OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 21 February 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 21 February 2023

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

6th Meeting 2023, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Paul Sweeney (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Amit Aggarwal (Association of the British Pharmaceutical Industry)
Dr Gary Duncan (Patient Safety Commissioner for England)
Shaun Gallagher (General Medical Council)
Dr Henrietta Hughes (Patient Safety Commissioner for England)
Matthew McClelland (Nursing and Midwifery Council)
Richard Phillips (Association of British HealthTech Industries)
Dr Chris Williams (Royal College of General Practitioners)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 21 February 2023

[The Convener opened the meeting at 09:05]

Decision on Taking Business in Private

The Convener (Gillian Martin): Good morning and welcome to the Health, Social Care and Sport Committee.

I have received apologies from Stephanie Callaghan.

Agenda item 1 is for the committee to decide whether to take item 5 and the next meetings of the committee on 28 February and 7 March in private. Do members agree?

Members *indicated agreement.*

Patient Safety Commissioner for Scotland Bill: Stage 1

09:06

The Convener: Item 2 is continued scrutiny of the Patient Safety Commissioner for Scotland Bill. We have two evidence sessions this morning, the first of which involves representatives from industry bodies and professional organisations that relate to patient safety. After a short break, the committee will then hear from the Patient Safety Commissioner for England, as a number of members thought that that would be useful.

I welcome to the committee Dr Amit Aggarwal, the executive director of medical affairs for the Association of the British Pharmaceutical Industry; Shaun Gallagher, the director of strategy and policy for the General Medical Council; Matthew McClelland, director of the Nursing and Midwifery Council; and Dr Chris Williams, the joint chair of the Royal College of General Practitioners Scotland. Joining us online is Richard Phillips, the director of strategy for the Association of British HealthTech Industries. Good morning to you all.

I will issue my usual caveat that not every member will be able to ask every witness to answer every question or we will be here all day. However, I like to start with an opening question to allow witnesses to state their case.

What are your general views of the establishment of a patient safety commissioner? What value would a patient safety commissioner add to the existing scrutiny mechanisms for patient safety?

Dr Amit Aggarwal (Association of the British Pharmaceutical Industry): Thank you for the opportunity to contribute today. I am here on behalf of the ABPI, which is the United Kingdom trade association for the innovation research-and-development based pharmaceutical industry. I am a physician by background and I have been in the industry for 15 years, the first one and a half of which were in pharmacovigilance or drug safety. I have a good first-hand impression of how seriously the industry takes the issue of patient safety.

To answer your question about the value of a patient safety commissioner for Scotland, we see it as an opportunity for a uniquely patient-centric wider systems-based approach to signal detection. What do I mean by that? Industry and regulators are good at collecting and collating information from a wide range of sources such as patients and healthcare professionals, and at looking for signals that affect the safety profile of the medicines that affect the benefit-risk balance. Traditionally,

however, that signal detection has been geared towards looking at the medicine, the chemical and the compound itself, and we know that many other factors affect the benefit-risk balance of a medicine when it is used in an individual or group of individuals such as pregnant women, for example. Although the system is now better at taking some of those other prescribing factors into account when assessing the benefit-risk balance, it is still not perfect, and that is where a patient safety commissioner can add real value by taking a wider patient-centric systems-based approach to signal detection and, in so doing, investigate accordingly and make recommendations.

The bill also offers an opportunity for the patient safety commissioner to give sufficient weight to anecdote. Baroness Cumberlege's report cited the fact that anecdotal evidence was often dismissed, but the patient safety commissioner can give weight to such anecdote in a systematic, evidence-based and objective way, and therefore set priorities that are important to patients and to the public. Fundamentally, that is where I believe that the value of the role lies. I think that it provides an opportunity to fundamentally alter the landscape of patient safety for the better.

Shaun Gallagher (General Medical Council): Good morning. It is good for us to be able to give evidence to the committee.

I am from the General Medical Council, which is the statutory regulator for doctors. We operate UK wide, and our fundamental purpose is to protect patient safety through the regulation of doctors' education and practice.

Like Dr Aggarwal, we very much support the establishment, through the bill, of a patient safety commissioner for Scotland. That is mainly because of the evidence that we have seen from plenty of inquiries and reviews—not just from Baroness Cumberlege's review—and instances of healthcare concern that the voice of patients is still often underrepresented in the way in which the health and care system operates. We think that a commissioner can play a very useful role in amplifying that voice and strengthening the voice of the patient throughout the system.

We have some suggestions or views about where the bill could be strengthened, which I am sure that we will come on to during the course of the discussion.

The Convener: We will. You are more than welcome to offer those suggestions now, but if you want to wait, that is fine.

Shaun Gallagher: I will quickly mention three things. First, we think that there could be an open and full consultation on the principles that the bill requires the commissioner to have, mainly to address the concerns that many people have had about a cluttered patient safety landscape, duplication and ensuring that the role fits in the most effective way and adds value.

The second issue, which is probably the key one for us, relates to powers of data sharing. We want to check that the commissioner's powers are set in the right way to enable sharing of data, particularly with the GMC, as a professional regulator. We think that, as things stand at the moment, the arrangements for the commissioner in that regard are a bit constraining, compared with other organisations of a similar kind.

Our third point is a relatively small one. The powers to ask organisations to report on how they have implemented recommendations that have been made seem to be a one-off—they seem to give the commissioner one chance to do that, rather than giving the commissioner the opportunity to revisit and review that on an on-going basis.

The Convener: Thank you—that is very helpful. I am glad that I asked you to continue.

Matthew McClelland (Nursing and Midwifery Council): Good morning. Thank you for giving me the opportunity to talk to the committee. I am director of strategy and insight at the Nursing and Midwifery Council. We are the statutory regulator of nurses and midwives across the UK, and we regulate around 72,000 nurses and midwives in Scotland.

Like colleagues who have already spoken, we very much welcome the bill and the establishment of a patient safety commissioner for Scotland, which provides an opportunity to amplify the voices of patients and to take a system-wide approach to improvement.

I absolutely endorse the points that Shaun Gallagher made about areas in which improvements could be made to the bill. I would add one proposed improvement to those, which is to make sure that the commissioner is also able to take account of the social care landscape and how that might evolve in the future. We think that it is very important for people who use services that the commissioner has a wider view across social care, too.

Dr Chris Williams (Royal College of General Practitioners): Good morning. The RCGP Scotland has consulted our Scottish patient forum on the bill. Along with our patient forum, we are very supportive of the proposal to have a patient safety commissioner for Scotland, which we think provides an opportunity to create a more open, just and transparent environment, in which health workers can help to progress issues that are sometimes difficult to progress in the current landscape of patient safety support. Currently,

there are multiple organisations and frameworks involved.

The bill affords, allows and enables the opportunity—which does not exist at present—for further advocacy and, to pick up on earlier comments, will make it possible to put weight behind individual and collective patient voices.

09:15

Patient safety issues can often be complex. Multiple things can often happen simultaneously that can combine to create real, genuine harm. Data will be a key part of being able to understand what is happening. The ability to tap into different sources of data, to open and commission investigations, and to compel people to provide information is very interesting. That is an opportunity that we have not seen before.

RCGP Scotland is very supportive of the broad scope of what has been proposed.

The Convener: I want to pick up on what you have said about investigations and individual voices. Do you support the rationale of the approach not being about taking on individual cases but about cases prompting wider investigations?

Dr Williams: RCGP Scotland and I would view the issue as being about the patient safety landscape rather than the complaints landscape. There are methods for raising individual cases and for asking questions of healthcare organisations. Establishing the office will allow a broader approach to be taken across different organisations and the ability to scan the horizon and spot emerging problems or issues that people can describe which might not be at the surface in what is being looked at.

The Convener: Sandesh Gulhane will probably want to pick up on some of your points, but it is important to bring in Richard Phillips, who is online, so that he does not feel left out. I have not forgotten about him. Richard, what are your general views on the patient safety commissioner?

Richard Phillips (Association of British HealthTech Industries): Thanks, convener. Like everyone else, I am grateful to be with the committee this morning to assist you in your work in the inquiry. Please accept my sincere apologies for not being at the meeting in person. I have a school-age daughter on half-term break and a 17-week-old puppy, my wife is away on a course this week, and we have no other family. Being at the meeting is therefore simply not practical.

I am director of strategy at the Association of British HealthTech Industries. We represent manufacturers and suppliers of medical devices, diagnostics and digital health technologies. We have around 315 members in a sector that has around another 3,500 companies in the space. Many of those are small and medium-sized enterprises, and the vast majority are small innovative companies that develop solutions often in close working partnerships with clinicians. We are essentially an engineering industry.

I do not disagree with what anyone has said so far, but I will try to give a slightly different slant on it and give the committee some thoughts, from what some of my colleagues have said, about how the bill might be strengthened.

The Cumberlege review is, at its heart, about people, particularly women, not being taken seriously—I saw in the *Official Report* of the previous session that that issue came up then. That chimed with me personally from my own life experiences—the experiences of my mother up to the point of her death and of my wife, who, like many women, is experiencing a lot of inflammatory-based conditions as a result of childbirth. She has not been taken seriously.

That is tragic in itself, but it is also a problem because it causes people to lose confidence in the use of medical technologies and systems that are in place to protect them and keep them safe. Hearing that voice is really important. We are therefore delighted that there is now a Patient Safety Commissioner for England, and we look forward, in due course and following due process, to working with the commissioner for Scotland.

The patient safety commissioner can also play a role in encouraging grown-up conversations about the risks and benefits of medical interventions. No effective medical intervention is completely without risk, and we need to recognise that that is a difficult conversation for any of us to have when we are in front of a doctor and want to be helped quickly in a pain-free and risk-free way. We should recognise that the balance of, and the appetite for, risk might shift depending on someone's personal circumstances, such as their age, their condition and so on. We saw that during the pandemic when people, including me, were willing to be vaccinated very early on.

There is an issue in relation to innovation being incremental. Often, there is not a big-bang explosion that changes clinical practice overnight; instead, particularly with medical devices, there are small steps that, over time, add up to big change in clinical practice and patient care. I can give some examples if that would be helpful.

There will be a conflict in that regard. It is interesting that the Government's response to the Medicines and Healthcare products Regulatory Agency's consultation on its new programme of work refers to five pillars, the first two of which

might illustrate that potential conflict. The first one, quite rightly, states:

"Strengthening MHRA power to act to keep patients safe".

The second one states:

"Making the UK a focus for innovation, the best place to develop and introduce innovative medical devices",

and that is writ large in our latest scientist strategy, too.

The last thing—

The Convener: I am going to stop you there, because I am very conscious of time, and members want to ask questions. I apologise for that.

Sandesh Gulhane (Glasgow) (Con): I will pick up on what the convener said about individual cases. Dr Williams, I appreciate that there are lots of different ways of doing things, but might it be useful for the commissioner to be able to hear about and log individual cases in order to find the golden thread that runs through them?

