 per cent of our population who use up to 50 per cent of hospital and community prescribing resources. We support partnerships to do their local analysis to see who their 2 per cent of people are. On the basis of that understanding, we provide practical support to see where partnerships should target their redesign work. You will recognise the very practical approaches that we use, as they are the standard approaches to continuous quality improvement.

As an example, on the back of the work on high-resource individuals that we are doing in Glasgow at the moment, the partnership has identified palliative care as one of the pathways that it wants to focus on, because the data shows that that is where it could have a significant impact. We have helped it to map its palliative care system across health, social care, the third sector and the independent care sector, and we have produced summary visual maps—I would be happy to forward one to the committee, if members are interested. The maps are great, because they allow people to see the system as a whole in one go. As part of the work that we have been doing in Glasgow, we helped the partnership to overlay data on the map to understand where the key problems are, and we developed a questionnaire to survey a range of staff who work across the whole system and get their views on where the key opportunities are.

One of the next steps is to work with individuals who use services to get their views on key opportunities. On the back of that, we work practically with an area. Once it understands the high-impact areas where it can intervene, we provide practical support based on what we know works in other areas to address those issues.

We work very closely with NHS Education for Scotland, which provides training. It is important that improvement work is led by people who work in the partnerships and the boards—clinicians, managers and practitioners. As well as commissioning training, we help to deliver it; Brian Robson might want to say more, particularly about the work that we have done with clinicians on training and giving them practical skills for quality improvement.

Dr Robson: We could have a whole conversation about that, but let me give one further example of how we use data and the evidence base.

Scotland has some of the best data on diabetes of any country in the world; I am sure that the committee has heard from experts in the field in Scotland. However, one thing that came through that evidence base was about whether we were identifying patients who were admitted to hospital and whose blood sugar had gone too low. The data tell us that one in six hospital admissions is a patient with diabetes. The majority are not admitted because of their diabetes, but 30 to 40 per cent of them have insulin as part of their treatment. We found that low blood sugar or a hypoglycaemia was recognised less than 25 per cent of the time. Diabetic patients tell us that low blood sugar is one of the most terrifying situations that they experience.

We put in place a piece of work—we studied the processes, watched what happened, did process mapping and identified a series of failures. As Ivan McKee will recognise from the field of engineering, sometimes the simplest things make the biggest difference. We looked around the world and saw a thing called a hypo box. It is simply all of the things that we need to assess and treat a patient if they develop hypoglycaemia. I went to see it—it is a simple Tupperware container with all the equipment required to make it easy for the staff to do the right thing. As a result, in wards in Glasgow we are now seeing the appropriate response in the appropriate time in more than 80 per cent of incidents. That dramatic improvement came from process mapping and applying simple methods.

I will touch briefly on the fact that we engage clinicians in the improvement journey. We work closely with NHS Education for Scotland and now have almost 190 Scottish quality and safety fellows who have been through the training programme over the last seven or eight years. It is important to note that six other countries join that training programme because it is so good. We have input from Denmark, Northern Ireland, the Republic of Ireland, Wales, Norway and Sweden—input from across the world to see how to improve care through the eyes of clinicians. As Ruth Glassborow says, clinicians and managers come to work to do a good job, but if we do not help them to understand improvement, they find it very difficult to do improvement.

Ivan McKee: I am delighted to hear that. If we do that stuff right, what tends to happen in my experience is that the costs start to fall away and, before we know it, we are amazed by how much progress is made and how much money is saved. That is what the preventative agenda is all about. Are you starting to see light at the end of that tunnel?

Dr Robson: I should have finished that story about the think, check, act diabetes programme. Although that is driven by the evidence and the patients' experience of low blood sugar, one thing that we are measuring is length of stay in hospital. We are seeing reductions of between one and two days per stay per incident of hypoglycaemia. Stuart Ritchie, a clinician in Lothian, and Debbie Voigt, a clinician in Tayside, have been leading that work with Thomas Monaghan in our organisation. They are looking for that data. Clinicians previously were not interested in that sort of data—they did not think that money was important. Money is critically important, whether for drugs or treatments or some of the fancy stuff that we can now do. Clinicians are now interested in how we can reduce waste and invest money better.

Ivan McKee: We get to focus on outcomes rather than inputs, and stop the sterile debate about the amount of money that we put in and start worrying about what happens in the process.

My final question is on that exact topic. The budget has gone up from £15 million to £25 million. I want to prod a wee bit on that, to see if there was some logic behind it.

Robbie Pearson: The budget increase of around £9 million for 2016-17 is based on a number of layers. The principal layer of the extra money—approximately £6 million—is for our new responsibilities in improvement support and the transfer of responsibilities from the joint improvement team and elements of QuEST, which is the Scottish Government's quality, efficiency and support team. That represents a large chunk.

11:00

Another chunk is the extra £2.5 million that we are getting from the Scottish Government for integrated improvement resource support. Another piece of the increase is the £1.3 million that we now have in our budget for the death certification review service.

It is a combination of elements, including extra funding to enable us to fulfil our various roles and the transfer of budgets. One of the key benefits is that we now have a stream of income from the Scottish Government that is integrated in a way that it previously was not. That is great news for our organisation.

Alison Johnstone (Lothian) (Green): I would like to discuss the issue of standards. A recent freedom of information request by the care charity Sue Ryder found that no NHS boards were implementing all the HIS standards for neurological services. How often do you update your standards? How do you assess an NHS board against those standards? What happens if a board simply is not meeting them?

Robbie Pearson: I will come back to the committee on the specific question of where we are on refreshing our neurological standards and our approach to updating them.

On the broader point about standards, we as an organisation recognise that standards are an important part of our work. In the work that we do with HEI—for example, when we assess the quality of cleanliness in our hospitals—we use HEI standards. We use standards for older people when we assess through our inspections the quality of care that is afforded to older people in our acute hospitals.

As an organisation, we are reflecting on the need to update our standards in the broader context of looking at health and social care standards, which are now subject to consultation. We will use those new standards in our relationship with the Care Inspectorate—in looking at the quality of care, for instance.

Alison Johnstone: I come back to my question about how often you update your standards. Do you have a concise response?

