OFFICIAL REPORT
AITHISG OIFIGEIL

# Health, Social Care and Sport Committee

**Tuesday 31 January 2023**

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

# Tuesday 31 January 2023

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## HEALTH, SOCIAL CARE AND SPORT COMMITTEE

**4th 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:**

Baroness Julia Cumberlege (Independent Medicines and Medical Devices Safety Review)
Kevin Stewart (Minister for Mental Wellbeing and Social Care)
Simon Whale (Independent Medicines and Medical Devices Safety Review)

**CLERK TO THE COMMITTEE**

Alex Bruce

**LOCATION**

The Sir Alexander Fleming Room (CR3)

# Scottish Parliament

## Health, Social Care and Sport Committee

*Tuesday 31 January 2023*

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

## Decision on Taking Business in Private

**The Convener (Gillian Martin):** Good morning, and welcome to the fourth meeting in 2023 of the Health, Social Care and Sport Committee. I have received no apologies.

The first item is a decision on whether to take item 5 in private. Do members agree to do so?

**Members** *indicated agreement.*

## Patient Safety Commissioner for Scotland Bill: Stage 1

10:00

**The Convener:** The next item is our first oral evidence session on the Patient Safety Commissioner for Scotland Bill.

Today we will take evidence from Baroness Cumberlege, who led the independent medicines and medical devices safety review. Joining the committee remotely are Lady Cumberlege, the review's chair, and Simon Whale, who was a review team member and communications lead.

I will move straight to asking Baroness Cumberlege a question about the review. One of the review's recommendations was on the need for a patient safety commissioner. That is happening in NHS England. Through the bill, the Scottish Government proposes that Scotland will also have a patient safety commissioner. What, in the review, led you to conclude that a patient safety commissioner would be a good way of addressing the public's issues with patient safety?

**Baroness Julia Cumberlege (Independent Medicines and Medical Devices Safety Review):** I start by thanking you for this opportunity, which we very much welcome. I am accompanied by Simon Whale. Simon, Cyril Chantler and I were the panel who went around England looking at safety issues. We also came to Scotland and went to Northern Ireland and Wales, but we were commissioned to look at England.

We were very concerned by what we heard from patients about the suffering that had gone on. We were told heartbreaking stories, so we thought that something must be done. We thought a lot about it and decided that there should be somebody—we used the name "patient safety commissioner"—whose whole remit was to talk with patients, to listen to them and then to act to ensure that services would be much safer in the future.

Simon Whale will come in.

**Simon Whale (Independent Medicines and Medical Devices Safety Review):** I echo what Baroness Cumberlege has said. We found that the healthcare system is disjointed and it is siloed. It is too often defensive and it was not listening to patients who had suffered avoidable harm. As Baroness Cumberlege says in the foreword to the report, we saw the patient safety commissioner as the "golden thread" that would link the system together and hold it to account.

The commissioner needs to be independent of the system and to have the resources to do the job properly. Its focus and remit needs to be on

patient safety, on detecting trends that cause concern, and on getting the system to act promptly when the commissioner detects such trends.

**The Convener:** My colleagues will ask questions later about the difference between what is happening in the English NHS with regards to the remit of the Patient Safety Commissioner and what is proposed for the Scottish patient safety commissioner.

During your deliberations when deciding on whether to have a patient safety commissioner, were there discussions about alternatives? Was anything discounted or put in the mix that you thought might be a way forward that would not go down the route of creating a patient safety commissioner?

**Baroness Cumberlege:** Of course, our review was comprehensive. We spent two and a half years going around the country and listening to people—professionals as well as users of the service. We felt that the system was disjointed and that it needed somebody who would pull it all together—who would be that golden thread—and ensure that safety was at the top of everyone's agenda.

Having appointed Henrietta Hughes as Patient Safety Commissioner for England, I have to say that she has made remarkable progress already, and we have been hugely encouraged by how she has embraced that new role, because it is the first such commissioner for us in England. I am not sure that there are many across the world—although I do not know, because I have not done the research. Certainly, she has taken it extremely seriously. Of course, we had a comprehensive and competitive system in order to appoint a commissioner.

**Simon Whale:** We felt that having a patient safety commissioner was the only way to ensure that the system could be held to account. We did not believe that an existing organisation or person within the system would be able to do the job in the way that an independent patient safety commissioner could do it. That is why we came to the view that we should recommend the establishment of a patient safety commissioner.