Dr Williams: We already have some systems that attempt to do that, but I do not think that those systems extend globally across our healthcare system. For example, they do not extend well across the boundary between primary and secondary care. In general practice, we record a lot of information throughout a patient's lifetime, but in order to tap into what is happening in individual episodes of care or to find out how different conditions might overlap or cause an unintended outcome, it is important to have, as you said, some sort of logging process to keep track of potential incidents and potential harm.

In individual practices, significant event analysis is done. When we know that something adverse has occurred, we can look into individual cases and try to unpick what has happened, but sharing learning and being able to pick up on the possibles, the probables and the maybes also has value.

The speed of response was mentioned earlier. Being able to intervene earlier, in order to raise the profile of something that is causing harm and strip that out, seems to be a large benefit that is waiting to be realised.

The Convener: Gillian Mackay has questions on medicines and medical devices.

Gillian Mackay (Central Scotland) (Green): Dr Williams, how can the patient safety commissioner for Scotland complement the work of the Patient Safety Commissioner for England and the MHRA, and how will the commissioner interact with the work of clinicians up here?

Dr Williams: As technology progresses, we will be able to use different materials and devices and to use, in other ways, drugs and medicines that were previously used for different purposes.

There are all sorts of small changes in practice that can overlap and accumulate. Having the different organisations means that they can provide different forms of oversight or can bring together different bits of information.

As has already been mentioned, it is important that data that has been collected for one purpose can be used for other legitimate purposes. I have a slight fear about the length of time that it might take to develop a level of expertise around what data is being collected, what information-sharing agreements are in place and what memoranda of understanding exist between the new organisation and the multiple organisations that it would need to interact with.

Expertise will be held in various places. Specifically on the patient safety commissioner's work in advocating for patients, the commissioner will be able to focus on a specific issue or area and to go from topic to topic in order to highlight instances related to it, and to work between agencies to raise issues and allow people with relevant expertise to look into them.

Gillian Mackay: Is there potential for conflict in the relationship, particularly given the overlap between the oversight roles of the two commissioners and the interaction with the MHRA?

Dr Williams: There is the potential for crowding, but I think that conflict will be avoidable. Again, a memorandum of understanding can help two organisations to know what complementary roles they might have, although that does not mean that they will not both work in the same space. My thought is that a new office of this sort would very quickly mature and find where the boundaries naturally sit.

Dr Aggarwal: On overlap with the MHRA, it should be clear that the powers of the regulator are very much tailored to licensing of medicines. There are many facets to licensing, such as how a medicine is prescribed and the restrictions on it. Licensing would be one aspect of the patient safety commissioner's role, but many other parts of the story make for good and appropriate decisions on prescribing, including the healthcare professionals' education and the education of the public, and how they interact. A patient safety commissioner can have an overview; its interaction with the MHRA and how it governs licensing is a fundamentally important part of the commissioner's role, but it is only one part.

If there is a bit of overlap, that is okay. The powers of sanction that a patient safety

commissioner has are distinct from the powers of the regulator, so I would be less concerned about overlap being a danger.

Gillian Mackay: Are there any areas relating to medicines and medical devices that you would like to be included in the remit of the patient safety commissioner that are not covered by the bill?

Dr Williams: I highlight software and advances in technology. We are seeing decision support being enabled by devices and systems, but those systems not only manipulating and presenting information, but helping to produce or to prompt a specific course of action, is a recent and modern area of focus that we have had to grapple with ethically and professionally. The patient safety commissioner will certainly need to give thought to that.

09:30

Sandesh Gulhane: My question is for Dr Williams. I am sorry if I seem to be picking on you. I note that, in its submission, the RCGP talks about the interface between primary and secondary care being where half of all errors and problems occur. You touched on that in response to my opening question to you.

Perhaps I can highlight as an example something that happened when I was in general practice last week. A patient came to me, telling me all the things that the hospital had said and done to them, but I did not get a discharge letter telling me any of that. As a result, I knew less than the patient did about their care. Can you give us any more examples of problems with the interface between primary and secondary care? What, exactly, do you feel a patient safety commissioner could do in that area?

Dr Williams: You are absolutely right to highlight the deficit that often exists in communication between primary and secondary care. Some of the deficit relates to the format of communication. For example, a person might spend several days going through an emergency admission to hospital, with all sorts of professionals involved and all sorts of discussions being had and scans and other tests being done. Some of the information that is relayed at the end of all that might have been carefully summarised or distilled down, but we have often have the sense that more has happened in the period than gets handed over.

Moreover, we are not yet at the stage at which patients can check what their summary medical information contains or even whether their contact details are up to date for the various organisations that look after them. We are still in a place where people who receive care and people who are carers of people in our health system do not have assurance about, or the ability to check, what is being done on their behalf or for them. The patient safety commissioner might well want to pick up on multiple instances of that sort of thing happening across the board, and might improve use of information and communication among the parts and across the interfaces where we know error or harm might occur.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I have a quick question about the remit of the patient safety commissioner. Sometimes the impact of care or—I should say—unsafe care is not directly or overtly evident. I note that Dr Williams suggested that the commissioner's remit should include advocating for patients. I am thinking of groups or populations in which harm has occurred as a result of, say, a lack of compassion or some other issue that is not directly related to safety. Would you expect the patient safety commissioner's remit to be wide enough to cover the patient population to whom overt harm might not have been caused?

The Convener: To whom do you want to direct that question, Emma?

Emma Harper: It is for Dr Williams.

Dr Williams: I can certainly think of lots of instances of people receiving poor care but there being no patient safety issue. For example, the patient might have been let down or disappointed, or not have had a good experience. However, despite the fact that a broad range of clinicians enthuse about patient safety and try to make improvements, patient safety issues still occur regularly. The work that will lie ahead for a patient safety commissioner will be substantial, so I hope that they will be able to focus on patient safety elements. That said, I appreciate that there are all sorts of issues of poor healthcare that we want to eradicate or improve on.

Matthew McClelland: I take a slightly different view to Dr Williams in that I think that there is actually a very close link between compassion and safety—in particular, with regard to listening to patients and people who use services. There absolutely is scope for the patient safety commissioner to take a slightly broader look at things. I accept, and absolutely agree, that some things to do with service delivery might be better dealt with through a complaints mechanism, but there is a really strong link between systemic lack of listening or compassion and patient safety. Therefore, it is crucial that the patient safety commissioner be able to take issues on, to look at them and to make recommendations for improvement—across the system, where necessary.

The Convener: Thank you. We move on to questions on the voices of staff, which will be led by Paul O'Kane.

Paul O'Kane (West Scotland) (Lab): Thank you, convener. Good morning.

In evidence, the committee has seen a high degree of support for the patient voice, but it is important that we explore the staff voice, too—especially with regard to whistleblowing processes and provision of safe spaces for staff to communicate their concerns and to add to intelligence on what patients are saying in the process. Therefore, my initial question is whether, with regard to the role of the commissioner, there is a place for that and for engaging the staff in that way. That question is for Matthew McClelland, first.

Matthew McClelland: There is certainly a place for the views of staff, because many staff—nurses and midwives in particular, from our perspective—deal all the time with patients and people who use services, and they are well placed and trained to advocate for them. Therefore, it is absolutely the case that there is a place for hearing those views within what the patient safety commissioner does.

However, I come back to the idea of the Ronseal approach: it will be the patient safety commissioner, and therefore it is really important that the primary voices that the commissioner hears are the voices of patients and people who use services. There are existing routes for staff voices, and we as a regulator are clear, as are others, that openness and learning are absolutely key to patient safety, and that colleagues have a duty to speak up when something goes wrong. We have, with the General Medical Council, developed joint guidance on that.

We acknowledge that it is not always easy for people to raise concerns, so we provide guidance to colleagues to assist them in doing that. As I said, there are various routes for staff. The council is a "prescribed person" under whistleblowing legislation, so people have a measure of protection when they come to us, as they would if they went to Healthcare Improvement Scotland and other organisations.

Therefore, it will be important—as it will be in all the commissioner's work—to look at the whole landscape, and to work out the right routes for people to raise issues, and to enable the commissioner to listen to a range of views and to focus on the things that are important for patient safety. That might include voices of staff, but I do not see the commissioner necessarily becoming a primary route for colleagues to raise concerns, because there are existing routes that might be usefully continued and exploited.

Paul O'Kane: Shaun—do you want to comment?

Shaun Gallagher: I do not want to repeat what Matthew has said, but I would absolutely reinforce an awful lot of what he has just said. I believe that you will hear evidence from Henrietta Hughes later today: that question might be worth pursuing with her. One of the things that she has set herself as an objective is to think about the culture in healthcare organisations that support patient safety and what she can press healthcare organisations on, and what she can encourage in them in order that they think about the voice of the patient. That might include organisations' being able to create safe environments in which staff feel able to speak up. That is a critical indicator for safety and effective care for patients.

Again, if we look back at inquiries on and reviews of incidents that have happened, we see that it is clear that, far too often, people—staff and professionals working in the service—knew that there was something wrong but did not feel safe enough to speak up. That is a critical issue: as Matthew McClelland said, it is central to patient safety. However, it might be tricky for the patient safety commissioner to balance the time and energy that they give to that with trying to pull out the voices of patients that are heard less often.

Paul O'Kane: I would like to expand that question for Amit Aggarwal. Should we explicitly include people from the pharmaceutical and health technology industries? Should the commissioner engage with people in those industries in order to understand the bigger picture of what can go wrong and, thus, how we can take steps to prevent it?

Dr Aggarwal: The patient safety commissioner presents a good opportunity to engage with industry. Many people work in research and development, drug safety and pharmacovigilance, which means that there is a rich resource in industry that the patient safety commissioner can draw on and learn from, where necessary. The industry is ready to work with the patient safety commissioner. Industry is also mindful of the independence of the role of the patient safety commissioner and would be happy to engage with him or her on the terms that the commissioner deems appropriate.

I will reinforce a point that has already been made this morning: the focus has to be the patient voice. If people in the industry want to raise concerns, they have internal whistleblowing procedures and a regulator to which they can escalate issues. The industry has a strong self-regulation system. Given that there are already many well-established mechanisms to escalate concerns in the industry, I do not see the industry

going proactively to the patient safety commissioner to raise concerns.

Richard Phillips: That was a fantastic question: Paul O'Kane has nailed the valuable role of the patient safety commissioner. Someone mentioned earlier that patient safety is a rather cluttered landscape and that the commissioner could bring independence, as a convener and advocate.

In a couple of weeks, the Healthcare Safety Investigation Branch, the Care Quality Commission, the MHRA, the ombudsman and the Patient Safety Commissioner for England will meet to see how we can bring all the elements together, which will include health tech. Paul O'Kane is absolutely right: patient safety is at the forefront of what the industry does.

Tess White (North East Scotland) (Con): My question is for Matthew McClelland from the Nursing and Midwifery Council. You talk about whistleblowing. What mechanisms are in place for staff to raise safety concerns?

Matthew McClelland: There should be opportunities within organisations for staff to raise concerns in their teams—or beyond them, if necessary. The national whistleblowing officer has issued guidance on how concerns should be handled by organisations. Across teams, there will, in order to ensure that issues are explored and resolved, be a wide variety of practice—including stand-up huddles, ward rounds and similar mechanisms—for people to discuss issues that concern them and issues that come from patients and people who use services.