Robbie Pearson: There is a process for reviewing the standards, which varies according to the different standards that we are looking at. For instance, the standards on breast screening reflect the fact that technology has moved on and the approach has changed so there is a need for the standards to be updated. There is no set time period for review; we need to keep standards under review all the time.

Alison Johnstone: What action do you take if an NHS board simply is not meeting the standards?

Robbie Pearson: To take the HEI standards as an example, we have a robust process. At the conclusion of an inspection, we set out requirements and recommendations. Requirements are categorised according to whether the risk is high or medium. For requirements that are categorised as high risk, we expect the board to have dealt with the matter within one month. We will then revisit the issue—for instance, we will carry out unannounced follow-up inspections for HEI. If we are not content with the sustainability of progress or the responsiveness of the board, we can escalate the matter to the Scottish Government. That

emphasises the point about the accountability mechanism that exists in the NHS in Scotland.

Alison Johnstone: It is obvious that standards are a key factor in ensuring quality and safety. In 2014, you outlined plans for more comprehensive quality and safety assessments, including an examination of staffing and leadership. Have you implemented that new approach? How do you rate current staffing and leadership levels in the NHS?

Robbie Pearson: We are undertaking a phased implementation of the approach that we set out in 2014, through what we refer to as quality-of-care reviews. We have taken that approach because we recognise that workforce, leadership, and the effectiveness and responsiveness of care are all dimensions of quality that we need to look at. That takes us from the boardroom and the leadership at the very top of the organisations right through to the experience of individual patients in wards.

That work is already under way, and we will see examples of where quality practice is already happening. Last year, for example, we carried out a review of hospital-based complex clinical care in Lothian and published the results. The review touched on workforce issues and leadership in that particular service. We are currently piloting quality-of-care reviews in child and adolescent mental health services in NHS Lothian, and we are working with NHS Grampian, too. We are building a momentum that will take us towards a more comprehensive assessment of the quality of care.

I think that the second part of your question was about the workforce. We recognise that there are real challenges around the workforce. One thing that we recognise from our inspections is that it is important to comment not only on the quality of care but, increasingly, on the system and on the challenges within that system, such as attracting people into demanding roles. There are issues to do with training and development. We need to increasingly look at the "supply" of the workforce coming in and assess the totality of the workforce and the challenges around that in a much more rounded way.

Alison Johnstone: So you would not hesitate to comment if you thought that any workforce deficiencies were impacting on care?

Robbie Pearson: Absolutely not. For instance, take the work that we did in the Aberdeen royal infirmary review, where we looked specifically at the emergency department and the concerns about the quality of care and workforce issues and commented on those directly.

Dr Robson: On the workforce, as Robbie Pearson said, it is not just about numbers; it is about mix, training, and staff experience. One of the groups that we run—along with NES—is a sharing intelligence group. It brings together six external agencies in Scotland—HIS, NES, NHS National Services Scotland or ISD Scotland, the Mental Welfare Commission for Scotland, the Care Inspectorate and Audit Scotland. We meet and review every NHS board every year.

We look at all the data, including on the workforce. The workforce and the workforce experience form part of our assessment of every single board. Increasingly, over the past six months, we have started to look at IJBs as well. The workforce experience—which we learn about through, for example, the General Medical Council trainee survey on whether junior doctors are experiencing safe, supported training environments—is a core part of our evidence base.

Richard Lyle (Uddingston and Bellshill) (SNP): I will touch on the intelligence gathering system. As a Lanarkshire MSP, I remember that, in 2014, there were reports of higher than expected mortality rates in acute hospitals in NHS Lanarkshire. HIS committed to establishing a health intelligence review group, bringing in the Care Inspectorate, the Scottish Public Services Ombudsman, Audit Scotland and so on. The intention was to bring together intelligence on what was happening on the ground. What is happening with that group?

Robbie Pearson: I will give you a bit of background and then I will get Brian Robson to say a little more about the group. The group was set up because of the deficiencies in England, highlighted by the Mid Staffordshire issues. The need to address the failure of national organisations to share, respond to and act on intelligence was a key aspect of the Francis inquiry recommendations. Through HIS, we are on the front foot in Scotland in addressing that issue. Brian will elaborate on the group itself.

Dr Robson: In fact, that is the group that I have just referred to—we did not end up calling it what we were going to call it. We now call it the sharing intelligence group.

Richard Lyle: It sounds a bit like the Central Intelligence Agency.

Dr Robson: Well, we want to make the best use of intelligence. Maybe the CIA does that or maybe it does not.

The six agencies come together every two months. This coming Monday, we will consider four health boards. It is not just about the data in the reports; it is about the conversations round the table. As a result of sharing conversations round the table, we get information on themes such as culture, leadership and management grip.

I should say that the six agencies that come together round the table all have their own

governance arrangements so if there are any issues that need to be taken forward or accelerated by, for instance, Audit Scotland, the Audit Scotland representative will take them back to Audit Scotland and engage with the chief executive and other officers of the board.

Richard Lyle: Taking on board that clarification about the group, have there been any examples of the new intelligence gathering approach helping to pick up problems?

Dame Denise Coia: One thing that we are trying to achieve with that group is to get to amber warning systems because, at the moment, we operate in a red zone the whole time. We would like to use that group to pick up amber warnings, which we are certainly doing.

Ultimately, we would like boards and IJBs to tell the truth to themselves in the self-assessments that we send out and we would then quality assure that. We are not anywhere near that at the moment. At the moment, we are moving from red to amber but our ultimate aspiration is to move to each board and integration joint board doing self-assessments.

I ask Robbie Pearson to talk about the amber warning system.

Robbie Pearson: The amber zone, as Denise Coia described it, is important to enable us to make the appropriate intervention sooner. Some of the examples in the past have been at the moment when, to be frank, there was a crisis and intervention from Healthcare Improvement Scotland was needed.

The sharing of intelligence will be crucial to establishing amber warning systems. One of the key aspects of that concerns the quality of the training environment for junior doctors. We now have a wealth of data from the GMC and NHS Education for Scotland survey of the quality of training. The quality of training is a good indicator of the quality of care. Therefore, we now use that intelligence in a much more sophisticated way.

Brian Robson may wish to elaborate on how we use that in practice.

