OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 13 June 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 13 June 2017

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HEALTH AND SPORT COMMITTEE
16th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Morag Brown (NHS Greater Glasgow and Clyde)
Kirsty-Louise Campbell (City of Edinburgh Council)
Robin Creelman (NHS Highland)
Sir Robert Francis QC
Innes Fyfe (Scottish Government)
Ailsa Garland (Scottish Government)
Geoff Huggins (Scottish Government)
Cathy James (Public Concern at Work)
Christine McLaughlin (Scottish Government)
Shona Robison (Cabinet Secretary for Health and Sport)
Eleanor Stanley (Scottish Government)
Maureen Watt (Minister for Mental Health)
Ruth Wilson (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 13 June 2017

[The Convener opened the meeting at 09:15]

Subordinate Legislation

Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017 [Draft]

The Convener (Neil Findlay): Good morning, everyone, and welcome to the 16th meeting in 2017 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobile devices for social media, but please do not take photographs or film proceedings.

Agenda items 1 to 11 are on subordinate legislation. Under agenda items 1 to 10, we will consider five instruments that are subject to affirmative procedure. As is usual with affirmative instruments, we will take evidence from the responsible minister and their officials. Once all our questions about the instrument have been answered, we will have a formal debate on the motion.

The first instrument that we will look at is the draft Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017. I welcome to the meeting from the Scottish Government Maureen Watt, who is the Minister for Mental Health; Ruth Wilson, who is a senior policy adviser in the mental health and protection of rights division; and Ailsa Garland, who is a solicitor.

I invite the minister to make a brief opening statement.

The Minister for Mental Health (Maureen Watt): Thank you for providing me with the opportunity to speak about the secondary legislation that the Scottish Government is introducing as part of the implementation of the Mental Health (Scotland) Act 2015. That act makes changes to the Mental Health (Care and Treatment) (Scotland) Act 2003 to allow service users with a mental disorder to access effective treatment quickly and easily. The 2015 act also amends the Criminal Procedure (Scotland) Act 1995 and the Criminal Justice (Scotland) Act 2003 to improve processes and to introduce a victim notification scheme for victims of mentally disordered offenders.

The implementation of the 2015 act is part of the Scottish Government's programme to streamline, simplify and clarify the system for the efficient and effective treatment of people with a mental disorder. It does not seek to overhaul mental health law; it simply seeks to make the changes that need to be made to improve further the operation of the law in that area.

When the provisions of the 2015 act come into force, they will build on the existing measures and principles that are set out in the Mental Health (Care and Treatment) (Scotland) Act 2003 to help to ensure that people with mental health problems know their rights, are at the centre of decisions about their own care and are empowered to participate.

There are five affirmative statutory instruments to talk about. One instrument is about the arrangements for patients who have absconded, three relate to cross-border matters, and the fifth clarifies the holding powers for nurses. As each instrument is to be considered individually, I will take a few minutes to explain the particular proposals, including our reasons behind them, before I take questions.

Policy was developed in consultation with stakeholders, and the draft policy proposals for the instruments were discussed with stakeholders before the proposals were finalised. Given the complexity and technical nature of some of the processes, it was not practicable to run a single public consultation. In order to maximise responses, two separate consultations were conducted. The aim was to engage as fully as possible while minimising pressure on stakeholders to consider several topics in one go.

Policy officials set up a reference group, which not only helped to shape the form of the consultations but focused on the implementation of the 2015 act. The reference group consists of a range of stakeholders; its membership includes the Mental Health Tribunal for Scotland, the Mental Welfare Commission for Scotland, professional groups, service providers and rights, advocacy and service user representation organisations. The group has had a key role in providing advice and recommendations.

The Scottish Government considers that the implementation of the 2015 act and the introduction of the instruments will help to improve the care and treatment of people with mental disorders.

I am happy to discuss the first instrument that the committee is to consider.

The Convener: Thank you. I invite questions from members.