A wide range of mechanisms are in place within organisations, but problems occur when they do not work effectively. That is when lines out of organisations and into professions' regulators, such as the NMC, and into Health Improvement Scotland or the national whistleblowing officer, are important. Usually, those mechanisms should operate as close as possible to the environment in which care is delivered.

09:45

Tess White: Will a PSC add value to the processes that are in place?

Matthew McClelland: A commissioner has the potential to do that; it will all depend on the approach that the commissioner takes. I absolutely think that a PSC can and should add value, both in identifying opportunities for systemic improvement and in driving improvement among organisations. It could bring a measure of consistency and, as Sean Gallagher said, it could look at the culture within organisations in order to get an open, supportive and learning culture embedded in them—which is, in a way, at the absolute heart of patient safety.

The Convener: We move to questions from Evelyn Tweed on blame culture.

Evelyn Tweed (Stirling) (SNP): My first question is for Richard Phillips. You talked about grown-up conversations and also mentioned the issues that women, in particular, have in raising problems with services and so on. Do you think that a patient safety commissioner will open up avenues for women to be heard and taken seriously?

Richard Phillips: I can only hope so. The independence of the role will be important, in that case. You can see people who perhaps feel that they have been let down by technology or the system and do not feel that they have anywhere to go. That chimes with personal experience, which I am sorry to share with you; people need an independent place to go. It is vital that people feel that they have somewhere to go where they will be listened to and taken seriously. That will be a huge step forward and I think that everyone would wish to get behind that. Again, it is about independence that is removed from the service and the structures that are already there—a different place where people can go to feel that they have a strong advocate.

Evelyn Tweed: Is there a blame culture? If there is, why, and how do we move on?

Richard Phillips: Those on the panel who are from the profession might be better able to answer that—although I sit on the board of a hospital. I think that we try to move away from blame. We know that we need to frame issues as a learning experience, rather than blaming people. People make mistakes. We have to create a culture in which people are prepared to admit that mistakes were made and to learn from them. If sanctions are extreme and everybody is absolutely terrified, things will just get covered up and hidden away. We need to be able to come forward and say, "In the case of this particular device, there was a problem. Was it the device? Was it how it was implanted? How can we learn from that?" That is how we improve technologies and make the iterative gains that I talked about in my opening remarks.

Dr Williams: We absolutely want to move away from a blame culture. The duty of candour at individual clinician level and organisation level has helped transparency, but we want to create and foster an environment in which people can raise issues. That takes me back to what we were saying earlier: we want to do that where we suspect that harm is being caused, before we are even certain that harm is being caused.

Especially in a large organisation, there are often people who can see things that need to be escalated. Matthew McClelland mentioned several different structures that exist or ways of working whereby people are encouraged to speak up or we try to create the conditions in which people can speak up, so that quieter voices are heard. In terms of having a just culture, we need one in which people are able to say that there is a problem and can describe the problem without blame being apportioned to an individual.

I am not saying that there are not situations where people make errors that need to be dealt with. However, in general, if we are looking to improve patient safety we need an environment in which matters can be brought into the light and shared. I mention again systemic improvement and having a systematic approach. The patient safety commissioner brings an opportunity for that to happen outwith the multiple organisations in healthcare.

The Convener: Evelyn, may we move on?

Evelyn Tweed: Yes.

The Convener: Sandesh Gulhane has a question on this theme.

Sandesh Gulhane: I have a couple of questions. The first goes back to the voices of staff, and is directed to Shaun Gallagher. Matthew McClelland spoke about whistleblowing legislation, but my understanding is that people who sit on health boards are not covered by that. Does that not create an issue, especially when we are talking about a blame culture? Should we take steps to include members of health boards in such legislation?

Shaun Gallagher: I am afraid that I cannot speak to whether that is correct. I am sure that it is true that the whistleblowing legislation might not encompass everyone that it should encompass. More generally, though, it is absolutely critical that the right framework is in place to encourage people to feel able to speak up. As we know, healthcare is not an area where perfect outcomes are possible. It can be easy for a culture to develop in which any concerns will become adversarial and therefore people will think, "I'm not going to say something, because it will turn into a problem and I might suffer because of that, myself." We know that from inquiries and other areas where, after the event, it was established that people did not feel able to raise concerns.

As Matthew McClelland mentioned, there are many ways in which people have the opportunity to raise their concerns within organisations and through legislation that protects them in whistleblowing. We have a confidential helpline for doctors where they can speak about and understand what they are feeling and be supported on their concerns about how to speak up. We also issue a lot of good medical practice guidance on how doctors should consider such questions.

All the opportunities to raise concerns need to be there. However, the culture and the environment that people feel that they are in will influence whether they are able to do so.

Sandesh Gulhane: Just on that point, do you feel that our current culture is one in which there is blame, so people are a bit worried, and that the patient safety commissioner might help with that situation? Matthew McClelland, I direct that follow-up question to you, too. In previous committee meetings we have heard about cover-ups, with people being very worried and using Datix forms or the words, "I'm going to complain about you" as threats to get what they want. Do you feel that we have a culture of blame, which we need to move away from?

Shaun Gallagher: Absolutely. People tell us that they feel that there is a culture of blame, which can encourage them to cover up their concerns rather than speak out.

In any organisation it is useful to keep track of staff survey material, which includes questions about whether people feel able to speak up and whether they are confident that if they raised a concern they would be listened to and supported in doing so.

We always need to do more to encourage a culture of learning rather than blame. Adversarial processes can easily kick in whenever there are concerns, which is understandable when we think of the harm that patients might feel that they have suffered. From all the evidence, we know that the best outcomes come from a culture in which such concerns can be raised earlier and addressed without turning the process into a punitive one for the professionals involved, and where learning can be taken from the situation. That comes back to what the patient safety commissioner's role is in encouraging the broader culture of safety, rather than implementing specific mechanisms or legislation. I hope that that could be a contribution to that process.

The Convener: We will move on to discuss the powers of the patient safety commissioner, our questions on which will be led by Emma Harper.

Emma Harper: I am interested in the panel's thoughts regarding the patient safety commissioner having sufficient powers to bring about improvements in patient safety. We already have the Scottish patient safety programme, which has been widened to look at maternity and neonatal primary care, paediatrics and medicines. I was part of the surgical safety stuff when I worked in the operating theatre in California,

implementing the surgical safety checklist and things like that. Will the patient safety commissioner have enough powers to make safety improvements?

I do not have anybody in particular in mind.

The Convener: Panel members, please indicate to me if you want to come in.

I will take Dr Williams.

Dr Williams: There would certainly be a lot to be getting on with, given what the proposed powers would enable. It seems that the powers that are described in the bill go beyond what is currently being set up in England. The witnesses in the next part of the meeting might give the committee a better sense of where that extra space and those extra powers will take us all. I am quite comfortable that what is currently proposed will be able to advance things and is proportionate to some of the challenges that we face.

Even with those powers, however, there might be questions. I mentioned earlier the issues of how quickly we develop expertise around the data, the many conversations that will need to occur and the financing of things.

The powers as currently described will move things on enough and enable a patient safety commissioner to find their place suitably in the landscape. I am especially pleased about the power to compel evidence to be produced; that, in particular, will make a big difference.

Shaun Gallagher: I will quickly reflect a couple of points that I have mentioned already.

The scope of the powers is sufficient but the key issue will be how the patient safety commissioner uses those powers alongside all the other organisations. It will be critical to make that a really early priority.

There is also a need to strengthen the powers in relation to information sharing. For understandable reasons, section 15 of the bill bars the sharing of confidential information. That bar is very strong. Section 15 also names a couple of organisations that the commissioner is nevertheless able to share information with, but that does not include professional regulators. We think that there is a need to allow information to be shared with professional regulators—maybe not all the time, but certainly where appropriate; for example, where there is a concern that would be suitable for us to follow through on and investigate.

Emma Harper: In a previous evidence session, one of our panellists spoke about the Health and Safety Executive, enforcement orders and fines, and the patient safety commissioner's potentially having those sorts of powers. Do you have any thoughts or opinions on whether the patient safety commissioner should be able to act in that way?

Matthew McClelland: I have to confess that I do not know enough about how the Health and Safety Executive works to draw a direct comparison. My initial reaction comes back to the cultural point and the question of how we design a system that supports openness and learning, culturally. My instinct is that giving the patient safety commissioner a set of powers to fine and directly issue sanctions of that kind might take us more into an adversarial place. We might find that organisations that are named in and participating in patient safety commissioner organisations are more likely to adopt a defensive pose, if such outcomes result. That would be the trade-off. I can see why the idea was suggested. It might operate effectively in other sectors—I do not know. I would simply be thoughtful about whether having those sanctions would drive us into a defensive place rather than one that promotes openness and learning.

10:00

Dr Aggarwal: One of the powers is the ability to publicly name organisations that do not co-operate. I would not underestimate the power of publicly naming and shaming. For example, in the pharmaceutical industry, we operate a self-regulatory system, one of the sanctions within which is for breaches of our code of practice that bring the industry into disrepute. A full-page advert is taken out in various medical journals, and that has a powerful effect on the companies involved. The commissioner's powers to publicly name and shame are pretty strong. I do not see a common scenario in which an organisation would choose to ignore that completely.

Emma Harper: What Matthew McClelland said is pretty clear. I do not like the idea of a patient safety commissioner who would create an adversarial and defensive environment. I agree that a patient safety commissioner should promote patient safety.

Are there any additional powers that might need to be included in the bill, for example around naming a health board, company or business? Is anything like that missing from the bill?

Matthew McClelland: I absolutely agree with Shaun Gallagher's points about information sharing.

It is worth understanding whether the patient safety commissioner would be able to operate across social care as it evolves in Scotland. People do not experience primary care, secondary care, social care or nursing care; they experience care. The boundaries and divisions that we impose over the top of that are constructs of

management and the way in which we operate, rather than the way in which people experience care. The commissioner's powers need to be broad enough that when issues occur with care, wherever that might be, the commissioner is able to deal with the matter effectively, make recommendations and investigate where necessary. That is quite important.

Emma Harper: Okay, thank you.

The Convener: Thanks, Emma. We move on to some questions from Evelyn Tweed.

Evelyn Tweed: Issues have been highlighted to the committee around agencies not being joined up, so patients have to give the same feedback to numerous agencies. Could the patient safety commissioner have a role in joining up agencies? Might that mean their sacrificing a level of independence? I ask that of Dr Williams first.

Dr Williams: That would not jeopardise the commissioner's independence. Again, when it comes to the systematic improvement approach that we are looking for and the ability to highlight areas that are relevant across multiple organisations, there is an opportunity there that we have not managed to sort out with our current frameworks and organisations.

The Scottish patient safety programme was mentioned as an example of where we can look at things topic by topic or gather people together. That works to the extent that it is funded or that people have time within their professional roles. The ability to work across organisations and primary and secondary care means that higher-stakes patient safety events can be linked more to healthcare than to social care, although we are broadly looking to get rid of divisions and artificial constructs in health and social care.