**The Convener:** Thank you. That is a helpful starting point. The independence of the commissioner seems to be the paramount reason for taking them out of the system, so that they can be, I suppose, the watchdog of the system, on behalf of patients. It is helpful to know the process and why you came to that conclusion.

**Emma Harper (South Scotland) (SNP):** Good morning. I am interested in the remit of the patient safety commissioner for Scotland, and in comparing it with the English commissioner's remit. We have lots of commissioners in Scotland. According to my notes we have, for example, an equalities and older persons commissioner, a veterans commissioner and the Children and Young People's Commissioner Scotland. I am interested in how the proposed role would work with all the other commissioners and how it would be different.

**Baroness Cumberlege:** We, in England, also have commissioners—the Children's Commissioner for England and so on—but the Patient Safety Commissioner for England is the first that we have had within the health system. Certainly, we feel that it is very important, as Simon Whale said, to have somebody who is independent and outwith the system. We did not want somebody who was just a creature of the Department of Health and Social Care, for instance. We wanted the independence that a patient safety commissioner could bring.

We not only felt that the role would be important in holding the system to account; we also wanted to ensure that it was a statutory authority. It was not just a good idea; it had to be in legislation—and, of course, it is.

We also felt that a patient safety commissioner would have to have a very broad remit. I have to say that one of our concerns, even now, is the resources that are allocated to the commissioner, because it is a big job—it is the first time—[*Inaudible*.]

Henrietta Hughes, who is the commissioner, is still having to recruit staff and to set up the systems that she wants, because the role is, clearly, outwith the usual systems—for example, those of the Department of Health and Social Care. She is very independent. That is critical.

**Emma Harper:** I have another quick question about the remit. The committee has been looking at mesh harm and issues to do with sodium valproate. That work could be expanded. I am interested to hear your opinion on whether the proposed patient safety commissioner should look at wider issues, beyond medicines and medical devices. Our bill talks about forensic medical services, but I have concerns about rural issues, including the safety of a population that has, in engaging with the health service, longer distances to travel than people in urban settings have to travel.

**Baroness Cumberlege:** Being married to a farmer, I cannot but agree with you that rural issues are very important.

To begin with, I note that because there has been so much suffering, there was much to do in the areas that we examined. We wanted to start with them. One subject was Primodos, which was a medication that was given to women and which had poor results for babies. Another issue is

sodium valproate, with which we are still struggling. Doctors are still prescribing it and pharmacists are still dispensing it, but we know that it is damaging. The primary issue—of course—is mesh, which is a huge problem that has caused terrible tragedies for women and their families and babies.

**Simon Whale:** In our report, "First Do No Harm", we recommended that a patient safety commissioner focus on medicines and medical devices including the three that we examined in our review, but not limited to them. Henrietta Hughes's remit covers all medicines and all medical devices. It does not go further than that. We originally said that the remit should not go further because we felt that that scope was huge enough in its own right. In our report, we did not rule out the prospect of a commissioner taking on a wider remit. As the commissioner gets established and her resources come on stream, that will be perfectly feasible.

In answer to your question, there are plenty of aspects of healthcare, beyond medicines and devices, that have safety concerns or safety implications. In principle, therefore, the patient safety commissioners in England and Scotland should have the power and the opportunity to examine all the various aspects of healthcare—not just one or two of them.

**Tess White (North East Scotland) (Con):** I had two questions, but the second has just been answered, so I thank you for that.

My understanding is that the proposed approach in Scotland would mean that the commissioner would not consider individual cases but would instead monitor systemic issues: you have talked about the golden thread.

The "First Do No Harm" report emphasised that a patient safety commissioner should be a public leader with a statutory responsibility to champion the value of listening to patients. Are you satisfied that the approach that would be taken in Scotland would satisfy that recommendation?

**Baroness Cumberlege:** Yes, I am satisfied. I have read the bill that is before the Scottish Parliament and I agree with all of it. It is extremely well put together and much more detailed and prescriptive than what we have been doing. What you have done is extremely helpful to us.