Maureen Watt: Sorry, convener, but should I go on and introduce the first instrument?

The Convener: Yes—if that is what you were intending to do.

Maureen Watt: The first instrument relates principally to the provision of medical treatment to persons who have absconded to Scotland from elsewhere. The regulations have a dual purpose: to provide a process for the return of patients who have absconded from another European Union member state and to allow for the treatment of absconding patients pending their return.

When patients who are mentally disordered are detained in hospital, they sometimes leave without the agreement of the staff or go missing. That can be a concern, because many patients are detained in hospital because they are at risk of harming others or themselves in some way. We propose to make provision that follows the principle of least restriction and allows for such a person to receive medical treatment for their mental disorder. It is envisaged that the provision would be used when the absconding person is likely to be in Scotland for a short period before returning to their home jurisdiction once transport has been arranged. At present, the mental health legislation does not provide a framework to authorise giving treatment to a person who has absconded from detention in another jurisdiction and has been taken into custody pending return. We therefore propose to replicate some of the existing provisions that allow treatment of patients who are detained in hospital in Scotland.

The regulations set out a clear process for considering treatment, which includes confirming that the absconding person is subject to measures that correspond to Scottish measures involving detention. We hope that, in most cases, the person will be returned to their home jurisdiction within a few days. We have focused on what best meets the person's needs. It would have to be established that the absconding person has a mental disorder and, if they were not liable to be taken into custody under the absconding regulations, it would be necessary to detain them for treatment of that disorder.

I appreciate that one stakeholder would perhaps prefer us to take a different route. For example, it has recommended that absconding persons should be made subject to a short-term detention certificate. We have looked at the evidence in detail and officials have spoken to that stakeholder about its concerns. It acknowledges that a short-term detention certificate may not be appropriate in all cases, and we consider that additional provisions that it has requested are not needed. We are confident that the draft regulations are a suitable and proportionate way of allowing a person to be returned to their home jurisdiction when that is appropriate and to receive treatment for their mental disorder as required pending their return.

In the consultation process, most respondents agreed with our proposals. The best interests of the person should be uppermost in any decision. Under the Mental Health (Care and Treatment) (Scotland) Act 2003, anyone in Scotland with a mental disorder as defined by that act has the right to access support from an independent advocate. That means that any patient who comes under the absconding regulations would have a right to access support from an advocate. If there was likely to be a longer delay, it would be open to the medical practitioner who was responsible for the person's treatment to consider whether the person should be brought within the Scottish system.

I am now happy to take questions on the proposals.

The Convener: Thank you.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, minister, and thank you for coming. At the top of your remarks, you referenced the fact that the instruments were produced in consultation with groups of stakeholders. I absolutely accept that, and that may well be the case, but it is clear from briefings that members of the committee have received from the Scottish Association for Mental Health that not all the concerns that were raised in the consultation process have been acted on.

I particularly want to address issues surrounding these regulations. First, the draft regulations allow the responsible medical officer to authorise any person to take someone into custody. Arguably, that definition is vague and does not ensure that the person who is specified will have appropriate qualifications or experience to fulfil the duties. SAMH flagged that up during the consultation process. Why did you decide to omit any qualification threshold for people who can take patients into custody?

Maureen Watt: In general terms, we are aware of SAMH's concerns. My officials met a representative from SAMH last week, and we thought that we had allayed most of their fears and concerns about the instruments, but after the representative went back and discussed the matter with colleagues, that does not seem to have been the case. Perhaps more reassurance of other people at SAMH is required.

The change is needed because there is currently a difference between the list of persons who can take an absconding civil patient into custody and return them, and the corresponding list for mentally disordered offenders. There is a list of people who can take people into custody, but the new provisions ensure similar specified

persons in the two cases by including persons who are authorised by the patient's responsible medical officer. The policy objective is to make both approaches similar to allow an RMO to authorise a person to take a mentally disordered offender into custody and return them to the hospital or other place from which the patient absconded. The accompanying code of practice will make clear which factors an RMO should consider when specifying a person.