The role can be across multiple organisations, it can be effective across multiple organisations and it can work for specific topics and patient groups. I do not think the nature of that will jeopardise its independence.

Matthew McClelland: Evelyn Tweed raised a key issue. One of the things that we hear from people who have suffered harm is exactly what you describe. They might be engaged with multiple regulators—the system regulators, multiple professional regulators and the police—and they might be taking legal action. All those bits of engagement require them to relive the issues and produce witness statements for all the bodies.

A key role for the patient safety commissioner will be to support people to understand and navigate those various routes as effectively as possible and, indeed, to guide and direct organisations to do what they can to make those pathways as easy as possible. There are really good examples of organisations collaborating, but we too often hear stories about individual patients and their battles and difficulties with multiple organisations. It is really important that the commissioner brings co-ordination.

We are an independent organisation. We hold that independence very dear—we think that it is incredibly important—but we would not see the role of the commissioner impinging on that in this regard at all.

There is a related area, which is worth mentioning. The provision of advocacy services for patients who are going through such journeys is key. Organisations provide those services. We provide advocacy for people who are involved in our processes. We work with the regulators, including the GMC, to make sure that we can provide advocacy services on a multiregulator basis. However, currently, there is nowhere that patients can go to really understand what the current landscape looks like, how to navigate it and how they can get someone to advocate on their behalf. That might be an area that the commissioner could look at and support.

Paul Sweeney (Glasgow) (Lab): It is proposed that the patient safety commissioner for Scotland will be a parliamentary commissioner—in other words, they will be appointed by the Scottish Parliament, not by the Scottish Government. Is it preferable that the proposed line of accountability is to Parliament rather than to Government or the national health service as an institution?

I will bring in the front-line representatives on that, starting with Mr McClelland.

Matthew McClelland: Independence will be absolutely key and a line of accountability to Parliament rather than to Government will certainly help with that. The commissioner will need to guard their independence jealously and make sure that they do everything that they can to work with patients, to ensure that people understand their independence, and feel and experience that independence in the way that the commissioner operates.

The line of accountability to Parliament is crucial and will be a helpful underpinning, but the way in which the commissioner operates will need to reinforce that.

Dr Williams: I am comfortable with the line of accountability being to Parliament, for the reasons that Matthew has articulated.

Shaun Gallagher: I would certainly agree with that. As Matthew mentioned, as professional regulators, we are statutorily independent of Government and, indeed, of the professions that we regulate. That independence is fundamental to confidence in the regulatory framework, and in the

judgments and assessments that it undertakes. We hold that to be fundamental in the way in which we operate and the confidence that we hope that people have in that, and I think that that would also be true of the commissioner. Therefore, independence from the Scottish Government and the health service would be an important aspect of patients and the public having confidence in the work that the commissioner does.

Paul Sweeney: The Department of Health and Social Care in England has put forward the argument that being appointed by Government would give the commissioner a powerful role in the system and that

"A commissioner which is entirely removed from the policy department can be more easily overlooked by government."

Do you agree? Do you think that that is a potential risk?

Shaun Gallagher: I understand that the structure of the set-up of the commissioner in England is different. I expect that, when you speak to Henrietta Hughes, she will tell you that she feels that she exercises her independence and guards it jealously. Being appointed by Government does not remove the possibility of the commissioner acting independently. I have worked in organisations that were more directly responsible to Government, but which still acted absolutely independently. That is possible. However, having a visible degree of separation from the system provides an additional safeguard and gives the public confidence, which is an entirely positive thing.

The Convener: We move on to questioning about the resourcing of the commissioner and their office, which will be led by Sandesh Gulhane.

Sandesh Gulhane: Everyone on the panel has spoken about other areas that they would like to put under the wing of the patient safety commissioner. Under the current proposals, four members of staff will be allocated to the role, and there are many other commissioners, which is very expensive. Do you feel that the patient safety commissioner will be adequately resourced to handle the situation now and in the future? I direct that question to Shaun Gallagher and Matthew McClelland, who both mentioned the possibility of the commissioner having extra areas of responsibility.

Shaun Gallagher: I do not think that I suggested additional scope for the commissioner's powers. I would like there to be additional provision for information sharing, which I hope could be done simply and as part of the way in which the commissioner operates.

It is not for the GMC to take a view on the resourcing of the commissioner, which will be what the Scottish Parliament and the Scottish Government are able to resource. It will be critical that the commissioner works with the resources that she or he has and focuses their efforts where they can make the most difference and add the most value. A number of organisations have told the committee that there are already many organisations in the Scottish healthcare system that have some remit for patient safety. One of the first priorities for the commissioner should be to work out where to use their resources in the most effective way.

We have talked a little about being able to take a strategic view of information across the system. Dr Aggarwal used the analogy with signal detection. He talked about spotting areas of risk, analysing data and working with other organisations that may be able to share data in order to hear signals of risk and concern that might otherwise be missed. As we have said before, that does not necessarily mean a lot of work dealing with individual cases and complaints, but a certain amount of capacity is required in order to be able to assess, analyse and understand a broad range of information. The key question is whether that can be done with the sort of staffing structure that is proposed and through collaboration with other organisations.

Matthew McClelland: I agree with Shaun Gallagher. It is not for the NMC to take a position on the resourcing of the commissioner. Collaboration with other organisations to make the most of the information that is already there and to pick out the important themes will be absolutely key.

I mentioned the need to check that the commissioner's powers would extend to cover social care. From my perspective, that is about future proofing the bill and ensuring that it has everything in it that is required. It does not necessarily mean that the scope of the commissioner's work should immediately be significantly expanded; it is very much a case of focusing on the important areas.

Sandesh Gulhane: The NMC and the GMC both undertake investigations, which involve a very different skill to that of analysis, and can be resource heavy and difficult to do. Knowing how difficult it is to do investigations, do you feel that the patient safety commissioner should highlight areas of concern but use other agencies to carry out investigations, thus making resources go further?

10:15

Shaun Gallagher: That sort of approach may well be possible, but I would not want to impose on the commissioner a view on the right approach to take. Understanding the commissioner's functions, the priorities for what they should do, and the skills, capacities and capabilities that they will need to draw on is an important first test.

I reinforce the importance of working with other organisations that will have some of those skills and capacities. We would want to work closely with the commissioner and to offer contributions on how they may undertake their work. We gather and collect a lot of data in our work as a matter of routine, and we see part of our responsibility as being to offer that to the wider system to support understanding of risk and patient safety across a range of areas. We would want to offer that as part of our work with the commissioner.

Matthew McClelland: I have nothing to add to what Shaun has said.

The Convener: The final questions come from Paul Sweeney.

Paul Sweeney: Issues have been raised about the budget—the £500,000 per annum budget has been described as "a bit light". On the discussion about the heaviness and the sheer volume of the data, we know that most data is useless, because it is not necessarily reliable. It has not necessarily been collected in the same way or in a rational way, and it may be biased. Are there any critical competences or skills in process or technology that you would like the office to have for it to be meaningful and to give it best effect?

I open that up to anyone who might have a view.

Dr Williams: I have previously picked up on the data aspects. In our general practice clinical information systems—our patient record—we generally collect information for direct patient care. I think that a wider piece of work will be needed if we are going to change some of the practices that are involved in inputting and maintaining the information that goes into that record.

When it comes to how the office of the patient safety commissioner might work, I think that a degree of set-up is needed to make sure that it is informed by our data experts in the health service. We have lots of experts—we have lots of information analysts and people who have that expertise. I am sure that multiple health boards could donate some of that expertise to help to set things up.

On data, the issues are whether we are collecting the right things, especially when there is a lot of sensitive information there, how things can be collected and curated, and how an appropriate focus can be had without simply hoovering up information that, as you highlight, may have been collected for a different purpose.

I highlight the need for a feedback loop, whereby the commissioner can say to organisations, "We would have spotted this if you had collected things slightly differently or if an extra bit of information had been collected within a certain data set." The intelligence aspect of that—moving from information to data sets to being able to draw useful conclusions beyond direct patient care—is something that the commissioner will have to deal with across multiple different organisations.

Shaun Gallagher: As we talk about this, my mind is going back to the cases that led to the introduction of a commissioner and to Baroness Cumberlege's review. What would it have taken for a commissioner to highlight those concerns and bring them into the public debate?

In a sense, that would not have required supersophisticated data analysis—it would simply have been a case of hearing the voices, joining the dots and ensuring that there was a profile and a championing of that set of concerns, which I expect would probably have led to more intensive investigation that might well have been undertaken by somebody other than the commissioner in order to examine the situation and ask, "Actually, what do we think we've got here?"

We do not want to overcomplicate the role and must consider quite how much we ask the commissioner themselves to do on that, but bringing the patient voice more to the surface is the key thing.

Dr Aggarwal: I will answer the question in a slightly different way. I completely agree with everything that Shaun Gallagher has just said. Part of our submission was about the role profile for the patient safety commissioner and the importance of that—whether it is a clinician, what sort of background they have and their ability to look at things from an individual aspect but also from a public health perspective. An issue to be mindful of is the fact that this role is intended to be very public facing. Given that the patient safety commissioner might become aware of and highlight issues that represent a broader public health concern, they need to be someone who is aware of the impacts of the role and mindful of the public health impact.

I will give some examples. In 1995, there was the pill scare. An increased risk was highlighted and lots of women came off the pill and ended up having terminations instead. There was also the measles, mumps and rubella vaccine scare in the early 2000s. Therefore, the profile of the role holder is really important, as is their ability to navigate not only their role but the impact of their

role and the potential of their role to impact on wider public health.

The Convener: Thank you. As there are no further questions, I thank our five witnesses for their time this morning. I suspend the meeting for a 10-minute break.

10:21

Meeting suspended.

10:35

On resuming—

The Convener: Welcome back. We continue our scrutiny of the Patient Safety Commissioner for Scotland Bill by taking evidence from the Patient Safety Commissioner for England. I welcome Dr Henrietta Hughes, the Patient Safety Commissioner for England, and Dr Gary Duncan, the chief of staff to the commissioner. Thank you for coming at relatively short notice, because we were not originally going to take evidence from you. However, following discussion with patient groups, we felt that it might be important to hear how things have been going in England in the first 100 days of your role. I will hand over to my colleague Tess White to start the questions.

Tess White: Great, thank you. Dr Hughes, will you share with us your views of your first 100 days? Have there been any surprises or is there anything that you think that it would be helpful to us to know?

Dr Henrietta Hughes (Patient Safety Commissioner for England): Yes, absolutely. First, I want to thank you so much for inviting us to give evidence—we really appreciate it. Working in partnership and learning from each other will be the way forward.

On my first 100 days, I started at a time of quite a lot of political turmoil, which was really significant with regard to the ability to make the right connections. There were a lot of distractions at the time. We should not underestimate the task of setting up something entirely from scratch. It is the first time that the Department of Health and Social Care in England has had an independent commissioner role, so we have been learning together with officials the best way to do this. We have been setting up some of the structures, recruiting staff, procuring a website and finding office space—some very basic things, which have taken quite a long time to establish, partly because of some of the changes that were happening at the time that I was appointed.