The question about individual cases is quite difficult. If you get bogged down in individual cases, you get into inquiries and all the rest of it, so we saw a patient safety commissioner as having a broader role. We wanted that person to look across the whole piece. Of course, the commissioner will come across cases—cases have already been referred to this morning—but they are used to assess trends and to see what is happening across the piece. It is not for the commissioner to investigate individual cases. We already have the ombudsman and various other organisations and individuals to do that. We saw the commissioner's role as being different from what we already have.

**The Convener:** Paul Sweeney has a question on the remit.

**Paul Sweeney (Glasgow) (Lab):** Thank you for your comments so far. It is clear to me from reading the background to your report and the report itself that there are gendered aspects to complaints, in particular, and that harmful side effects seem disproportionately to affect women. How can specialised gendered consideration of complaints be not overlooked, given the otherwise vast remit that the commissioner will no doubt be undertaking and the volume of complaints that will be received?

**Baroness Cumberlege:** I might pass that question on to Simon Whale, actually.

I believe that the healthcare system has to deal with everybody, so it becomes quite difficult if we divide it up according to different genders and so on. I am not sure that that is a good idea.

10:15

**Simon Whale:** As the committee will have seen in the report, we found that women and children were, overwhelmingly, the people who were affected by the medicines and devices that we looked at. We found that the healthcare system seems to be particularly poor at listening to women and at taking seriously their concerns about their health and wellbeing and the outcomes of the procedures that they have.

Women whom we met around the country, including in Scotland, told us time after time that their doctors and other healthcare professionals and system participants simply did not listen to them and sometimes did not believe them and told them that, for example, the pain that they were experiencing was in their head. They told us of really quite worrying and disturbing responses from the system, and of there being sometimes no response at all. Paul Sweeney is therefore right to be concerned that women suffer particularly, in that regard.

However, it is for the patient safety commissioner herself or himself, once they are appointed in Scotland, to work out how best to engage with women and how to ensure that women—who, sadly, have a track record of not being listened to and taken seriously—are taken seriously so that the commissioner can advocate on their behalf and address their concerns with the system.

We do not need a separate mechanism. We argue that it is for the commissioner to ensure that the people who are isolated and often overlooked—be they women or others—are heard.

**Baroness Cumberlege:** I add that concerns are often family concerns; partners often came to tell us what their women had been suffering. That has been helpful. We have taken evidence from men and women who are partners of those people.

**The Convener:** A few members want to come in on the back of that. Can we have very short questions? We have a lot of themes to get through in the hour, which will, I feel, pass very quickly.

We will hear quick questions from Emma Harper and Stephanie Callaghan before I move on to the next theme.

**Emma Harper:** Thanks for letting me back in, convener.

The National Rural Health Commissioner in Australia listens to people and advocates for them so that their voices are heard. A new report has made it pretty clear that some people have been campaigning for decades. What are your thoughts on how firm the role of advocacy and listening to people needs to be in a patient safety commissioner?

**Baroness Cumberlege:** We have the most brilliant researcher, who still works with us. She did a lot of work on Australia and other countries; it was really helpful for us to see what other people are doing. However, in the end, the obligation and responsibility were ours—in our case, they were for England.

**Simon Whale:** Firmness is a very important point. A patient safety commissioner needs to be robust and clear and, if necessary, they need to instruct the system to act. Where there is a genuine concern about the safety of a medicine, device or other aspect of healthcare, the commissioner needs to have the clarity and strength of voice to compel the system to act. The legislation needs to provide for that.

**Stephanie Callaghan (Uddingston and Bellshill) (SNP):** I will come back to the gender aspect. My daughter was very ill when she was small: one bit of advice that I would give to female parents is that they make sure that they take a male with them, because they tend to be listened to more.

Is there scope for the commissioner to make the fact that women do not seem to be listened to an overarching issue that they look for in all the evidence that they consider across all the issues that they cover?

**Baroness Cumberlege:** We made it very clear that the commissioner could call people to account. As she is independent and had powers in legislation, it is possible for the commissioner whom we appointed to call people to account if she feels that they are failing—in particular, if they are failing users of the service.

**The Convener:** We will move on to questions from Sandesh Gulhane on the English patient safety commissioner.

**Sandesh Gulhane (Glasgow) (Con):** Good morning, and thank you for joining us. The committee held a private session in which we asked questions of the bill team. I have a question on the English model that I would like to be answered. Baroness Cumberlege, you just said that there are powers in legislation. What powers are available if bodies do not respond to Henrietta Hughes in the timely fashion in which she would like them to respond?