Alex Cole-Hamilton: The regulations are subject to affirmative procedure, so we cannot amend them. You are asking the committee to rubber-stamp something with which not all of us are entirely happy. I do not see how the Government position would be weakened by redrafting and amending the regulations to include the word "qualified" and delineating in the subsequent guidance exactly what is meant by "qualified", otherwise that could be open to interpretation and it might be misused.

Maureen Watt: Qualified persons are already specified. They include members of hospital staff, mental health officers and constables. The addition will allow the RMO to make a decision about the suitability of a person to take an absconding patient into custody and return them to hospital or another place from which they have absconded. The accompanying code of practice will make clear what matters an RMO should consider when specifying a person.

Alex Cole-Hamilton: With respect, just listing groups of people who can do that does not specify what qualifications they should hold or what expertise or experience they should have. I am not satisfied that that qualification threshold has been met.

Maureen Watt: Does one of my officials want to come in on that? The RMO will always take the decision at the end of the day.

Ruth Wilson (Scottish Government): The addition will allow an RMO to use their judgment on who should fulfil the role of taking a person into custody. The RMO will look at who from the prescribed list is best placed at that moment.

Alex Cole-Hamilton: The human judgment element causes me concern. Just saying that hospital staff can take somebody into custody without specifying qualifications might lead the RMO to infer that any member of hospital staff could perform that role. Given the distress that the person in question might be in—they might have been without their medication, usual treatment and support for some time—there could be a particularly charged situation that requires a very finessed skill set. We have not covered that by just saying that it is up to the RMO and the person can be anyone from the hospital staff.

Ailsa Garland (Scottish Government): The amendment in the draft regulations simply replicates the system that we have at the moment for civil patients. We have the list that includes a mental health officer, a constable, a member of staff of a hospital and any other person who has been authorised by the RMO. We are simply replicating that for offenders who have absconded within Scotland and therefore leaving flexibility for the RMO to consider who is most suitable at the time, as my policy colleague said.

09:30

Alex Cole-Hamilton: I am all for giving the RMO flexibility but I want parameters around that flexibility, and I do not understand the problem with bottoming that out in guidance and using the word "qualified" so that RMOs can discharge that responsibility confidently.

Maureen Watt: As Ailsa Garland said, the provision brings the situation into line with the system for other patients. We are talking about very few people—people who are in danger of being a risk to themselves or to others. I think that you will agree that speed might be of the essence in some cases: we need to quickly ascertain what the problem is and make sure that the person is given the best possible treatment and returned from whence they came as quickly as possible.

Alex Cole-Hamilton: I do not question that. Speed is obviously important. However, when people have to make speedy decisions, they often make the wrong ones. I just want to protect the RMOs and the patients they are dealing with. If that means bringing the system into line with the system for domestic patients, perhaps the system for domestic patients needs to be tightened up. I am still not happy with the regulations.

Ailsa Garland: I clarify that the amendment is just about domestic offenders who have absconded in Scotland. We are amending two different sets of regulations and replicating what is in the civil system. RMOs already make decisions that they think are appropriate for civil patients, so we are creating a similar system. I am not sure whether we are aware of issues around the making of such decisions for civil patients at the moment. We are simply replicating the system for offenders.

Alex Cole-Hamilton: I do not think that we are going to reach agreement on this, but I am not satisfied that that qualification threshold has been reached.

If I may, convener, I will move on to the other problem that SAMH raised about medical treatment for people who have absconded from jurisdictions outwith Scotland. As the regulations stand, the Government is proposing to treat

people over several days without the same authorisation under mental health law that would be provided for someone who is resident and receiving treatment in Scotland. People who abscond to Scotland could be subject to prolonged detention and treatment without a right of appeal, which could be seen as an infringement of their human rights. The issue was raised in the European Court of Human Rights through a case in Finland. In its judgment, the court said:

"forced administration of medication represents a serious interference with a person's physical integrity and must accordingly be based on a 'law' that guarantees proper safeguards against arbitrariness."