Dr Robson: In addition to amber warnings and getting advance notice of anything that could go wrong, we look for bright spots—areas of very good practice—and we come across them in every report. There are good things happening across NHS Scotland and in the integration of health and social care. Following meetings of the group, we meet the chief executive and other officers to discuss with them what we find. In fact, we met NHS Lanarkshire only last week and not only did the full executive team turn out but the chief officer from North Lanarkshire and officers from South Lanarkshire integration joint board were there as well. We had a rounded discussion about not only good practice but areas about which we wanted them to be alerted.

Richard Lyle: Where do you get that intelligence? Is it from patients, doctors, staff or reports? Is it flagged up on the internet or Twitter?

Dr Robson: It is from all of the above. Each of the agencies has ways of getting that from its formal inspection or review of services and from staff experience, patient experience and, particularly for the Mental Welfare Commission for Scotland, relatives' experience of the care of their loved ones. Patient opinion is part of the information that we consider as well.

Maree Todd (Highlands and Islands) (SNP): I might be biased as I was involved in writing some of it as a health professional, but I think that the Scottish intercollegiate guidelines network—or SIGN—guidance is of excellent quality. I contributed to the perinatal mental health guidance; indeed, I wanted to be involved in that because the first SIGN guideline in that respect was practice changing. However, an awful lot of bodies produce clinical guidance nowadays. Will you explain to the committee why Scotland needs to produce its own?

Dr Robson: Scotland needs to produce its own guidance because it can do so and because such guidance can focus on the appropriate priorities. The Scottish intercollegiate guidelines network has now been in operation for 22 years and, in that time, we have managed to agree the priorities based on evidence, patient experience and good Scottish data from the services. As you have experienced, it is literally a collegiate approach, with patients, expert clinicians and jobbing clinicians who just want to get on and do the work and who can tell us what it is really like and how difficult it is to put everything into practice sitting round the table.

The current chair of SIGN, John Kinsella, made a clear statement that the evidence base is as important as it has ever been but the products have to change. I do not know how big your SIGN guideline was but the SIGN guidelines for diabetes and for cardiovascular care are about 1 to 2 inches thick. What do I do with them? I am a general practitioner and, when I see patients on a Friday, that sort of product is not much use to me, nor is it much use to a patient with diabetes. As a result, SIGN has over the past few years changed its products to make them simpler, with simple messages for patients and clinicians.

11:15

If we linked in with all the other guidelines producers across the world, would we get as good—by which I mean, as detailed and as

bespoke—a service for Scotland? We would not. However, we do link in with all those networks, and the somewhat humorously titled GIN—the Guidelines International Network—meets regularly. SIGN's key role in that is to learn from others. The products are changing and John Kinsella and our team in SIGN are fully prepared for that change.

Maree Todd: In fact, the SIGN guidance that I contributed to was one of the first to produce a patient version, which meant that there was a plain English version to help people make those very difficult decisions about taking drugs during pregnancy and breastfeeding. I was personally delighted with that outcome.

Dame Denise Coia: We should never underestimate the amazing generosity of staff and the public in Scotland in contributing to such things. The posts are unpaid and the work is done in people's spare time; I am sure that Maree did the same, working in the evening and everything else. The major advantage for us is that people will give their time up because they genuinely want something to be improved.

Maree Todd: This is going to turn into a bit of a love-in. [*Laughter*.] What encourages us to contribute is that we actually see the improvement come out at the other end. As I have said, the reason why I got involved the first time was that the first guideline was practice changing. We pushed the boundaries again with the second one, so it was a good experience for me. I know that such involvement contributes to clinical improvement on the ground, because I am a jobbing clinician; I worked as a pharmacist in mental health and took all that good practice back to where I worked.

I also want to ask about the patient safety improvement programme. My experience of being involved in that as a jobbing clinician was again very positive; we felt empowered to make changes in a way that we had not in the past, and we were doing things such as medicines reconciliation. In the area of mental health, where I worked, it is very difficult to get change because the risks are huge, but as I have said, that experience was a very positive one. Can you say a bit more about what is happening on the ground in mental health? I know that there are a number of patient safety improvement programmes in the hospital where I worked until last May.

Ruth Glassborow: In the mental health patient safety programme, for example, we focused initial work on acute in-patient wards with the very clear aims of reducing levels of restraint, physical violence and self-harm. Our chair has talked about some of the data from that programme across Scotland and the quite significant reductions that we have seen on wards.

The key for us has been working with local clinicians and involving the service user or patient voice; indeed, we are particularly proud of the extent to which the service user voice has been woven into our mental health work. In Scotland we have developed the first ever service user-assessed safety climate tool, which we use to ask patients on the ward a number of questions about how safe they feel.

On the back of that, we are identifying areas on which to focus improvement work. According to the data on the impact of that work, the improvements in rates of reduction have been up to 78 per cent for violence, up to 57 per cent for restraint and up to 70 per cent for individual self-harming. Those are significant improvements for some of our most vulnerable individuals.

Dame Denise Coia: However, we face a big challenge. We have been given money to look at CAMHS, and a huge issue that we have in Scotland is the time that people wait at the top end for very specialist services. At the moment, our challenge is to look more at the integrated space and think about the kinds of pathways that we can put in for children so that they do not have to constantly access the most specialist child and adolescent psychiatric care. We are just beginning that work and we face huge challenges in starting to move it forward.

Maree Todd: Have you involved a patient voice in setting that agenda and dragging it forward?

Dame Denise Coia: Yes, although I should highlight one particular irritation. One of our board members is very vocal about children, because, as she constantly points out to us, we do not have any children on the board. We are still working on that area, but it is difficult. We have focused on older people, and now we need to focus on children. Brian Robson may want to say something about that.

Dr Robson: Are you going to talk about children?

Dame Denise Coia: No, I am not going to talk about children.

Ruth Glassborow: I just want to give an example—

The Convener: I need you to be brief.

Ruth Glassborow: An example of how the patient voice links in with the work of CAMHS is the young ambassador peer support model that has been developed as part of the CAMHS services in Grampian. In that model, a young person who is in recovery from a mental health issue joins the clinician at the point of the first assessment of another young person who comes in. It is a really innovative model; we are watching

closely to see its impact, and we will then share the learning from that across Scotland.