**Baroness Cumberlege:** There are powers in our legislation, which has been through the Parliament. I am sorry—I should have brought the act with me, but I have not. It is very clear that she has the power to call people to account. I saw the bill that you are scrutinising today and found it interesting that it includes powers, which is essential. It is no good just having somebody who can talk; they must have legislation behind them that enables them to act as they think is right. You are proposing that, which is excellent.

**Simon Whale:** The English legislation does not go quite as far as your bill does. The commissioner in England has the power to make it publicly known if an organisation fails to co-operate with her, but she does not have the power to compel them to do something. She can name and shame them, as it were, but the legislation stops short of saying that she can absolutely compel them. They have a duty to co-operate with her—that is built into the legislation.

**Sandesh Gulhane:** Do you feel that it would be useful to have powers such as the ability to fine a public sector organisation?

**Baroness Cumberlege:** In the bill, there is the power to “require information”. That is a very good power to have, because information is essential, as you will know from your profession as a doctor—you need information. That power is in the Patient Safety Commissioner for Scotland Bill, which is extremely good. It also brings in the question of confidentiality of information, which is part and parcel of that. In addition, the power to require information in a formal investigation is very powerful and a good way forward. I like the inclusion of an advisory group; of course, our commissioner, Henrietta, is now forming her own advisory group, which is in our legislation, too.

**Sandesh Gulhane:** Are there any lessons that you have learned from what has gone on, and is

there anything that we can add to the bill or do to improve it, so that we do not have to learn the same lessons as you have learned?

**Baroness Cumberlege:** I think that your bill is comprehensive and really good. There is a sort of tick-box system in it, and there is a duty to have a plan. That is a good start. Very often, people feel that they do not have a plan that everyone can sign up to and see what the purpose of it is. You have all of that in your bill, and I congratulate you on that, because it is a really good idea.

**The Convener:** We move to questions on clinical governance from Evelyn Tweed.

**Evelyn Tweed (Stirling) (SNP):** Written evidence has highlighted a cluttered scrutiny landscape for patient safety. Do you see the potential for the patient safety commissioner to add clarity? What would be required for them to do so?

**Simon Whale:** You are absolutely right in saying that the landscape is cluttered. Although it is cluttered, it is also siloed, which leads to increased risk around patient safety and increased risk of avoidable harm.

We feel that a patient safety commissioner's role is to encourage—if not to require—the system to act in a more coherent way. Because the role's focus is purely on patient safety and there is nothing else to distract it from that, the commissioner will be able to require and encourage the system to act in a more coherent way.

When we considered the role, we absolutely accepted the risk of placing yet another mechanism into an already crowded arena. Because of the role's independence—as Baroness Cumberlege said, it is outwith the system—the commissioner can orchestrate and require people to act in a concerted and co-ordinated manner, in a way that certainly did not happen in England prior to the commissioner's appointment.

**Baroness Cumberlege:** I will add one thing. It is critical that the patient safety commissioner whom you appoint has sufficient resources to do the job. We did not pay enough attention to that. The person whom we appointed is very good at negotiating, and she is managing to get more resources and staff; at the moment, she has only four members of staff. You picked up on her having four members of staff, but the role needs a great deal more, because people will have to look at the data, examine what is going on and look across the whole piece, which will require more people of great talent and integrity.

I offer a word of caution: make sure that there is enough resource.

**Evelyn Tweed:** Are you worried about the commissioner's role overlapping with other governance bodies' roles?

**Simon Whale:** We are not concerned about that. As has been discussed, there is an obvious possibility of overlap with the work of other commissioners, such as the Children and Young People's Commissioner Scotland, but it is for the commissioners to co-operate, talk to each other, keep lines of communication open and share information among themselves to avoid that duplication. That is perfectly possible. They have clear and distinct remits, and, yes, there are occasions when they could overlap, but that overlap could be powerful and in the public interest.

**The Convener:** Tess White has a question on the issue.

**Tess White:** Baroness Cumberlege, in Scotland we have the Scottish patient safety programme; the NHS incident reporting and investigation centre; Healthcare Improvement Scotland; professional regulatory bodies such as the General Medical Council; the Patient Rights (Scotland) Act 2011; a patient advice and support service that is provided by Citizens Advice Scotland; and the Scottish Public Services Ombudsman. How do you envisage a patient safety commissioner fitting into a seemingly saturated landscape without duplicating the work of existing bodies? Is there any evidence of that occurring in England?