In that case, those safeguards were missing. How confident are you that, if such a case were brought before the European Court of Human Rights, it would not be found similarly wanting?

Maureen Watt: The case of X v Finland involved a quite different set of circumstances and did not relate to absconding. We are content that the regulations provide significant safeguards in relation to the treatment of those who abscond to Scotland from other jurisdictions. Such medical treatment can be given only when the absconding person is subject to a measure in their home jurisdiction that corresponds to certain Scottish measures involving detention, all of which contain safeguards for the patients involved. Additionally, the absconding person needs to be medically examined before treatment is given. It needs to be established that they have a medical disorder, that they would need to be detained for the purposes of receiving treatment and that without treatment there would be a significant risk to the safety and welfare of the absconding person or to others.

On the safeguards, our mental health legislation is rights based, and we have sought to reflect that in the regulations. For some individuals, compulsory treatment is used to provide medical treatment to alleviate suffering and to protect the person and others and, as you know, compulsory treatment is allowed only in strictly controlled circumstances. Absconding patients are covered by the same safeguards.

Alex Cole-Hamilton: Okay. Going back to the judgment in X v Finland, we cannot hypothethise about the circumstances in which that would be applied under Scots law in terms of individual circumstances that might occur in relation to patients absconding to Scotland with regard to the regulations.

You talk about the approach being based on mental health legislation. The problem with that is that no protection under mental health legislation is afforded to patients who abscond to Scotland, because they are excluded from the provision of treatment authorised under the 2003 and 1995 acts. The regulations set out that the Scottish Government therefore proposes to provide treatment to patients without those protections. In other words, despite what you said about the work that was done and the agreement that was reached about the use of short-term detention certificates not being appropriate, that is, effectively, what we are talking about.

Ailsa Garland: The Scottish Government is completely committed to maintaining human rights in Scotland. There is a clear system in the absconding regulations. I do not think that it is quite correct to say that, because they are set out in regulations rather than in primary legislation, there are no procedures and safeguards.

A number of checks need to be done before someone can be given medical treatment. It has to be established that they have a mental disorder and that were they not liable to be taken into custody it would be necessary to detain them to give the treatment. All of that has to be decided by a medical practitioner, who must also consider whether, without treatment, there would be some risk to the safety of the patient or others. There is then a process whereby certain sections of the 2003 act are applied and modified so that they work appropriately for absconding persons. I therefore do not think that it is correct to say that there is no scheme or system or that there are no safeguards. All of that is set out in detail in the regulations.

Alex Cole-Hamilton: My fundamental point is that absconding persons are not afforded the same rights and protections as Scottish citizens, who are protected by primary legislation. I cannot see why we cannot change the regulations to give them those same protections.

Ailsa Garland: Our position is that, as I said, a clear system is in place for those people. The fact that it is in regulations rather than in primary legislation does not mean that it is a lesser system. I take your point that they will not receive treatment under the 2003 act—I think that that is one of SAMH's issues—but they will receive treatment in accordance with the conditions and requirements in the regulations. We feel that there is a clear system there.

Alex Cole-Hamilton: Access to justice is key. I would be anxious that people who are not protected by primary legislation, who will be dealt with through the hodgepodge of provisions in the regulations, will not have the same access to justice that they would have had if they had been protected in the same way that Scottish patients are protected under primary legislation.

Clare Haughey (Rutherglen) (SNP): I refer members to my entry in the register of members' interests. I am a registered mental health nurse, and I am one of probably only two people around

the table who have worked with mental health legislation in practice.

What rights does someone who has absconded and is now in the care of a Scottish mental health facility have in terms of accessing advocacy and making complaints to the Mental Welfare Commission, and what rights do they have in general? Alex Cole-Hamilton has raised concerns in that regard, so it would be helpful if the minister could clarify what those rights are and where those people currently stand in that regard.