However, I must say that it has all been done with a huge amount of work from everyone involved, a huge amount of professionalism and excellent partnership working. We are looking for win-wins and solutions and trying to get things up and running as quickly as possible in order to meet the needs of patients who have had such a terrible experience leading up to the Cumberlege review.

Tess White: Did you face any difficulties or hurdles that you had not envisaged?

Dr Hughes: I will take them in order. First, we had to get the appropriate domain for our website and email. From the beginning, getting a “dot org” rather than “dot gov” domain was a really important issue. Inevitably, it takes time to do everything, and I am probably a bit impatient for change. We have had to set up the recruitment of staff. As I said, we have not got an office yet, but we are working on getting a lease signed, and then following all the appropriate DHSC procurement processes takes time. It is just a case of thinking about this as a very long-term project rather than as a short-term project—we need to think about setting things up for the long term.

Having a small set-up team is really important in order to be agile and to be able to design and develop the functions of the office. However, it is also important to have a longer-term plan for the scope of the role and for the expansion of the team to meet the needs of patients, because it could be a bit of a distraction when setting up the functions to also be saying, “These are the types of roles that I need in the team”. Therefore, beginning with the end in mind would be a really good step in that situation.

Emma Harper: I welcome the witnesses to the Scottish Parliament—it is good to have you here. I am interested in how your remit and role compare with the proposed remit of the patient safety commissioner for Scotland, which seems to be a bit wider. Do you have an opinion on whether there would be any benefits or drawbacks of the remit being a bit different in Scotland? Has your remit given you enough to work on, without considering wider issues?

Dr Hughes: My remit is to promote the safety of patients in relation to medicines and medical devices, and to promote the importance of listening to the views and voices of patients and the public. That is already a very wide remit, because people are experiencing, or have experienced, an awful lot of different problems with medicines and medical devices.

We can look at the context of patient safety and at the large number of patient safety organisations that already operate in England. My team is working in partnership with a range of organisations, including the professional regulators, representative organisations, membership bodies, professional organisations

and providers. That is important because, otherwise, it could be confusing for the system.

Having read the bill, I can see that the scope in Scotland is wider. It is not for me to say how you should organise that scope, but you should consider what you already have and how the commissioner could work effectively in partnership with other bodies, not only those in Scotland. I hope to have a really good relationship with the patient safety commissioner for Scotland so that we can continuously improve and learn by watching and speaking to each other about successes and difficult areas.

Emma Harper: I asked the previous witnesses about the commissioner not focusing only on safety, because care and compassion are at the heart of how we support a patient's journey—whatever care they are in receipt of—and determine whether harm has occurred. Do you have any comments on whether we should focus only on safety aspects or whether we should consider the whole patient journey in relation to care and compassion?

Dr Hughes: That is a really good point. It is about not only being safe but feeling safe. I am a GP, so I know that, for some patients, the issue is not just about the safety of the procedure or the medicine that they are taking; it is also about their experience. It is welcome that that ethos be part of the role. In relation to my office's priorities for the year ahead, it is really important to have a "speak up, listen up, follow up" culture—a compassionate culture.

Emma Harper: People have also intimated that the patient safety commissioner's role should be about healthcare, not health and social care. However, if we move towards having a national care service, which would encompass the whole of a patient's care journey, would you expect the remit to be wider and to include social care down the line?

Dr Hughes: If it were to include social care, it would be important for the commissioner to have people in their team with the right experience and expertise to provide that support. Through the work that I have been doing involving listening to patients and patient groups, I know that patients want to ensure that everyone who is involved in their care is knowledgeable about their condition, shares information with them, ensures that they consent to their treatment and listens and acts when they raise a concern. If the remit were to extend to social care, those are the elements that, as I have heard, really matter to patients.

Emma Harper: Thank you.

Evelyn Tweed: Good morning. Dr Hughes, obviously you are quite new to your role. We are hearing in evidence that those who are most at risk find it really difficult to have a voice and to be believed; we hear that particularly from women. What are you doing to engage with those who are most at risk to make sure that their voices are heard?

10:45

Dr Hughes: Most of the patients who were involved in the Cumberlege review were women—women who had taken sodium valproate during pregnancy, had been given hormone pregnancy tests or who had been treated with pelvic mesh. I have been meeting a wide range of patients—not only those who were involved in the Cumberlege review but others as well. I absolutely agree that it is the voices of those who are seldom heard that we really need to focus on. If we get it right for those who are most vulnerable, we make it better for everybody.

For the advisory group that I am establishing, a real focus of mine has been to ensure that we have real reach into groups of patients and the public that would not often have a voice. I have been engaging with other organisations, such as the Patients Association, and I have been very interested in the networks of patients that already exist in different parts of the system. I am also interested in the patient safety partner roles that have been established in national health service trusts in some of the regions, because that is another way that we can get the patient voice included in the design and delivery of healthcare.

Although I have been in the post only for a few months, I have been visiting different parts of the country and meeting people—patients and the staff who look after them—and listening to their concerns. I have been looking into how this role can be forward thinking and not just backward looking. I am hoping to horizon scan and identify concerns before they become harm. That is the goal of this role: to be a forward-looking role.

Evelyn Tweed: Thank you. You are sponsored by the Department of Health and Social Care and appointed by the secretary of state. In the proposed bill for Scotland, there will be a parliamentary commissioner who is independent of Government. What is your view on the pros and cons of each of those approaches?

Dr Hughes: My role is independent of Government. Although my office is staffed by civil servants, I am not a civil servant, so we can meet different people. I do not speak for the Government. My financial reporting line is to the Department of Health and Social Care because that is where my funding comes from, but on the operational side, I report to the Health and Social Care Select Committee.

I think that that gives me independence. I will have an independent website. Members of the public will be contacting me and the responses that I give are independent of Government.

It is also important that I have good, close connections, not only into the Department of Health and Social Care but into the ministers, as well as into the regulators, the providers and others. It is the small changes that are going to happen across the whole system that will add up to the major changes.

I feel very lucky to have the arrangement that I have, because there is something about being independent without being isolated. It is really important to be able to build good relationships into all different parts of the system. I do not think that that hampers independence.

The Convener: We move on to questions from Sandesh Gulhane.

Sandesh Gulhane: Thank you for coming to the Scottish Parliament, Dr Hughes. My question is about individual cases. I know that you are not responsible for those, but does that lead to frustration with people who are contacting you?

Dr Hughes: I think that for people who get in touch and share information, it can sometimes be a hard message that I am not able to take it forward as individual casework. It is very important to communicate with the public, with patients and with patients groups what my office is there to do.

I would also say, having had a previous role in which I did investigations and casework, that there is a risk of having such a remit in that you cannot investigate every single person's experience, and there will be others in the system who might be able to do those investigations. The risk is that you either end up with a huge backlog on a waiting list or you must select the cases that you can investigate. All of those factors lead to a feeling of unhappiness in some people.

I do not think that there is any perfect solution. However, we make it clear to people who get in touch that, although we do not have an individual casework role and cannot investigate their cases, we can signpost them to parts of the system that can. I am keen that patients, many of whom have faced difficulties as they have been bounced around the system—which is quite a complex and baffling one—have a warm handover to the right part of the system. I know that you heard earlier from the General Medical Council in that regard. There are many examples of people coming to my office and being supported to the appropriate part of the system. That is also about treating people with care and respect.

Sandesh Gulhane: I understand that you are not able to take on individual cases. However, I go back to the idea of a golden thread. If, for example, multiple people come to you from different parts of the country and present you with a similar issue, will you unfortunately miss that because you cannot investigate individual cases, or do you log the information to see whether there is a golden thread that you are able to pick up?

Dr Hughes: We are still in early days, but we have been logging information regarding the themes that people have contacted us about—and we have often had patient groups contacting us about multiple cases that have similarities between them—and I have been able to speak to senior officials at, for example, the MHRA about particular concerns.

It is not necessarily going to be for my office to look into those details, because there are other organisations that have that remit. From my perspective, it is about our having a really good understanding of the health system so that we are clear about the appropriate part of the system to investigate whatever aspect has been raised. For example, if the issue is about professional practice, it will be investigated by the professional regulators; if it involves concerns about a particular device or medicine, it will be investigated by the MHRA; if there are broader patient safety themes, the matter will go to the national director of patient safety; and if it is about an individual national investigation, it will go to the Healthcare Safety Investigation Branch.

I think that the fact that we have multiple organisations that each have their own part to play shows the complexity of system. What is important is that we speak to one other and meet regularly and are able to understand the remit of one other's organisations and roles, so that we can be effective in supporting patients who have concerns.

Sandesh Gulhane: It is reassuring to hear that you are all speaking—one would expect you to, of course, but it still reassuring.

I suppose that the question is about the investigation. You said that you had previously been in areas where a lot of investigation was done, and that takes a certain amount of skill, time and resource to do. I appreciate that you have been in post for only 100 days, but do you feel that your role is to find those themes and perhaps pass them on to the relevant organisation, or do you feel that your job is to move on to the ones that you want to investigate further?

Dr Hughes: I would slightly shy away from the word "investigate", because I will not have an investigative function, but I hope to have a function in my team to do research, to horizon scan and to see where the concerns are at an early stage. One of the features that I see in "First Do No Harm"

and other reports is that it can sometimes take years or decades for patients' voices to get to the point at which they are heard and acted on. I am keen for us to get to a situation in which having patients' voices included in the design of services is business as usual and people's concerns—whether they are raised with a trust or another part of the system—are listened to, acted on and shared, so that we can get learning from them across the whole system.

There are multiple different strands of information that are coming through—from, for example, the MHRA's yellow card reporting system—and I am keen that we use and maximise the opportunities through those learning systems, the national patient safety strategy and the data that the Care Quality Commission has, so that we are able to spot things earlier, believe what we are told, which is a very important part of this, and then follow up.

Sandesh Gulhane: We heard from Dr Williams of the RCPG, who was on the previous panel, about the primary and secondary care interface. I think that that gap exists in all health services—it is not exclusive to Scotland; it is also in England, Wales and Northern Ireland. Are you able to focus on and make contributions on that, or is it about finding the relevant person to pass concerns on to?

Dr Hughes: As a GP, I am fully aware of the gaps that can happen between providers of care. Part of it is about having an understanding of the entire patient pathway, so it should be really clear that information is shared. I see the development of digital systems that are really enhancing that, for example. There are 237 million medication errors a year in the NHS. That is partly to do with the digital systems, which mean that people have to transcribe information again and again.

I am really looking forward to having an area on the website in which we are able to share examples of good practice so that organisations that are looking for innovation and inspiration will be able to find out what is happening in different parts of the country or in different countries, take that on board, and incorporate that good practice into the care that they provide to their patients. I see examples of really innovative practice in that area in which the patient record is visible across the whole patient pathway. With the right safeguards in place, that is the sort of thing that would really help to remove some of the gaps in knowledge.

As a GP, I am able to log into and have a look in the hospital system. That sort of thing can really help to reduce the pressure and the stress on patients and to keep people safer.