**Baroness Cumberlege:** I am sure that we can match the number of organisations that you mention, and perhaps we have more—I do not know. It is terribly important, first, that all those organisations know what each other is doing, and, secondly, that they talk to each other and there is a coherence about it all. Given what you describe, that will certainly be a big task.

**The Convener:** David Torrance will lead questions about the appointment process.

10:30

**David Torrance (Kirkcaldy) (SNP):** Good morning. Baroness Cumberlege, what is your opinion on the different approaches that are being taken in England and Scotland for the appointment of a patient safety commissioner? Which approach do you think would better achieve the ambitions that you have for the role?

**Baroness Cumberlege:** The appointment process is really important. We advertised it very widely and, to be perfectly frank, we were quite disappointed in how few people of the calibre that we were seeking applied for the job. Fortunately,

we appointed Henrietta Hughes, and she has made a tremendous impact already.

Of course, setting up a whole new organisation takes a lot of time, energy, effort, resource and everything else, so she has had to lay down the foundations, the architecture—everything—in order to get things into a strong position. On Thursday, she is having a very big meeting that will involve voluntary organisations and, of course, people who work in the NHS and beyond. That work is really important, because Henrietta has made people aware of who she is, what her remit is and how she is going to go about it.

**David Torrance:** Thank you for that. Do you agree that there is a risk that a Scottish patient safety commissioner who was not sponsored by a relevant Scottish Government department would be easily overlooked?

**Baroness Cumberlege:** I think that we have to be quite careful.

**Simon Whale:** As we understand it, the commissioner will be accountable to you, in the Parliament. That underlines the commissioner's independence from the healthcare system—and we include the Government in the healthcare system, because it sets healthcare policy. We want the commissioner in Scotland to be a clear, strong voice for patients—someone who does not have to look over their shoulder and worry about whom they might upset within the system and someone who says it as they see it and who is constantly thinking about the best interests of patients. We want the same in England. Reporting to the Parliament means that the commissioner will be accountable and that the system will be transparent. That is a good way forward, and we do not have any concerns about that.

**The Convener:** We will move on to questions about individual complaints and how you are managing that aspect.

**Gillian Mackay (Central Scotland) (Green):** Baroness Cumberlege, how would you respond to those who argue that a patient safety commissioner should have a role in dealing with individual cases and complaints?

**Baroness Cumberlege:** We have shied away from that, because we have other organisations that can deal with individual cases. However, it is absolutely critical that the commissioner has an organisation that really examines the data on what is coming forward and sees the whole system and the whole scene, because she needs to see the trends and what is happening. I do not think that the commissioner should get involved in trying to sort out individual cases.

**Gillian Mackay:** How can public expectations of the patient safety commissioner's role in promoting the voice of patients be suitably managed without their taking on those individual cases and complaints?

**Simon Whale:** There is a communication job to be done by the patient safety commissioner in England—and by the commissioner in Scotland, once they are appointed—which is to make very clear what their role is and is not, so that the public has some understanding of that. It is not that the commissioner does not receive concerns from individuals. The job of the commissioner is to receive those concerns, analyse them and consider whether they amount to a trend and/or a systemic problem. If an individual case did not amount to a trend but still represented a legitimate concern on the part of the patient, we would expect the commissioner—certainly in England, and, I imagine, in Scotland—to signpost the individual to an appropriate alternative organisation, so that it could look into the case.

It is not that a patient safety commissioner should ignore individuals. It is quite the opposite: they are there to listen to individuals. However, he or she is there to try to understand whether there is a big-picture problem or just an individual, isolated case of poor outcomes.

**Gillian Mackay:** Do I have time for one more question, convener?

**The Convener:** Yes.

**Gillian Mackay:** Thanks.

You mentioned communication in relation to the patient safety commissioner. What is the most effective way of communicating changes that are made as a result of issues where there are trends and things need to be changed either in individual health boards or in the system as a whole? That communication might provide redress and some comfort to some of those who have raised concerns. How can it most effectively be done?