Maureen Watt: The 2015 act builds on the rights and duties in the 2003 act, including the right to access support from an independent advocate. The new provisions will require local authorities, health boards and the state hospital to provide information to the Mental Welfare Commission on how they currently exercise their duty to collaborate and to secure advocacy services for people with a mental disorder, and how they plan to do so in the future. That will help to ensure that information on the provision of advocacy is easily accessible and that independent advocacy is provided, as it should be. The Scottish Government will continue to work with the Mental Welfare Commission for Scotland on the implementation of the new provisions. As far as I understand, the commission is broadly in agreement with the instruments.

Clare Haughey: Anyone who is detained under mental health legislation in Scotland has additional support through a mental health officer, who oversees the process. Are there any plans for mental health officers to oversee any part of the regulations?

Maureen Watt: There is no statutory role for an MHO under the regulations, as persons will not be detained under the 2003 act. However, the statutory guidance will set out best practice in terms of how the clinical team will engage with social work.

Clare Haughey: Thank you for that reassurance.

Alex Cole-Hamilton has raised concerns about RMOs deciding who would take someone back into custody. I have personal experience of fulfilling that role. My understanding is that, in the vast majority of cases, the role would fall to registered mental health nurses and nurses who work on the ward from where the patient absconded or who are part of the wider clinical team, such as community staff who have worked with the patient. Will the regulations lead to any changes in who fulfils that role? Do you envisage that similar people, with similar experience and levels of qualification, would be involved?

Maureen Watt: The system would be absolutely the same. I bow to your practical knowledge in the field—you are absolutely right.

Colin Smyth (South Scotland) (Lab): Good morning. Under the current process, if someone requires further treatment over a longer period, doctors are required to issue short-term detention certificates—Alex Cole-Hamilton made that point. What are the disadvantages of maintaining that system?

Ailsa Garland: A patient who is made subject to a short-term detention certificate is effectively brought into the Scottish system. To be transferred back to their home jurisdiction, they would have to go through the cross-border transfer process, which might involve a lengthier process than would otherwise be the case. However, as I have said, by allowing medical treatment to be provided under the absconding regulations, we are setting out a clear process for that treatment and the conditions under which it can be given, and when the patient is medically fit to return to their own country that can be done without any delay.

Colin Smyth: How many people are we talking about? There may be only a few such patients—I think that that is what the minister said—but you say that you require to change the system.

Ruth Wilson: No official statistics have been kept, but you will see from the evidence that has been submitted, and we know from own evidence gathering, that we are talking about limited numbers. We need to be clear that, at the moment, there is no provision for such medical treatment and that is what the regulations will introduce. People have been doing a workaround, which is why the issue of STDCs came into play. As Ailsa Garland pointed out, a consequence of putting such people on STDCs is that most will be in Scotland for a longer period.

Alison Johnstone (Lothian) (Green): I have been listening to the discussion with interest, but I am still not entirely clear how the minister will ensure that the person authorised by a responsible medical officer to take someone into custody will have the appropriate experience and qualifications. I am also still not clear why we do not have a prescribed list. Furthermore, I am really concerned that one of our foremost mental health organisations has such reservations about the proposals. It has provided follow-up evidence to the committee in which it says that it remains concerned that the regulations do not include an appeals procedure and that they provide

"no access to a Mental Health Officer for people who will not be familiar with the law".

I ask the minister to address those issues.

Maureen Watt: Ruth Wilson may want to take the question on someone being available to patients.

09:45

Ruth Wilson: All patients will have the right to an independent advocate. As part of that service, the advocate will ensure that the patient is aware of their rights. The treating clinician will also have a role in ensuring that the patient is aware of what is happening to them and what rights they have.

Alison Johnstone: Do you believe that there should not be a prescribed list? I am trying to understand your point. I cannot understand why you do not agree with what SAMH is asking for.