Gillian Mackay: Earlier on, you mentioned communication. There is an interesting line that you might already have had to walk, or that you might have to walk in the future, between individual cases that people believe indicate wider patient safety issues but the investigative body believes do not, and stories of multiple cases that patient groups have talked about happening over and over in different places. How do you see your office, and you as the commissioner, communicating to people—who have often been traumatised as a result of their treatment—where the line is between individual cases that involve an individual failing and individual cases that might have wider implications for patient safety?

Dr Hughes: That is a really good question. That is very difficult. The other interesting area that I have come across from patients who have contacted me is cases in which there has not been a failing in the treatment—in the sense that it has been used according to all of the licence, there has been no recklessness and the indication was correct—but there is a known and recognised side effect that can be catastrophic.

It is about having good relationships with the regulators, understanding what is already known and what steps have already been taken, and opening mindsets so that we are able to look at things in a patient-centred way. The more we can get the patient voice into all the different aspects of care—the provision and regulation of care and all the other areas—the better. I have been really pleased that, when I have asked officials in various organisations and healthcare leaders how they listen to patients, people have been really open to the idea of incorporating the patient voice. That is the sort of movement in the system that I am looking for. I am looking for us to get patient safety as a higher focus in our priorities, to see patients as partners, and to see shared or supported decision making as the destination that we are aiming for.

Some organisations are already there; others are not quite there but are open to looking at things differently. By doing that and making sure that the patient voice is a significant and contributing part of how we design and deliver the services, it will be easier for organisations to attend to early signals when concerns are brought to their attention.

11:00

Emma Harper: I have a quick question. Looking at the report on your first 100 days, I see that concerns have been raised about electroconvulsive therapy and Covid vaccination. I am the co-convener of the cross-party group on mental health, and the ECT issue has come up with us, as well. There is a lot of fake news out

there about Covid vaccines. Will your role help with concerns where evidence issues need to be addressed? Will it combat fake news, for instance?

Dr Hughes: The word "believe" is important in this, because people have concerns and need to be listened to. At the same time, we must be clear about the evidence base, although people can still have concerns. For example, on Covid vaccination damage, the concerns that were brought to my attention were about delays and problems that people had encountered with the redress system.

It is important to keep an open mind so that it is possible to hear what people's concerns are and to ensure that people get the opportunity to express what they are looking for help with. That is where the value of working with parliamentarians comes in, because people go to their MP or an all-party parliamentary group, which results in a body of patients who have a particular concern, rather than there being an individual concern. Similarly, when it came to electroconvulsive therapy, concerns were about its regulation.

I do not want to miss the next pelvic mesh, sodium valproate or Primodos. That is about my team having supportive and challenging conversations so that we continuously keep an open mindset. When we look back at the history of patients not being listened to, we see so many examples over the decades—and not just of medicines and medical devices. It is easy to shut people down; the hard thing is to keep an open mind. That is my position.

Emma Harper: Earlier, you talked about the value of your independence, and you are talking about listening to people and hearing their concerns. Are you already finding that people are engaged with and have trust in the role of patient safety commissioner for England that has been created?

Dr Hughes: The patients to whom I have been speaking—I have met a lot of patients and I have been listening hard to their experiences—have been let down so badly by different parts of the system that to build trust in a brand-new role is quite a difficult thing to do. I have been overwhelmed by the incredible generosity of the patients who have been helping me, providing information, wanting to meet and share their experiences, and looking for this listening and supportive role.

Given the volume of people who have contacted us and the size of my team, it has been beyond us to follow up as much as we would like to do and to support all the different patients and patient groups. That is really tough, because, when somebody has already been to lots of organisations and been told, "Nothing to see here", and then they come to the patient safety commissioner and we say, "We would love to help but, with such a small team, we are not able to do it", it is challenging to maintain a good relationship with those patients. It is only because of the incredible generosity of the patients who have contacted us that we have been able to do that.

I am keen that we help many more patients and patient groups. I am looking forward to going out over the next year and doing public engagement events at which we can meet a wider group.

However, a lot of concerns that have been put on ice over the years are still unresolved and they are coming to me and my office.

Emma Harper: Thank you.

Paul O'Kane: Thank you and good morning, Dr Duncan and Dr Hughes. I am interested in the particular powers that you have in your role and the powers that we might seek to provide to our commissioner in Scotland. When we talk about the establishment of a commissioner, everyone shows that they are keen that the commissioner should have teeth; that expression is used quite a lot. What powers do you have? Are there any powers in your role that you would like to be expanded? That is quite an open-ended question.

Dr Hughes: The powers that I have are to request information and to make recommendations. The power to request information is an important one, but I hope not to have to deploy it, if that is the right expression, because I hope that organisations will be keen to work in partnership and set the shared objective of keeping patients safe and that they will see sharing information as an important part of that.

When it comes to making recommendations, I am aware that the health service and the health sector as a whole are under enormous pressure. As I said earlier, there are many different organisations that are all making recommendations, so there is a risk that the situation could be confusing, contradictory or burdensome. My hope and expectation therefore is that, if I make recommendations, they will be not burdensome but more inspirational in the sense that they will be for organisations to accept gladly and see the value in, and that they can do that while understanding the context of what is happening in the service and of the other recommendations that might be being made on the system. It is difficult for organisations that have 95 recommendations to prioritise, so they might just pick one. It is about understanding where in the system I might make a recommendation and what the read-across would be for the rest of the system.

Paul O'Kane: Thank you for that overview.

This morning, we had an interesting discussion with representatives of people who work in health and social care about whether the recommendations that are made to organisations and staff have to be more binding, being cognisant of the whistleblowing nature of making whole-system and lasting improvements. In your experience so far and your initial assessment of the role, would it be useful to you, and to us in the Scottish context, to have the ability to make binding recommendations or enforcement orders?

Dr Hughes: When we speak to people in the health service or across the wider sector, we hear that there is always a risk around whether something is a "should" or a "must", and that people only have time to do the "musts", so what do we do with the "shoulds"? That speaks volumes about the pressure that is on the service.

On the converse of that, a huge number of allies are already doing fantastic work in the system. Part of this is about ensuring that they have the support, information and resources to be able to get on and do that good work.

Therefore, part of the role that I see for myself is adding to that support, adding to that information through the website and encouraging leaders to see safety as a really high priority in their organisation, not as an add-on. There are a lot of pressures on leaders at the moment, but I am really keen that safety is seen as a core part of our business, so that we are in the preventative space rather than dealing with mitigating the consequences.

Using powers, fines or enforcement feels like quite a punitive thing to do. I am keen to encourage, support, suggest and influence in that much more positive space. Clearly, if I find that there are parts of the system from which I am not receiving the information that I am asking for, or that a recommendation is not being followed, that would be about looking at where the other powers in the system are and working collaboratively with the other regulators in the health system.

That is the take, I would say, because, in my experience, having a just culture and a positive and encouraging way of doing things is more effective than deploying powers in the first instance.

Paul O'Kane: Do you sense that patients have responded well to that approach, in terms of feeling that they are getting to the answers and results that they need through that more collaborative and encouraging approach, or is there a sense that they want to see an option of last resort, almost, in terms of being able to enforce things?

Dr Hughes: It is still early days for me, and the organisations that I have approached for information have responded. I am hoping that we will be very much in that space most of the time. I think that there will be times when the powers will need to be used, but I have not got to that point yet.

Paul Sweeney: Thank you, both, for attending. What you have said so far is interesting. You said earlier that you would publish best practice, for example, against which health authorities could benchmark and perhaps implement recommendations. Do you feel that there should be some sort of mechanism for escalation, if there is something so egregious, or some area of injustice, that you feel needs to be urgently addressed, which cannot merely be left to collegiate discussion or recommendation?

It would not necessarily be you issuing an enforcement order, as the Health and Safety Executive does, for example. Perhaps, in your case, it might be a recommendation to the minister that they should use a statutory instrument to implement changes, or, in the case of the proposed commissioner, it might be a recommendation to Parliament to do that. While bearing in mind that there is a need to foster openness and inclusivity to avoid people shutting down and feeling as though they will be attacked if they dare to raise issues openly, do you feel that a potential mechanism for escalation is important? Do you feel that there is a balance to be struck in terms of escalation?

Dr Hughes: Absolutely. As I said, there are powers that already exist in the system. There is the emerging concerns protocol, which is where the regulators can get together and share their understanding of a particular concern, but there is also the opportunity to encourage other organisations to use the powers and instruments that they have. That is where the role of the commissioner is really important, because it is about having a deep understanding of the powers that exist in the system already and encouraging organisations to move forward with those.

It is still quite early days so it is hard to say, if I was to get a knock back on encouraging another organisation to use an instrument that it had, where the next step of escalation would be. My reporting line is into the select committee, which is a really important aspect. I also have the annual report, where I am able to share all the detail as well. Multiple paths already exist in the system. It is partly about understanding the powers that others have, but it is also for others to understand the powers that exist in the system and to work collaboratively towards a shared goal.

Paul Sweeney: That is helpful. It is a help to know about the line to the select committee, which is something that we can reflect on.

11:15

The Convener: Our final theme is resourcing. The questions will be led by Sandesh Gulhane, and Paul Sweeney also has some questions.

Sandesh Gulhane: My first question is very straightforward: do you feel that you have enough resources?

Dr Hughes: I will bring in my chief of staff, Gary Duncan, if that is all right.

Dr Gary Duncan (Patient Safety Commissioner for England): Thank goodness I am here.

Henrietta Hughes already touched on the fact that, when you are setting up a new office, it is very important to begin with a relatively agile team. If you had put 20 people in our office on day 1, I do not know what they would have done. They would probably have run around like headless chickens, except that we did not have an office space to run around in.

You have to start with something relatively agile to be able to set up the initial process, which is what we have done. Henrietta talked about looking for office space and setting up a website. We have recruited an advisory group and will do a public consultation on the principles that will underpin the role, which is another statutory requirement.

Moving on from that, there is the question of what the office needs to be successful. There is a continuum from that starting point. How much work do you want the office to do? The more people you have, and the more structure you put in place, the more you can achieve. That does not mean that a small team cannot achieve impactful results. Any patient safety commissioner in Scotland would need to consider that.

The commissioner will also have to consider how to structure their work. Members asked about investigations. We have said that we do not see ourselves carrying out investigations. Henrietta and I have discussed having a policy unit, a strategy unit, a business management unit to look after functions and processes such as data protection, and a data and analytics unit. Those are the four functions that we think we need in order to be successful.

When we know the size of those, we will be able to assess whether we can take on all the tasks that we are being asked to do or all the issues that are being raised by patients. If there are things that we cannot do, we must consider how to most effectively signpost people to the right part of the system. As we have said already, there are some areas for which we can do that quite clearly. At other times, just shining a light on the subject can be impactful. I have noticed that many of the patients we have heard from are pleased that someone is listening. That in itself, and the directing of a little attention to an issue, can still have a big impact.

We have started small. We will be looking to expand in the coming months and years. To my mind, that is the most effective way of setting up: be agile at first but have a plan for expansion and growth.

Sandesh Gulhane: Do you have enough resources to be able to expand as you want to?