**Simon Whale:** It can be done partly by a patient safety commissioner. They should be communicating clearly and strongly using all the appropriate channels to make the public aware that they have detected a trend or a systemic problem, that they have recommended or compelled the system to change practice or whatever needed to be changed, and that that is resulting in harm being avoided.

The commissioner has a role, but we argue that, alongside that, the system has a role in saying, "The commissioner has helped us to understand that there is a problem here, and here's how we have acted." It should not be a confrontational relationship; it should be a co-operative one, because we would expect—and you would expect—the healthcare system to be dedicated to safety, just as the patient safety commissioner is.

**The Convener:** A number of members want to ask questions on that issue. We will start with Evelyn Tweed.

**Evelyn Tweed:** I am fine, convener. My question has been covered.

**The Convener:** Paul Sweeney is next.

**Paul Sweeney:** Thank you for your comments so far. I am curious about the information from the Scottish Public Services Ombudsman that shows that about 64 per cent of the complaints and inquiries that it received related to clinical treatment and diagnosis and that approximately 60 per cent of those complaints were upheld.

I note that the patient safety commissioner is not responsible for dealing with those individual cases, but does Baroness Cumberlege believe that there is an argument that the PSC should focus heavily on specific areas of healthcare and patient safety such as clinical treatment?

The 278 compensation payments that NHS Scotland made in the past year represented £60 million of expenditure. Surely, if we can get to the root cause of why so many complaints are being made regarding clinical treatment and diagnosis, we will be in a better position in the longer term not just to improve the patient journey, but to achieve great cost avoidance as well.

**Simon Whale:** We would completely agree with that. The proposed patient safety commissioner has the opportunity to reduce the risk of harm and, in the process, to reduce the likelihood of litigation and litigation costs. Their role is about helping the system. It is ultimately about helping the taxpayer, because it is the taxpayer who funds that redress—that compensation—as well as ensuring that people do not suffer avoidable harm.

The commissioner needs to be able to understand the picture in front of them, to interpret it and to draw conclusions about what needs to happen, and then the system needs to act. If all of that happens, the outcomes that you suggest will be delivered.

**Baroness Cumberlege:** Henrietta Hughes has had a lot of talk with NHS Resolution, which is involved in litigation, and it has been very helpful to her. The more that the different silos are breached, the better. She is working with many different organisations. Because of her background, she knows the NHS and healthcare very well indeed, which is a great asset for her and also for the role. That is one of the reasons why we appointed her, actually.

**The Convener:** We move to questions on social care inclusion from Paul O'Kane.

**Paul O'Kane (West Scotland) (Lab):** A number of respondents to the consultation on the Scottish bill felt that the patient safety commissioner should also cover social care. Indeed, social care is topical given the challenges in that sector. Also, as we have come out of Covid, there has been a renewed focus on safety in social care. Baroness Cumberlege, do you think that there is a case for including it in the patient safety commissioner's remit?

**Baroness Cumberlege:** The person who is appointed has a huge role. Once your bill is passed—I presume that it will become an act—that person will have to set an awful lot of things in train. I am thinking about ensuring that they recruit the right people, have the right premises and have their independence. It is a complex role and I do not think that England's commissioner would want to take on social care at the moment, although one has to appreciate how much it builds into or impacts on healthcare and the reverse. It is something for the future but I would not put it on the shoulders of somebody newly appointed.

**Paul O'Kane:** I am grateful for that. I was keen to understand the challenges that might exist in including social care in the commissioner's remit, so it was useful that you followed on from my question.

I appreciate that this is a known unknown, but is there any sense that, further down the line, there might be a distinct and separate commissioner for social care? Is it your sense that it would be better to try to separate out the two and have cross-cutting issues but not necessarily the same person doing it all?

**Baroness Cumberlege:** You are right. I think of the time that I was very involved in the NHS—much more on the ground than I am now—and chaired social services for England. It was very important to ensure that we all worked together. However, at the beginning, let us get a robust system working. Let us get a good person in post who will manage those difficult issues. There is always the opportunity to talk and have meetings together to unpack some of the issues that clearly involve social care and the health service.

**The Convener:** We now want to talk about something that the witnesses have raised a little bit: it is about resourcing what is, as you say, a complex role and the service that a patient safety commissioner will provide. Stephanie Callaghan will lead questions on that.