Dr Robson: There is another evidence base that relates to Maree Todd's field of medicines, although it is more to do with patients and doctors as prescribers than with pharmacists. We have produced all sorts of leaflets and materials so that the public better understand the advantages of medicines and when they could become unsafe. In Highland, you invented that work—

Maree Todd: We are leading the way in all sorts of areas.

Dr Robson: Highland is leading the way by giving cards to family members so they can stop someone taking medication in the event of diarrhoea or vomiting or if the person is particularly unwell. That is making a big difference to rates of acute kidney injury, which is one of the biggest issues that we now face in modern healthcare.

I have a wonderful example. Through the area drug and therapeutics committee, we are working with the idea of "Not sure? Just ask" in relation to starting new medicines. One of our roles in HIS is to share best practice, so that approach, which has come from NHS Tayside, is now being circulated and distributed through pharmacies, GP practices, libraries and other outlets near you.

Miles Briggs (Lothian) (Con): Good morning. I want to follow up on Alison Johnstone's questions, specifically with regard to senior management in the health service. Do you think that we have the right people in place? Do they have the right skills and experience to take forward what will be a period of major reform in our health service?

On the recruitment process, is the pool of people from whom we recruit for senior management wide enough? Leadership is a key factor in taking forward reform in the health service. Do you have concerns around that?

Robbie Pearson: I will kick off on that. The fact is that the context is changing. For example, the traditional NHS Scotland in which there was a simple line from an NHS board all the way up to St Andrew's house is now changing in the context of health and social care, and there is much greater diversity among the participants contributing to the leadership of health and social care than ever existed previously.

As a slightly indirect answer to your question, I think that we need to ask which skills we need for the future. Those skills are less about command and control—if that was ever effective—and more about influencing, negotiating and working with a much wider range of partners with different perspectives, cultures and histories. That requires a different approach to leadership.

That was just a general reaction to your question.

Dame Denise Coia: We need to start to look—as people are doing—at how we train leaders across the whole public sector. The skills that we are looking for in a chief executive of a health board should be about transformational change and strategic planning, and that does not always require a health background. The same goes for education. In the public sector, we should be looking much more at leadership development across the piece.

Everywhere you go across the UK, everyone is struggling with succession planning and recruitment, and we are having similar headaches here. The easiest way to resolve those issues at present is by trying to grow some of our own leaders in Scotland. That will have to be the way forward. Indeed, Brian Robson is involved in that work.

Dr Robson: Ruth Glassborow might want to say something about the development programme for non-executives—

The Convener: Can you be very brief, please? We are running out of time.

Dr Robson: Sure. I will just make the point that the management of the NHS is, like any healthcare system, extremely complex, and the partnership between managers and clinicians is critically important. If we look at all the failings in the NHS in the UK, we will find that there was a breakdown in the management and clinician relationship, so that arrangement is one of the areas that we are focusing on. For the running of hospitals in NHS Lanarkshire, for instance, there is now a clear tripartite model, with a chief nurse, a chief medic and a chief manager. People know who is in charge and know that those people work closely together and are responsible for care.

Miles Briggs: Since being elected in May, I have been incredibly concerned about what seems to be a postcode lottery across Scotland for health services. The problem appears to be increasing. In your experience of our health service, do you agree that there is a postcode lottery in relation to many services, with some health boards doing really well and others not doing well in key areas?

Dame Denise Coia: Ruth Glassborow is the expert on variation.

Ruth Glassborow: We certainly see a level of variation across Scotland. What is important is to understand what sits behind the variation, because sometimes it is based on differences in local need or population profiles. In that case, it is good variation. We are trying to get better data on

variation and to support our system to understand what sits behind it.

Miles Briggs: How are you driving that work forward? We have made freedom of information requests and asked parliamentary questions, and over the years we see the situation worsening and the postcode lottery problem getting worse. As we have heard, a key individual in a health board sometimes drives improvement in an area in which they have a specific interest. How is HIS ensuring that every health board shares knowledge so that there can be improvement? The committee keeps hearing about pilot studies, but often things do not get beyond the pilot study.

Ruth Glassborow: We are doing a number of things. First, transparency around the data is key to the issue, and in that respect, we are working closely with our colleagues in ISD. We are getting a new programme—the effective care programme—up and running, the focus of which is on reducing unwarranted variation in clinical processes and interventions. We start with the question, "What is the data telling us about where the key variations are?" and then work with health boards and clinicians on the skills to understand the root cause of the variation. If the cause is unacceptable differences in practice, we work with boards and clinicians to address the issue, pulling in the evidence guidelines.

Miles Briggs: Can you give an example of a case in which such intervention has led to improvement?

Ruth Glassborow: There has been improvement through the patient safety work, a lot of which was about identifying inappropriate variations in practice across the system. On the acute side, Brian Robson can talk about work on ventilator-associated pneumonia.

Dr Robson: There was work to highlight that if we concentrate on patients who are on ventilators we can eradicate VAP, which is a fatal condition; 50 per cent of people who got ventilator-associated pneumonia died. We studied the issue in Tayside and rolled out work to share experience.

In Scotland, we have the opportunity to share best practice. A phrase that is commonly used elsewhere in the world is, "We have the best care but we don't have the best care everywhere." In the delivery plan, there is a commitment to developing an atlas of variation. Such work has driven significant and widespread change in other countries and we are keen to work with ISD and the Scottish Government on such an atlas.

Clare Haughey (Rutherglen) (SNP): First, I must declare an interest as a mental health nurse. Like Maree Todd, I have used SIGN guidelines to improve my clinical practice and, I hope, the outcomes for the patients whom I have treated.

As Miles Briggs has said, the committee has heard about lots of pilots in boards and IJBs that have produced great outcomes; there have been great patient satisfaction rates and clinicians have been really pleased. However, there is concern that such practice takes place in silos and is not rolled out. The panel has touched on that already, but can you say a little about how you are scooping up all that good practice and ensuring that it is disseminated across the country?

Dame Denise Coia: Ruth Glassborow will talk about spread. It is such a difficult problem.

11:30

Ruth Glassborow: We use a range of approaches and methods to spread good practice, part of which involves networking and pulling together individuals who are working on the issues. Increasingly, we are producing tools and guidance to support implementation at a local level. The use of data is really important in highlighting areas in which things are working well, and we are pulling together case studies and sharing them across the system.