Dr Duncan: We would need expanded resources if we wanted to take on further work.

Sandesh Gulhane: The remit for the Scottish commissioner is already a bit bigger than yours. A lot of people have come to the committee and asked for other things to be included in that remit, so the role seems to be expanding. Do you feel that our current budget and resource will be enough, or do you feel that it will be okay for the initial phase, with an agile team, but that we would need scope for future expansion?

Dr Duncan: That is a question for your new commissioner, because it depends on where they want to focus their priorities. One of the great things about the role is that there are many different ways to do it. A benefit of the way in which we have operated is that Henrietta Hughes has had the opportunity to set her own priorities and consider how she wants to set up her role.

It is hard for me to say, but the new commissioner can decide how they want to set up their team and what they think they need. That is the most effective way to do it.

Sandesh Gulhane: You have a set budget and you report to the Health and Social Care Committee. Do you feel able to tell that committee what you have found out so far and what you need to be able to go a little bit further or, because your funding comes from the Department of Health and Social Care, do you have to take that route—or do you have to take both routes?

Dr Duncan: I would say that we take both routes, but I will hand over to Henrietta Hughes.

Dr Hughes: The role is already very visible. A lot of people have got in touch and there has been a lot of activity. You may have read our report; there is plenty going on.

It is important that any new role has the opportunity to thrive. I am not just talking about the people in the team; it is about the concept of the system welcoming a new and better way of doing things, which includes patients. I hope that that will allow us to move away from always looking back at the problems that have happened in the past so that we can look forward in order to get into that preventative space.

In conversations around funding, the Department of Health and Social Care is very aware of what we are asking for. When I raise the issues that I am hearing from patients, it is important that the department listens and that we get that expansion that Gary Duncan described. In the final select committee hearing on "First Do No Harm", the witnesses were very clear to the Health and Social Care Committee that the resources in the set-up phase of the commissioner's office are too small to allow it to continue with the ambitions for the future. Both routes are important. However, we want to support not what is important for the office but what is important for the patients.

Sandesh Gulhane: Thank you.

Paul Sweeney: I want to pick up on the point about resourcing. Budget and head count are one thing, but understanding the competences that you need in the team is critical. There is a huge risk of data inundation and having to make sense of large volumes of information. Have you given much thought to how you can build a process that is resilient enough to draw meaningful conclusions from what is being fed into your office and how you process that? We have a major concern about how that can be managed by what is, initially, such a small team.

Dr Hughes: I will start and then hand over to Gary Duncan. It is not just about the data that we have—there is also a huge amount of data in the Care Quality Commission, the MHRA and other parts of the system. People have been incredibly generous and have said that they would like us to be able to work with their data. That is where partnership working has real value. It is key that we have a data and digital function in my team, so that we can use and manipulate that data in a way that can bring fresh insight. That will help the system to attend and listen to things that it may not have been aware of in the past. Another issue is data protection and ensuring that we can respond to requests in a timely way, under our statutory obligations. I will hand over to Gary Duncan to talk about the support that we get from the Department of Health and Social Care in responding to requests.

Dr Duncan: We are independent of the Department of Health and Social Care, but we make use of its expertise and advice on how we should handle things. We follow some of its processes as best we can—there is no reason why being independent should deter us from following the robust processes that are used in the department. The department is very supportive and we appreciate that.

Henrietta Hughes is right to say that, without a data analytics function, the novel insights that a commissioner could have would be limited. There are things that good-quality policy and strategy professionals can do with the data that exists, but we are keen to do something a little more sophisticated. That would require that high-level strategic function and data analytics capability within our team to identify, gather and analyse data to produce novel insights.

Paul Sweeney: I am thinking about the need for a combination of powers and the capacity to gather meaningful insights. Let us take, for example, the transvaginal mesh scandal, where the patient voice was ignored and not heard by the data collecting mechanisms in the Scottish national system, which meant that patients found themselves at a loss to express their concerns beyond petitioning Parliament—it was only then that an inquiry was pursued. Do you see the need to advise change in the way in which data is collected and managed? If you were hearing qualitative insights from patients, but you did not have the quantitative information to verify whether there was a wider national issue, would you be able to recommend that such information would have to start being collected at a certain point in the patient journey in order for us to understand over time whether there was a wider concern? Would you consider such a mechanism necessary?

Dr Hughes: I am already having conversations with the team at NHS England who are leading on the registries. That is a substantial step forward—indeed, it was recommended in the "First Do No Harm" review—but it is not just about saying what device is going into which patient on which day; it is about establishing patient outcome and experience measures, too, which take time to develop. We are looking for that culture shift to make it clear that we are as interested in what patients are saying as we are in other types of evidence that already exist in the system. If we are not getting or gathering that feedback and bringing it into how we look at the outcome of a procedure or treatment, we will be missing substantial evidence.

I do not think that there are any quick fixes in that respect, but I think that a substantial part of this is having a shift in mindset and finding out how we can have a health system in which we are able to incorporate information from incident data, complaints and other types of feedback as well as research to ensure that there are really robust ways of measuring these things and assessing the patient-reported outcome and experience measures.

Paul Sweeney: Thank you.

The Convener: I thank Dr Gary Duncan and Dr Henrietta Hughes for their time this morning.

I will not pause before we move on to the next item on our agenda. Our guests can leave or

stay—it is up to them—but I am going to move straight on.

Petitions

Rural Scotland (Healthcare Needs) (PE1845)

11:26

The Convener: Agenda item 3 is consideration of three public petitions. The committee took evidence on the petitions from the Cabinet Secretary for Health and Social Care on 17 January, and I will go through them one by one. Members should let me know whether they wish to comment on any of them.

The first petition is PE1845, which calls for a health agency to advocate for the healthcare needs of rural Scotland. I believe that Emma Harper wants to come in first, after which I will go to other members.

Emma Harper: I am well aware of this petition; I was at the Citizen Participation and Public Petitions Committee meeting at which it was presented by the petitioners, and I know that other members in the room were there, too. I know the history behind it, and I am keen that we do not lose sight of rural health and social care needs and that we hear people's voices.

The example that I have before me is the experience of people in Stranraer. A key issue that the petitioner has been trying to raise for 20 years now relates to the fact that NHS Dumfries and Galloway is part of the south-east cancer network and that, as a result, patients in the south-west of Scotland—which isnae in the east of Scotland—end up having cancer treatment in Edinburgh instead of at the closest cancer centre for radiotherapy, which would be in Glasgow. It means that, instead of just going up the road to Glasgow, people who are undergoing radiotherapy or other cancer treatment have to travel a distance that is pretty hefty for them.

My understanding is that, for 20 years now, Dr Gordon Baird, who is a retired GP and former chief medical officer at the Galloway community hospital, has been trying to look at ways in which we can hear the voices of people who live in remote and rural parts of Scotland, particularly Dumfries and Galloway—although, as we can see from the other petitions, the issue goes wider than that to, for example, Caithness. The question is how we support what is best for patients; it is not about telling them, "You'll get your treatment where we tell you," but about giving them the best opportunity to get the best care where they choose and reducing the issue of travel.

Currently, the people in question are means tested for their travel, whereas those in other parts of Scotland are not and get their care without

having to cough up from their own finances. That is a health inequality issue, too—means testing people for their care should not be happening.

There are other issues regarding maternity services. I know that a review of the midwifery-led service in Galloway is happening right now because no baby has been delivered in Stranraer for four years. That is similar to the issue at Dr Gray's hospital, which has been raised in the chamber of Parliament on a number of occasions.

11:30

My concern is that, for 20 years, little progress has been made to hear the voices of the people who live in remote and rural areas, whether that is in the area that NHS Dumfries and Galloway covers or more widely. If we in the committee do not keep the petition open and hear from witnesses, I am concerned that we might lose sight of what the real issues are for people in remote and rural areas.

The Convener: I want to press you on the substance of the petition, which makes a targeted call for an agency. We need to decide whether to take evidence on the idea of having an agency. Are you talking about taking evidence on the wider aspects that surround the call for an agency?

Emma Harper: I know that the Cabinet Secretary for Health and Sport said that he did not want to

"clutter a landscape"

that

"already has a fair bit of bureaucracy around it"—[*Official Report, Health and Sport Committee,* 17 January 2023; c 14.]

through the organisations, agencies and institutions that we already have. I am aware that the establishment of an agency is not the route that the cabinet secretary wants to take. I suppose that the big issue is how we ensure that rural voices are heard. We have raised the issue in debates and through questions in the chamber, but how do we get rural voices heard if we do not continue to pursue evidence taking?

I know that the petition calls for the establishment of an agency. I need to understand whether we need the petitioner to submit a new petition that addresses the specific issues with remote and rural healthcare rather than calling for an agency.

Sandesh Gulhane: I will make a wider point to start with before focusing on the petition itself. The dedication of our staff who work in remote and rural areas is without exception. They are extremely dedicated and work very hard. However, despite their hard work, I feel that our patients who live in remote and rural areas get a far worse service than those who live in urban communities. There are a number of reasons for that, and Emma Harper has mentioned a few of them, including travel and there not being the required expertise. We also know that there is a lack of staff in remote and rural areas in comparison with urban areas. That applies to nurses, doctors and GPs. Retention is also important in those areas.

I have done a GP shift in Dumfries and Galloway, so I know that travel is one of the issues. When I drove to my shift, the road was flooded. At one point, I genuinely thought that I was going to drown. Admittedly, there was a storm. Patients face travel issues day in, day out in rural areas. What we offer is not good enough.

I would advocate our looking into rural healthcare generally and having an inquiry that would incorporate a lot of what we have spoken about and a lot of what the petitions highlight.

On PE1845, I am not sure that an agency is the way forward. However, I think that the issues that it raises need to be part of our potential work on rural healthcare.

Paul Sweeney: As a former member of the Citizen Participation and Public Petitions Committee, I recall sitting in the session on 8 June 2022 with Gordon Baird and others in which we took evidence on four petitions covering rural healthcare. It quickly developed into a much more effective and quality discussion. It did not just home in on the idea of an agency but took in the broader issue of the agency of patients to advocate for themselves and for clinicians to advocate on their behalf. In particular, it focused on the power imbalance between health boards and other stakeholders in the system.

In that respect, the petition remains relevant, so there is scope for the committee to consider how we take those legitimate and sincere concerns forward. Although it is inevitable that inequalities will exist by virtue of geography in any healthcare system, because you cannot have a fully functioning neurosurgical department in a town of 100 people, we nonetheless need to look at ways in which we can mitigate those issues effectively.

Where changes to service provision are occurring, are we effectively ensuring that ambulance provision, travel allowances and protocols are in place to reduce the risks of, for example, going into labour in a way that means that someone is dangerously far from a maternity department? We should be cognisant of all those issues, which I do not think are necessarily being fed back into the healthcare decision-making system through health boards. Perhaps that is where this committee would have a locus in

helping to further the petitioners' concerns. That would be my suggestion.

The Convener: With regard to the substance of the petition's calls for an agency, are you of the view that Sandesh Gulhane has just expressed, which is that we could close the petition but look at the issues that brought the petitioners to lodge it?