Ruth Wilson: There is an existing list of prescribed categories of people; we are simply adding a new line to allow an RMO to say who, in the circumstances, would be the best and most qualified person to take a patient into custody.

As Ailsa Garland said, we are equalling up what happens to those who are involved in mental disorder offences and who are likely to abscond during the transfer process with what already happens in civil cases.

Alison Johnstone: Why, therefore, is SAMH concerned about the regulations?

Ailsa Garland: You raise a couple of different issues. The first issue, which we have discussed, is the addition of RMOs to the list of people who are able to authorise people who they think are suitable to take an offender into custody.

SAMH has raised separate concerns. For example, with regard to the Finnish human rights case that we have discussed, SAMH feels that there is a lack of proper process. We are saying that there is a process set out in the regulations that we feel is sufficient. It allows someone to be returned fairly speedily to their home jurisdiction, which would probably be best for them in the circumstances, rather than having them remain in a country that is not their own.

Alison Johnstone: Okay—thank you.

The Convener: Depriving somebody of their liberty is a huge step. For me, the issue is the reference to “any” person. A number of us have a problem with that, and the Government really needs to reflect on it. Do you recognise that that is a problem?

Ailsa Garland: Two different issues are being amalgamated. The RMO issue is simply about adding to the list of people who can take an offender into custody for the purposes of returning them. That relates to absconding offenders in Scotland.

We are extending the existing regime for taking into custody and returning absconding persons to people from other EU member states, and we are allowing for medical treatment, which the 2003 act currently does not provide for.

While I have the floor, I should reiterate that we are using powers in the 2015 act to expand the regulation-making powers so that we can provide specifically for two different categories: first, we are extending the regime to people from the EU who abscond and, secondly, we are applying to all absconding persons the ability to be provided with medical treatment. That was fully debated as part of the bill process, and I submit that we are not doing anything particularly unusual in relation to the new powers that we have, as revised in relation to the 2003 act.

The Convener: The second element that I am concerned about is the fact that, for those who abscond to Scotland, there is no legal right to challenge treatment and no right of appeal. I have a fundamental problem with that.

Maureen Watt: SAMH suggests that the regulations offer the possibility of deprivation of liberty for an unlimited period without appeal. We have no reason to expect that that would be the case. We have made clear from the outset our intention that the absconding regulations should be subject to specific conditions and that any treatment should be given only for a short period of time. We would hope that, in most cases, absconding persons will be returned to their original jurisdiction within a few days. We have consulted on the issue, and there was no clear consensus from respondents on what the relevant time period should be. That takes us back to your question about a short-term detention certificate.

Because there is a range of variables, for example whether the person is well enough to travel and what transport arrangements have been put in place, each case would be different, and there would have to be a clinical decision on what was best for the particular person. That will be supported by guidance to determine the best course of action. That is why we are saying that it would be inappropriate for the regulations to specify a time limit.

Ailsa Garland: To clarify, we are talking about absconding people who are subject to measures equivalent to Scottish detention measures in their home jurisdictions. It is not that we are taking them into custody as an initial measure. They are already subject to measures in their own country, they have come to Scotland and it has been established that they have absconded. They are taken into custody for the purposes of return. So it is not—

The Convener: I think that we get that.

Ailsa Garland: Thank you.

Maureen Watt: I accept that the matter is extremely complicated, especially as most of us were not involved in the passage of the 2015 act. If the committee wishes, we could have an informal briefing to set out the issues in more detail and perhaps to answer more questions.

The Convener: Thank you for the offer. We will consider that.

Maureen Watt: I would prefer to do that and to take the proposals away, rather than see the motion go down. That would not help anybody with the act.

The Convener: Do you want to take the motion away?

Maureen Watt: I have heard what only a very few members feel about the regulations.

The Convener: We are about to move to the debate on the SSI. We can have the discussion, and it is up to you whether you then withdraw the motion.