**Stephanie Callaghan:** It was good to hear Simon Whale talk about reducing the risk of harm and, possibly, reducing litigation costs. However, the Scottish Public Services Ombudsman has expressed some concern that the resources that are set out in the financial memorandum fall short of the ambition for the post. What are the witnesses' comments on that?

**Simon Whale:** Baroness Cumberlege has already suggested that you need to pay particular attention to ensuring that the commissioner has the right resources to do the job, as we want to in England. It is a brand-new role. The person will be starting with a blank sheet of paper—or, at least, with nothing more than the legislation.

As we understand it, the financial memorandum suggests that the commissioner will have four members of staff and a total budget of £500,000, which would include the commissioner's own salary. That is fairly modest in our opinion, given the scale of the task that the commissioner will take on. I refer not just to the task of getting things going—setting up the organisation and creating momentum around the role—but the day-to-day requirements of the role going forward, which will really stretch a staff of only four.

10:45

Baroness Cumberlege has mentioned the importance of data and data analysis. If there are to be only four staff, there must be real capability among them to receive, interpret and analyse data and to draw conclusions from that. Each step of that data processing is complicated and quite significant. How will the patient safety commissioner's office go about collecting data? Where will they get that from and how will they get it? How will they process it in a way that is compliant with data protection legislation? All those things, let alone the interpretation of the data, require significant resources.

Our advice, respectfully, is that you must ensure that you are satisfied that the commissioner will have sufficient resources and that, if there are only four staff, those are four very competent people who will work very hard, because there will be an awful lot for four people to do.

**Stephanie Callaghan:** How would that compare with the resources in England? Do you have a view on the size of team that you think would actually be required in reality in Scotland?

**Baroness Cumberlege:** I am not sure how the number four has come into the picture. This is the first trawl that the commissioner in England has done. She has recruited four people, but she will be recruiting a whole lot more. It may be that she would want to put some of the data collection out to other organisations that are experts in that field and would be reliable sources of information.

It is difficult to say at the moment how many staff there should be or what the budget would be. I know that the patient safety commissioner in England has already negotiated a bigger budget than the one she was first allocated. She has very strongly put across why she needs more resources. So far, the department has agreed with her and she is now able to do more than she was first set up to do.

She knows the remit of the job and the person that you appoint for Scotland will know the remit of their job. I am sure they will find that they need a great deal more support and resource in order to do the sort of job that they are expected to do.

**Stephanie Callaghan:** That is interesting and helpful; thank you.

**The Convener:** Paul Sweeney has a final question.

**Paul Sweeney:** Thank you for your comments so far about the budget and resource constraints.

During consultation on the bill, there have been suggestions that those constraints would leave the proposed patient safety commissioner unable in practice to dedicate resources to any kind of investigatory work, except in exceptional circumstances. Do you share that concern, given the current budget of around £644,000 per annum? Is there a danger that having a commissioner could end up becoming a public relations exercise, rather than a substantive mechanism for delivering justice, or good outcomes, for patients?

Is there an opportunity to build collaboration with adjacent organisations, perhaps by working more deeply with Parliament committees to extend the resource and practice that is available? Do you see that as an opportunity, rather than having the commissioner sitting in a separate silo within bureaucracy?

**Baroness Cumberlege:** That is a helpful comment. Henrietta Hughes and I meet formally at least once a month to keep in touch about what is happening, but it is her show, not mine; I am just there if she wants advice.

You are absolutely right that that is the way forward. It is really important that enough resource is given. People always want more—I am sure that you have experienced that in other areas—so there has to be a rein to ensure that things do not get out of control, but there must be enough resource to make the job doable and effective and for people to respect what is happening.

Henrietta has been negotiating that. She has been on a lot of platforms. She has been going round England and I think she has been to Scotland. Communication is absolutely critical to the role.

**The Convener:** I thank Baroness Cumberlege and Simon Whale for their attendance, which has been extremely helpful and for the tremendous work that they have undertaken on the review so far. Please pass on our best wishes to Henrietta

Hughes, as we begin our process of getting a patient safety commissioner for Scotland.

10:50

*Meeting suspended.*

11:05

*On resuming—*

# Subordinate Legislation

## Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2023 [Draft]

**The Convener:** Our third item is consideration of the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2023. The purpose of the regulations is to increase the value of payments for free personal care and nursing care by 9.5 per cent. This is an annual increase. The policy note states that emerging evidence in recent years shows that the cost of providing personal and nursing care has increased significantly and the payment made to providers by local authorities for self-funding residents has not kept pace with it.