The challenge in improvement work is that we cannot just take something from one area and transplant it to another. Context matters, and the key is to understand what it is about a particular area that has led to the delivery of improvements and to support the translation of that practice to another area while ensuring that it is adapted appropriately to the new context.

Dr Robson: We are studying those who are trying to do that around the world. For three years now, we have been running a webinar series called QI connect in which, every month, we bring together 48 different countries and more than 500 organisations for a one-hour webinar. Easily half of those webinars involve discussion of the point that you have just raised: how do we move beyond pilots, and why is good practice not spreading?

We are not just studying that in an academic way; as Ruth Glassborow has said, we are putting it into practice. The more we get leadership, management and professional bodies round the table with us, the more they feel responsible for ensuring consistent practice. The more evidence that exists, the better.

Clare Haughey: I know that we are tight for time, convener, but I want to ask a brief question. The Scottish patient safety programme worked particularly well because it took a bottom-up rather than top-down approach. You have mentioned leadership, which is important as we need to know who is in charge and who is accountable, but how

are you capturing some of the good practice among clinicians at the coalface and using that to drive some of the improvements that you seek?

Ruth Glassborow: We agree completely on the importance of the bottom-up approach. One of the challenges is that we are trying to spread solutions to problems that people do not know that they have, and it is crucial that we do the work at a local level to diagnose the key quality improvement issues and support people to make changes. Across a range of our improvement programmes, we work with local areas to capture case studies. We are increasingly using videos to share examples, so people can now go online and watch a range of short video stories that capture what has been done and the improvements that have been delivered.

We run networking events, as I have said, and we do a lot simply through individual discussions. We will go into an area that is facing a challenge and say, "We know that the board just next door has already faced this challenge and solved it". We connect individuals and enable them to learn from each other.

Dame Denise Coia: It is important to tie quality assurance and improvement together, because we then have the authority to go into an area and say, "This is what is working well for you, and these are the areas that you can improve on". The fact that we can say that with authority drives the improvement, whereas regulation for its own sake will not achieve that.

Dr Robson: Every one of our programmes that is dealing with a clinical area has a national clinical lead, so we now have 53 or 54 national clinical leads in our programme. Those people work for us for one or two days a week but are in practice for the rest of the time. Nursing staff, medical staff, pharmacists and allied health professionals are all involved in our work.

The Convener: I have two final brief questions. If we were to bring you back before the committee in a year's time, what would you say that your big achievement had been?

Dame Denise Coia: Our big achievement would be convincing you that having an amazing organisation that undertakes quality assurance and improvement works better than anything else that you have seen in the rest of the world in driving improvement in healthcare. If we were to come back to the committee, we would give you a lot more data in support of that.

The Convener: Finally, Denise Coia said that we need an open and honest debate about funding and the future of the health service. She also said that people need to tell the truth to themselves and that HIS is an independent organisation. In the spirit of independence, telling the truth and open and honest debate, can you give us your view on whether you see cuts to services happening in the NHS and in the social care field across Scotland?

Dame Denise Coia: You said that the issue is funding; I think that it is how we use our funding. As an organisation, we have to live with the current reality across the western world, which is that, whatever we do, funding is going to be tight.

The Convener: That was not the question that I asked.

Dame Denise Coia: No, but I do not think that what you asked is the question. The question is not really about cuts to services; it is about changing services—

The Convener: Can you answer the question that I asked? Given that you see health and social care across Scotland, you are probably one of the best people of whom we can ask it.

Dame Denise Coia: Absolutely, but I reiterate that this is not about cuts to services but about people shifting resource. In fact, it is about taking some money out of some areas and not putting the whole amount back in.

This is not about cuts in particular; it is definitely about shifting resource, and the need for us, as the public in Scotland, to decide what we want to spend our money on. We could drive ourselves down a negative rabbit hole by saying that it is about cuts. What we need to say is that we can do a lot better with the money that we actually have at present.

The Convener: So there are no cuts happening.

Dame Denise Coia: I am not discussing that—I am talking about doing better with the money that we have at present.

The Convener: I was hoping that the spirit of the words that you used earlier to describe your organisation would come across, and I asked you a question to which I hoped you would give us a straightforward answer, but unfortunately that has not been the case.

Dame Denise Coia: I think that it is a straightforward answer. The straightforward answer is that we need to do things better.

The Convener: Anyway, thank you all very much for your very helpful evidence this morning. I suspend the meeting briefly for a changeover of witnesses.

11:36

Meeting suspended.

11:40

On resuming—

Transplantation (Authorisation of Removal of Organs etc) (Scotland) Bill

The Convener: The second item on the agenda is an evidence session on the proposed transplantation (authorisation of removal of organs etc) (Scotland) bill. We will hear from Mark Griffin MSP, who is the member in charge of the draft proposal. Andrew Mylne, who is clerk team leader of the non-government bills unit at the Scottish Parliament is also in attendance.

I invite Mark Griffin to give an opening statement.

Mark Griffin (Central Scotland) (Lab): Good morning, everyone, and thank you very much for having me along to the committee. You have in front of you my proposal for a members' bill on a soft opt-out process for organ donation, and the statement of reasons that goes along with it, in which I have explained why I think I should not have to go out to consultation before introducing a final proposal.

I have strong personal reasons for proposing a members' bill. When I was 12, my father was diagnosed with a heart condition and was told that he needed a heart transplant. He waited 10 years for a transplant and got one, but after 10 years of being on the appropriate drugs and so on, his body had been through such a decline that he was not strong enough to make it through the operation, and he died. I was 22. Members around the table—for example, Richard Lyle—will know exactly the situation that I and my family were in and why I have proposed the bill.

Aside from the policy behind the proposal, a wealth of information and research is already out there and a number of consultation exercises have already happened. Nothing that I would do would add anything new, and might actually be counterproductive. People might be fed up of being consulted and instead just want us to decide whether we are going to do something. Anne McTaggart, who proposed the previous bill, went out to consultation in 2014 and in October 2015 this committee's predecessor consulted on the issue. Meanwhile, the Government is running a consultation, which started in 2016. That is three consultations in three years. I do not see the need to have a fourth consultation of my own. The list of organisations and individuals that the Government has consulted is fantastic—there is no one that I would add to the list, so if I consulted I would not get any more information than the Government has received or will receive.