Paul Sweeney: When we had the discussion at the Citizen Participation and Public Petitions Committee, the petitioners were not committed hard and fast to the idea of an agency. They were happy to row back from that opening gambit. I do not know whether there are technical rules around this, but I would be content to keep the petition open with an understanding that we could look beyond the simple ask for an agency, because the issue is the concept of who has agency in the system.

The Convener: The protocol is that the committee must decide either to take forward the petition, which means looking at an agency, or to close the petition and then make a decision about further scrutiny of the more general issue of rural healthcare that has been raised. We could absolutely do that—we can discuss that when we discuss our work programme.

I believe that NHS Dumfries and Galloway is one of the health boards that will come to the committee in due course as part of our general scrutiny of health boards. Therefore, a lot of the issues that Emma Harper has just raised—the issues that that health board area is facing and the decisions that have been made there—can be put directly to that health board.

With regard to petition protocols, we either take further evidence on the idea of an agency or close the petition. That would not preclude the petitioners from coming back with a new petition based on something that we find out as a result of any further work and scrutiny that we might do as part of an inquiry or whatever.

Paul Sweeney: My view is that we are not bound to the petitioners' specific ask, and an inquiry would give us a useful basis on which to roll the issues forward. We can still retreat from that. In my view, it is not a binary thing, in that we have to agree whether there should be an agency or not. We can certainly take on board—

The Convener: Protocol-wise, either we keep the petition open or we close it. If we keep it open, we have to go forward on the basis of what the petition asks for. Closing it would not mean that we would forget everything that was in the petition. We can take the learning and evidence from the petition as part of a wider inquiry and roll it into that work, so we would not be dismissing it or the things that people have said about it.

Sandesh Gulhane: I just want to make it clear that I would like to take evidence from Dr Baird, but as part of that wider work.

The Convener: Yes—as part of a wider inquiry.

We take cognisance of and pay respect to the fact that the petition was lodged. As Paul Sweeney says, the petitioners were not really wedded to the idea of an agency but wanted the issues to be looked at, so they might be quite happy with that. That does not preclude them from deciding, "We have not changed our minds and we are going to bring back a new petition, exactly the same, and get this looked at again because, as a result of the work that the committee has done, we feel the same."

Paul Sweeney: If the impact of the petition is that the committee holds a related inquiry, it will have done its job in a way. In that sense, perhaps whether or not the petition is kept open is not such a big deal. I would be content to rest on that.

Emma Harper: I know the work that Dr Gordon Baird and the Galloway community hospital action group have done to get the petition to the Parliament, and I know that local people feel powerless. I know that Professor Sir Lewis Ritchie is interested in how Australia's National Rural Health Commissioner works—Australia is also a big rural country. I also know that a centre of excellence for remote and rural medicine is being created, but it does not have an advocacy role. That is what Professor Sir Lewis Ritchie said when he gave evidence.

The proposed agency is not about picking up individual casework. That is not what Dr Gordon Baird was after when he asked for an agency to be created. It is about advocating for and giving a voice to people who feel powerless and who do not know that, for example, they should be offered a choice of care that might be closer to home. That is one of the challenges.

NHS Dumfries and Galloway committed to addressing cancer care pathways and then Covid came along. Therefore, when the board comes in front of us, we will need to ask specific questions about where it is with altering cancer care pathways and what steps it has taken. This is not about addressing all the challenges overnight. I know that there are real challenges—everybody does; I was a healthcare clinician as well.

I am keen to ensure that, whatever pathway we take, Dr Gordon Baird is permitted or invited to give evidence about the challenges for remote and rural healthcare and advocacy for patients.

The Convener: That is a really good point. As you say, there are a couple of reviews going on in the health board area.

Does Gillian Mackay want to come in on the petition?

Gillian Mackay: My comment is not specifically on this petition; it is on the others.

The Convener: To avoid confusion, before we move on to the next petition, we will take a decision on this one. There are too many letters and numbers, and we will all get confused otherwise.

On PE1845, which calls for an agency to advocate for the healthcare needs of rural Scotland, can I have a show of hands of members who want to close the petition with the proviso that we look into doing a wider review, which is something that seems worth while?

I see that a majority of members are in favour of closing PE1845 but with the proviso that we include the issues in a wider piece of work that we might do.

Rural Healthcare (Recruitment and Training) (PE1890)

The Convener: PE1890 is on finding solutions to recruitment and training challenges for rural healthcare in Scotland. The theme is very similar. Gillian Mackay wants to comment.

Gillian Mackay: We should consider the issue as part of a wider piece of potential work. The petition is broad and covers a number of areas.

In the evidence session that we had with the cabinet secretary, we explored why some of the challenges are not purely healthcare recruitment issues but issues to do with life in rural environments in the first place. If we were to incorporate the petition into a wider piece of work, it would be interesting to hear from other ministers about how their portfolios could support recruitment in rural areas and support people to consider working in rural and remote areas. At the moment, it is people who come from or have a connection with such communities who take up recruitment and training opportunities and then go back to the community, rather than our making working in those areas an easy choice.

Sandesh Gulhane: I reiterate what I said about the previous petition. I think that we should also fold this petition into our potential look at rural healthcare.

I agree with what Gillian Mackay says about the other issues and about listening and talking to other ministers. As I said, when I was on my way down to Dumfries and Galloway, the roads were terrible. That would put people off going there and moving around. We should certainly ask the Minister for Transport about that.

Further, it is not possible for people to obtain housing in rural and island areas because it costs so much or it is just not available. Those are all factors when it comes to recruitment and retention.

11:45

The Convener: Yes. The petition is on finding solutions to recruitment and training challenges for rural healthcare in Scotland, so it is almost asking for an inquiry.

Emma Harper: I did not think that I would be talking about roads in Dumfries and Galloway—the A75 and the A77—at a meeting of the Health, Social Care and Sport Committee, but the issue is relevant to the many challenges with recruitment and retention.

We must remember that we have the Scottish graduate entry medicine programme. It would be really good to hear how that is working. What is the retention level? Where is that programme doing well? That is part of it. There are also programmes for trained general nurses to become midwives and vice versa, although that is not happening in my part of the South Scotland region because Dumfries and Galloway was not selected for the dual training approach.

Work is being taken forward, but it will not be an overnight fix. I support doing whatever we need to do to look at rural health and social care.

The Convener: Your point about ScotGEM is timely. The first cohort has just graduated, so now is a good time to follow that up and consider what we might do in that regard.

Are there any other comments on the petition, or is everyone more or less in agreement with the points that have been made? Do we agree that we should again bundle the petition into a wider piece of work about rural healthcare, given that all the issues will come up?

Let us take the decision. I ask for a show of hands of members who are in favour of closing the petition but with a view to doing a wider inquiry.

I see that we agree unanimously to do that.

Women's Health Services (Caithness and Sutherland) (PE1924)

The Convener: The final petition that we are considering today is PE1924, which calls for the completion of an emergency in-depth review of women's health services in Caithness and Sutherland. I know that Tess White and Gillian Mackay want to comment on the petition.

Tess White: I note that the petition uses the word "urgently" and that it is dated 20 December 2021. These are systemic issues and I think that

we all agree that they need to be looked at. It is important to make sure that the women feel listened to and that services are not just centred around the central belt. For example, there are two mother and baby units in Scotland and they are both in the central belt. One was supposedly planned for Grampian, but it was kicked into the long grass—

The Convener: That was a perinatal unit. That came up in the inquiry that we did.

Tess White: I think that it is very important for us as a committee to progress something specifically on women's health in rural areas.

The Convener: You are calling for us to do something specifically on women's health and not just something as part of work on rural healthcare. I am not sure that the committee has the scope or the capacity to do two separate pieces of work on rural healthcare. I think that it will have to be one larger piece of work that encompasses women's health.

Tess White: I will make two points. First, we now have the women's health champion, which is a major step forward. That was not factored in when the petition was lodged. It would be interesting to find out what the women's health champion's thoughts are on the petition.

Secondly, as you say, there is a piece of work to be done on wider rural healthcare issues, but we need to make sure that we do not water down the points that are made in the petition.

The Convener: I totally agree.

Gillian Mackay: On the back of what Tess White has just said, I think that a wider inquiry into rural healthcare services is really important, but I propose that we defer a decision on the petition because of the current work that is being done. The best start north review is based on maternity services in particular, and the minister, Maree Todd, has other pieces of work that are looking at wider issues, including abortion care and other women's health needs. The other pieces of work that are being done could be lost in a wider inquiry. If those things develop, we might want to take evidence on them, and other issues could arise.

Given that those other pieces of work are still on-going, particularly the best start north review, I propose that we defer a decision on the petition so that we can pick it up again if there are other things going on.

The Convener: That is a good point. Someone has only just been appointed to the women's health post, so the committee would want her to come before us anyway. Keeping the petition open is therefore an option, with a view to seeing what comes back from the best start north review and other work.

Do members wish to raise any other points?

Sandesh Gulhane: The petition is focused on one particular area, but we know that there is an issue at Dr Gray's hospital and that plenty of other rural areas have the same issue. Paul Sweeney said that we cannot always have an expert in a small village. However, experts could travel to different areas where they are needed, which would make it easier for people to get the help that they need. I would like expand our wider inquiry into rural health so that we could have an evidence session on maternal health in rural areas.

The Convener: Okay. Paul, do you want to come in, or are we ready to move on?

Paul Sweeney: I have nothing to add.

The Convener: Those were all really good points. Gillian Mackay has proposed that we keep the petition open. Are we agreed?

Members *indicated agreement.*

The Convener: We agree that we will defer our decision on the petition until we have found out more about on-going work. We will therefore keep PE1924 open.

Subordinate Legislation

National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2023 (SSI 2023/19)

11:51

The Convener: The final item on our agenda is consideration of two negative instruments. The Delegated Powers and Law Reform Committee considered both instruments at its meeting on 7 February 2023 and made no recommendation in relation to either instrument.

The first is the National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2023. The regulations reflect a routine annual rise in rates as regards residential care charges, increasing the value of savings credit disregard by 5.4 per cent, in line with average earnings. They also increase the lower capital limit from £18,500 to £20,250 and the upper capital limit from £29,750 to £32,750, in line with the consumer price index forecast of 10.1 per cent. The regulations also disregard payments from the Windrush compensation scheme from financial assessments for individuals living in residential care.

No motion to annul has been lodged. As members have no comments, I propose that the committee make no recommendation in relation to this negative instrument. Are we agreed?

Members *indicated agreement.*

National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2023 (SSI 2023/20)

The Convener: The second instrument reflects a routine annual rise in rates, increasing the value of the personal expenses allowance by 5.4 per cent, in line with average earnings.

No motion to annul has been lodged. As members have no comments, I propose that the committee make no recommendation in relation to the negative instrument. Are we agreed?

Members *indicated agreement.*

The Convener: Our next two meetings, at which we will consider our draft stage 1 report on the National Care Service (Scotland) Bill, will be held entirely in private.

That concludes the public part of the meeting.

11:53

Meeting continued in private until 11:56.

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