The Delegated Powers and Law Reform Committee considered the regulations at its meeting on 24 January 2023 and made no recommendations in relation to the regulations.

We are now going to have an evidence session with the Minister for Mental Wellbeing and Social Care and supporting officials on the regulations. Once we have had all our questions answered, we will proceed to a formal debate on the motion.

I welcome Kevin Stewart, who is the Minister for Mental Wellbeing and Social Care. Accompanying the minister are Scottish Government officials Marianne Barker, who is the unit head of adult social care charging, and Clare Thomas, who is the policy manager of adult social care charging. Thank you for joining us today. I invite the minister to make a statement.

**The Minister for Mental Wellbeing and Social Care (Kevin Stewart):** Good morning, convener, and thank you for giving me the opportunity to speak to the committee today about a proposed amendment to the Community Care (Personal Care and Nursing Care) (Scotland) Regulations 2002.

The draft regulations before the committee today make routine annual increases to the rates for free personal and nursing care. Those payments help to cover the costs of services for self-funding adults in residential care.

Historically, those payments have increased in line with inflation using the gross domestic product deflator. However, emerging evidence, including from the Scottish care homes census, shows that the cost of providing care has increased. To help to redress that, in the past two years we have

made above-GDP-deflator increases to the rates of payment of 7.5 per cent and 10 per cent respectively, which is a significant increase on the inflation rate that was previously used.

We feel that it is appropriate to make an above-GDP-deflator increase to the rates this year, and the regulations before the committee propose to make a 9.5 per cent uplift for 2023-24. That will mean that the weekly payment rates for personal care for self-funders will rise from £212.85 a week to £233.10 a week, and the nursing component will rise from £95.80 to £104.90. It is estimated that that will cost approximately £15 million in the next financial year. That will be fully funded by additional provisions within the local government settlement as outlined in the recent Scottish budget 2023-24.

The most recent official statistics show that more than 10,000 self-funders receive free personal and nursing care payments. They should all benefit from these changes.

Convener, I am happy to take any questions from the committee.

**The Convener:** Are there any questions for the minister?

**Paul Sweeney:** Minister, given that this is an annual manual exercise, have you given any consideration to whether a formula could be introduced that would make it more of an automatic stabiliser and would mean an immediate increase?

**Kevin Stewart:** The same system has been used since the inception of free personal care in 2002. As I indicated, we made adjustments in the past three years, taking cognisance of the pressures out there to ensure that we do not ask people to pay too much for their care.

Some things could be improved in all this, one of which would be the United Kingdom Government reintroducing the attendance allowance payments that were given to Scotland prior to the inception of free personal and nursing care here. If that money were restored—assuming an average of £80 for the roughly 10,000 people who receive free personal and nursing care, which is not the highest rate for attendance allowance—we would have £41.6 million extra to play with.

**Paul Sweeney:** Has the Government undertaken any analysis of the extent to which profit is extracted from the care system? Obviously, it is important to undertake expenditure to ensure that care is provided, but there might well be instances in which profits are being generated as a result. Does the Government maintain oversight of the profit that is being generated to ensure that it is not excessive?

**Kevin Stewart:** As the committee is well aware, we are undertaking a huge number of exercises in our work for the formation of the national care service. Obviously, ethical procurement is at the heart of all of that. We will, of course, look at all aspects of the care system, including profit.

**The Convener:** There are no more questions, so we will move on to agenda item 4, which is the formal debate on the affirmative instrument on which we have just taken evidence. I remind the committee that members should not put questions to the minister during the formal debate and that officials may not speak in it.

Minister, is there anything that you wish to say in relation to motion S6M-07494?

**Kevin Stewart:** No thank you, convener.

**The Convener:** I ask you to move the motion.

*Motion moved,*

That the Health, Social Care and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2023 be approved.—[*Kevin Stewart*]

*Motion agreed to.*

**The Convener:** That concludes consideration of the instrument. I thank the minister and his officials for their time this morning.

In our next meeting, we will continue our scrutiny of the Patient Safety Commissioner for Scotland Bill and take evidence from patient representatives and patient safety organisations.

That concludes the public part of the meeting.

11:12

*Meeting continued in private until 11:31.*

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