If the committee were to approve my statement of reasons, that would give me permission to lodge a final proposal in Parliament. However, I do not think that that would be appropriate yet; I will not lodge a proposal until the Government has concluded its consultation and decided whether it will develop legislation. I do not want to short-circuit the process. Instead, I hope to be informed by the Government's consultation. I am happy to take questions on my statement of reasons.

Alex Cole-Hamilton: Thank you very much indeed for your presentation. None of us can fail to have been moved by your personal reasons for proposing the bill. You rightly point out that we will have had three consultations in as many years. In the first two, was there much variance in what came back from the public?

11:45

Mark Griffin: Anne McTaggart's consultation had almost 600 responses, and the committee's consultation had almost 900 individual responses to its survey. Responses came back broadly in favour of the proposal. A number of public opinion polls that have been conducted by the British Heart Foundation have all come back in favour of a move towards an opt-out system. Today, we are talking about whether there is a need for another consultation.

Alex Cole-Hamilton: Exactly.

Mark Griffin: I think that another consultation would be counter-productive.

Alex Cole-Hamilton: I am certainly of one mind with you on that. You rightly point out—in particular, in respect of the moving case of your father—how important time is in this matter. Any delays in possible legislative change will be measured out in human lives, so I am very much minded to support your case. Should there be no further questions, I would like to move that we back Mark Griffin on this.

Colin Smyth: Good morning. You mentioned three consultations—two that have already been conducted and one that is being done by the Government. Are there any organisations or persons that are not being, or have not been, consulted in those three consultations, in particular the one by the Government, that you think should be consulted?

Mark Griffin: No. There have been three extensive consultations. By virtue of this being a member's bill, if I carry out a consultation it would be with just the resources of my office. When that is compared with the Government, with its range of civil service advisers and its publicity budgets, I cannot see how any consultation that I would conduct would have as big a reach: mine would

inevitably be smaller and less far-reaching and would not gain as many responses and as much information.

Richard Lyle: I know your personal reasons behind all this; I was a good friend of your dad's, as you know, and went through the pain that your family went through at the time. When you launched your bill proposal, did you know that the Scottish Government was planning a consultation on the issue?

Mark Griffin: I launched my proposal on 19 December, along with the statement of reasons. I knew that the Government was carrying out a consultation.

I hope and believe that the Government will develop legislation on opt-out; it will have my full support in that. I hope that the Government does not decide, after conducting its consultation, not to proceed with legislation. I am going through this process so that if the Government decides that it is not right to develop such legislation, I will be in a position to pick up the ball and move forward with my proposal.

In the previous session, I introduced the British Sign Language (Scotland) Bill in my first year after being elected. It took four years from its being introduced to its being passed and becoming legislation. If the Government were to decide not to progress with opt-out legislation, and I were to start afresh with a member's bill more than a year into the parliamentary session, there might be difficulty in respect of time and its being passed in this session. That is why I decided to run my proposal in tandem. If, when the Government's consultation concludes, it decides to bring forward its own legislation, that will be fantastic and it will have my full support. I will give the Government the time to come to its own conclusion. However, if it decides not to proceed with legislation, I will, because I have run the process for my proposal in tandem, be ready to take it forward.

Richard Lyle: I say with the greatest respect to members of the committee now, that I was on the Health and Sport Committee last session, and we basically went through this process then. I travelled with Duncan McNeil to Madrid to see the Spanish system. There were quite a lot of concerns about Anne McTaggart's bill. Anne McTaggart is a very nice lady, but unfortunately the bill was not passed. When it was voted on, the Government committed to bring forward a bill.

Knowing that, and given your personal history in relation your father—I am sorry to bring up that pain again—why did you feel that you had to pick up the issue? Was it mainly because of your father? I apologise for asking, but I am interested to know because in the previous session the Government gave a commitment that it would introduce a bill in this session, and it has launched a consultation. To reiterate, you are basically saying that you will hold back and wait to see whether the Government introduces a bill, and that if it does you will then work with the Government on it. To be quite honest, we all want legislation—I want it, you want it and, I am sure, everybody in the room wants it. However, I say with the greatest respect that Anne McTaggart's bill in the previous session was flawed, which is why I did not vote for it. I totally agree with carrying on with legislation, but that is why I did not vote for the bill in the previous session.

Mark Griffin: In the previous session, the Government made a commitment to go out to consultation, which is what it has done. I am not aware that it made a commitment to legislate on an opt-out system. If the Government introduces a bill, as you suggest it will, that will be fantastic and I will get right behind it. That will end any involvement from me through a member's bill, and I will support the Government in any way I can. My proposal is almost purely as a safeguard so that, if the Government decides not to proceed with legislation, I can come in with my member's bill. However, I hope that the Government introduces a bill; it will have my full support if it does so.

Richard Lyle: Thank you, and sorry for putting you through that.

Alex Cole-Hamilton: On that point, irrespective of whether the Government made a commitment to consult or to legislate, I fully endorse Mark Griffin's position that his proposed bill is a kind of backstop. In 2012, in "Do the Right Thing", the report to the United Nations Committee on the Rights of the Child on the implementation of children's rights in Scotland, the then Minister for Children and Early Years made a commitment to legislate on the age of criminal responsibility in the previous session of Parliament, but that did not happen. Therefore, it is absolutely right that Mark Griffin is taking that twin-track or belt-and-braces approach, albeit that he is doing so in good faith that the Scottish Government will make good on its commitment and will work alongside him. I absolutely endorse his position.

Clare Haughey: Thank you for coming along today, Mark, and thank you for explaining why you are doing this now, which was going to be one of my questions. You say that there is sufficient evidence and that sufficient consultation has been done. Obviously, the Scottish Government has put the issue out for consultation, so we cannot use that as evidence that we do not need consultation on your member's bill. I am looking at the issue from a health professional's point of view. You said that there were two previous consultations, one of which was for Anne McTaggart's bill.

Mark Griffin: Anne McTaggart carried out a consultation, and the previous Health and Sport Committee carried out its own consultation.

Clare Haughey: From what I understand, the Health and Sport Committee carried out a self-selecting online survey of about 900 people. From the information that I have, that survey was very much promoted by organisations that were actively campaigning for an opt-out bill.

Am I correct that there were 559 respondents to the previous member's bill consultation?

Mark Griffin: Yes.

Clare Haughey: They included 529 individuals and 30 organisations. From my reading of the consultation, the organisations, which included church organisations, professional bodies and organisations involved in transplantation, were split over the proposal. Can you give me a flavour of your rationale for saying that those consultations are sufficient and that you do not have to go back and consult the public?

Mark Griffin: My proposal is the same as Anne McTaggart's, so I would be going out to consultation on the same proposal to the same people and would, in all likelihood, get the same responses. The previous Health and Sport Committee carried out an online survey, which we could say was self-selecting, but any such consultation is self-selecting. The Government consultation will have a self-selecting audience.

It was not just individuals who responded to the call for evidence from the committee. The organisations that responded included six health boards, the General Medical Council, the UK Donations Ethics Committee, the Scottish donation and transplant group and the Nuffield Council on Bioethics. Some pretty big organisations that have a lot of experience in the field responded.

Clare Haughey: I cannot quite follow the logic in asking the same questions as resulted in a flawed bill. Would you consider exploring other areas? Since 2015, there have been advances in medical technology—for example, in tissue and limb transplant. Would you consider also covering some of those areas in a consultation, if you had to do one?

Mark Griffin: I have made a one-line proposal. Its being the same as Anne McTaggart's proposal does not mean that the bill that would be introduced would be the same as hers. Obviously, I would look to take advice from the committee, and look at the evidence that the committee in the previous session received and the debate that we had in Parliament. I am already discussing with the Government the particular issues that it had with Anne McTaggart's bill, so I would seek to introduce a different one. The same bill certainly would not be introduced again.

Clare Haughey: Okay. I apologise. I thought that you said that the information would be the same. We need to ensure that a bill on the matter that is placed before Parliament is 100 per cent right; it would be too important not to get right, and we would need to get it right first time.

Alison Johnstone: For clarification, if the committee voted against your proposal not to consult, we would ask you to carry out a further consultation. There seems to be some discussion about whether two or three consultations have already been carried out. In effect, we would be asking for a fourth consultation. You have said very reasonably that you are very happy to absorb the Government's on-going consultation.

Mark Griffin: That is correct. Technically, if the committee does not agree with me, I would have two months to go out to consultation and go through the normal member's bill procedure, and I would not conclude that consultation by the time the Government had concluded its consultation. It would be the fourth consultation in three years.

Alison Johnstone: There would probably be some repetition and duplication in that, and it is clear that progress would be delayed. I am concerned that the Minister for Public Health and Sport, Aileen Campbell, said in her letter to the convener:

"The Scottish Government intends, subject to the outcome of the consultation ... to bring forward legislation".

Therefore, there is no guarantee. If members of the committee are determined to see great progress or guaranteed progress, we should support your proposal.

Mark Griffin: Yes. There is certainly no guarantee with the Government consultation. However, I guarantee that I will introduce a bill at some point if the Government does not. If the committee is minded to see opt-out legislation, the only way to guarantee that is through that process.

Tom Arthur (Renfrewshire South) (SNP): Thank you very much for coming to the meeting. I think that we all sympathise with you and commend your aims in bringing forward your proposal. For the record, can you categorically guarantee that you will not lodge a formal proposal until the Scottish Government's consultation has been completed and it has published the results and an analysis?

Mark Griffin: Yes—I guarantee that 100 per cent. The Government consultation is due to end in March. I expect that it will be a month or two after that when it publishes responses.

Tom Arthur: The date 14 March has been referred to. I want clarification of whether that is when the consultation will close or when the Government will publish the results.

Mark Griffin: I would not plan to introduce a bill until even later than that: I would plan not to do so until the Government came to a firm decision on whether it will introduce a bill.

Tom Arthur: Thank you. I just wanted to clear that up.

The Government's consultation is not specifically on an opt-out system; it is about how we can increase organ donations. Obviously, it is a broad consultation that includes consideration of opting out, as Parliament mandated in February last year. Were the consultation to come back and the evidence and analysis to suggest that your proposal would not, in the view of the Government, lead to an increase in organ donation—which is what this ultimately about—would you still introduce a member's bill?

12:00

Mark Griffin: There will be responses to the consultation that support an opt-out system and there will be responses against it—similar to Anne McTaggart's consultation and the previous session's committee's consultation. In my view, an opt-out system would increase the number of organs that would be available for transplantations, which would save lives. Based on that, I am committed to taking forward legislation in the Scottish Parliament.

Tom Arthur: I appreciate that. In your statement of reasons you cite a consultation, but you have indicated that you will proceed regardless of the outcome of that consultation.

Mark Griffin: On the same basis, the Government will take a view at the end of the consultation as to the merit and weight that it applies to each submission. It will agree or disagree with the consultation responses and will plot a course from there. I will be in the same position: I will agree or disagree with the responses and, as I have said, I will plot a course to introduce legislation if the Government does not do so.

Tom Arthur: I appreciate that, but you seem to be prejudging the consultation. You would decide not to lodge a final proposal only if the Government indicated that it was going to legislate. You have not stated that you would withdraw your proposal if the consultation and analysis demonstrated that an opt-out system was not the best way to proceed. If you cite the consultation as evidence for your bill but you are not going to use the consultation because you have already made your decision, is that really adequate for the statement of reasons? The point that I am making is that the process is being prejudged.

Mark Griffin: The statement of reasons relies on the consultations that Anne McTaggart and the Health and Sport Committee carried out. I am simply pointing out that asking me to consult at the same time as the Government is consulting—

Tom Arthur: That is the point that I come back to. If you accept that the Government consultation is under way but you will use its results only if they support your proposition, we come back to the consultation that Anne McTaggart carried out in the previous session, which led to a bill that was flawed in the view of the then committee and Parliament.

We have exactly the same aims, but I raise the questions because I want to ensure that we get this right. Why are we being asked to waive the requirement for a consultation? Why are you citing the Scottish Government consultation if it will have no impact on whether you proceed with your proposal?

Mark Griffin: The process for a member's bill is that a member takes the view that legislation is needed to change a situation and goes out to consultation to seek the public's view on whether a particular mechanism or avenue is appropriate. However, at the end of the day, the member in charge will still be of the opinion that legislation is needed. The consultation is on the mechanisms. Almost every consultation on a member's bill in the history of the Parliament will have been prejudged, because the member who proposed the bill believes strongly in the course of action. The member consults on the mechanism for that course of action.

Tom Arthur: I appreciate that and, given that time is moving on, I will let that point rest.

Your explanation for lodging the draft proposal was to expedite the process—what Alex Cole-Hamilton described as a belt-and-braces approach. That was on 19 December, but it is only the end of January and the proposal is already before the committee. If the committee accepts your statement of reasons, you will be free to go ahead and lodge a final proposal. If we factor in the recess, the process has taken a matter of weeks. Why did you lodge the proposal before Christmas rather than wait until the Government had concluded its consultation, when you would have all that analysis and evidence available? Why not wait to lodge your proposal until you have an indication from the Government of whether it wishes to legislate?

Mark Griffin: After the election, I came back to Parliament with the intention of lodging a proposal

straight away. I would have done so, but I had asked for a meeting with the minister and I did not want to take anything forward without speaking to the minister first. I wanted to see what the lie of the land was and whether there was any way that the Government and I could work together.

I did not get the meeting with the minister until November. We sat down and talked through where we thought that things could have been changed in Anne McTaggart's bill and how the Government broadly supported the proposals.

The reason why a proposal was not lodged in May or June, before the summer recess, is that I thought that the best thing to do was to sit down with the Government first. The timing was determined by my wish to meet the minister and to go ahead only after that discussion.

Miles Briggs: It is worth putting on record the work that Anne McTaggart did on the issue, although her bill was not successful.

It is concerning that you received no assurance that the minister would take forward a bill. Has there been a delay on the Government's part? If you and the Scottish Government worked on the issue at the same time, would that help to eventually deliver a strong bill that could be supported across the parties?

Mark Griffin: Within the year following the election, the Government has pulled together a consultation document and started the consultation process. It has taken the time to get that right, as is appropriate. I hope that it will take the time to get things right throughout the process and will bring forward good, strong proposals on an opt-out system.

In a recent article, the minister said that the Scottish Government has a presumption in favour of introducing legislation after the consultation, which is excellent. If the Government decides to take forward the legislation, it will have the full weight of the civil service behind it, which represents much more resource than is available to me in my private office. I simply say to ministers that, if I can do anything to help, they can give me a call—that is the extent to which I, as a back-bench member, can offer support.

Maree Todd: I will ask specifically about the purpose of the consultation process. I am conscious that the previous bill failed. I imagine that, in any new round of consultation, there would be an opportunity to consider the specific areas in which that bill failed, so that we could use that information to inform the development of a new bill that would be stronger and more robust, and therefore more likely to succeed. Is that not the purpose of consultation?

Mark Griffin: I would not be consulting on a draft bill, so there would be no bill that people could look at to say whether they agreed with section 1, section 2 or whatever. The consultation would be simply on the one-line proposal. The previous committee and the Scottish Government have already said that they commend the aims of Anne McTaggart's bill, which are, in effect, contained in the one-line proposal. The meaningful discussion of the specific details and content of that bill happened in committee and in the chamber.

At this point, without having a specific bill to ask about, we would not generate the same level of discussion. Any consultation on the one-line proposal would generate broadly similar responses to the responses that we have already had.

Maree Todd: So there would be no opportunity to drill down into the particular failings of the previous bill.

Mark Griffin: There could be pre-legislative discussions with the Government and the civil service, but the way in which the process works is that a member lodges a one-line proposal, which goes out to consultation. The member analyses the responses before sending a policy document to legal draftsmen, who then draft a bill for introduction in Parliament.

Maree Todd: I did not look at the consultation that took place in Wales, so I do not know whether that process was more robust, but I was struck by the numbers. Last time, the consultation here got 500-odd responses. In Wales, which has a small population, there were nearly 3,000 responses. That suggests that the consultation in Wales was much more robust, which might be why the Welsh legislation passed. That is my concern. If everyone around the table agrees that we want a successful bill to be introduced, perhaps we could think about that issue.

Mark Griffin: I agree. The reason why the Welsh consultation got so many responses is that it was on a Government bill, so it was backed by the full weight of the Government.

Maree Todd: Would you expect about 3,000 responses to a consultation here?

Mark Griffin: The Welsh Government would have had a public relations department and a budget for the publication of documents. That is why there were so many responses. If I went out to consultation, I would be using the same resources as you have—that is, two or three members of staff—and would be posting stuff on Facebook and other social media. With the best will in the world, I would not reach as many people as the Scottish Government could. The Government's consultation is better placed to seek

a much wider range of responses, which is another reason why I will not do anything until that exercise is concluded and the Government has decided whether it will go forward with legislation.

Ivan McKee: I have a question about procedure and timing. I do not know whether you can answer it or whether the committee clerks might have to comment.

You are bringing forward a proposal at this stage, and you will bring forward a final proposal after that, when the clock will start ticking for a month. You have undertaken not to bring forward the final proposal until the Government's consultation has finished and it has commented on that. My understanding is that, even if the committee agreed to your proposal at this stage, no time would be gained, because you are waiting for the Government's process to take place anyway. Given the concerns that have been raised and given your commitment not to proceed until the consultation has ended, would it be a good option to defer consideration of the proposal and ask you to come back to us later in March, when the consultation has finished? Procedurally, is that an option?

Mark Griffin: The clerks can correct me if I am wrong, but I think that, procedurally, the committee has to make a decision within a certain timescale, which I think ends in the February recess. The committee has to decide before recess whether to ask me to go out to consultation. It could ask me to go out to consultation, and I would undertake that exercise but, as Maree Todd pointed out, the Government's consultation, which is running at the same time, will have a much wider reach, a much bigger budget and, I suspect, a much higher response rate than I would generate through my private office.

Ivan McKee: That is fine—thanks.

The Convener: I thank Mark Griffin and Andrew Mylne for coming to the committee. As agreed, we will take the next item in private.

12:12

Meeting continued in private until 12:49.

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