Maureen Watt: Well, if you want to have the discussion.

The Convener: Thank you. Item 2 is the formal debate on the affirmative SSI on which we have just taken evidence. I remind the committee that members should not put questions to the minister during this formal debate, and officials must not speak in the debate either.

Motion moved,

That the Health and Sport Committee recommends that the Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017 [draft] be approved.—[*Maureen Watt*]

Alex Cole-Hamilton: I am grateful for the clarity that the minister and her officials have sought to bring, yet it has not given me satisfaction that the concerns that have been outlined by fellow committee members and by SAMH in its briefing to us have been met. I do not think that an informal briefing on the technical aspects of the 2015 act would assuage that. I do not think that what is being asked of the Government by way of taking the regulations away and redrafting them is particularly onerous. I do not think that that will jeopardise the thrust or spirit of what the Scottish Government is trying to do.

If anything, what has been suggested will improve the instrument and will offer protection for both staff and patients regarding the observance of human rights, rather than leaving us open to future litigation at a European level.

Clare Haughey: I am speaking about this subject with a background of professional knowledge. I hear the concerns that some of my fellow committee members have, but I would offer them the reassurance about professional judgment being used in all areas and about the patient being at the centre of all care in mental health. That is how all healthcare professionals practise. The proposals are not as big a change to legislation as people might feel them to be. In practice, the proposals are about expediting patient care and, potentially, providing better safeguards, if people are currently practising outwith the guidance.

Alison Johnstone: I cannot help but think that the regulations could be improved. The committee has raised concerns about the fact that the RMO would be able to authorise anyone to take an absconded person into custody, so clarity around the prescribed list would be helpful. We have also heard concerns about safeguarding people's rights, the fact that no appeals procedure is outlined, the lack of access to a mental health officer and the fact that there is no mention of independent advocacy. Members have also raised concerns about the issuing of short-term detention certificates. I feel that the regulations could be brought back to the committee in an improved form.

Miles Briggs (Lothian) (Con): I want to touch on what Alison Johnstone said. To date, we have worked hard to ensure that all legislation is built using a rights-based approach, but the regulations do not feel right in that regard. The convener raised two points, on challenging treatment and the right to appeal. We would all appreciate it if the SSI was rewritten to take those two points into account.

The Convener: Minister, in reflecting on what the committee has said, do you still wish to pursue the motion?

Maureen Watt: Alex Cole-Hamilton perhaps wants the whole 2015 act to be revisited, but we are not in a position to do that. The subordinate legislation is bringing the act into play. As my officials and I have said, it is absolutely rights-based legislation. Further details will be set out in the code of practice—

The Convener: Minister, we are very short of time, so I really need you to decide whether you want to withdraw your motion or pursue it.

Maureen Watt: I will press the motion.

The Convener: The question is, that motion S5M-05753 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Haughey, Clare (Rutherglen) (SNP)
Todd, Maree (Highlands and Islands) (SNP)

Against

Briggs, Miles (Lothian) (Con)
Cameron, Donald (Highlands and Islands) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Findlay, Neil (Lothian) (Lab)
Johnstone, Alison (Lothian) (Green)
Smyth, Colin (South Scotland) (Lab)

Abstentions

Arthur, Tom (Renfrewshire South) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
McKee, Ivan (Glasgow Provan) (SNP)

The Convener: The result of the division is: For 2, Against 6, Abstentions 3.

Motion disagreed to.

The Convener: I suspend the meeting briefly to allow the officials accompanying the minister to change.

09:58

Meeting suspended.

09:59

On resuming—

Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017 [Draft]

The Convener: Item 3 is the second instrument that we are looking at today. The minister is now joined by the Scottish Government officials Eleanor Stanley, policy officer in the protection of rights unit in the mental health and protection of rights division; Nicola Paterson, head of the protection of rights unit; and Fraser Gough, parliamentary counsel.

I invite the minister to make a brief opening statement.

Maureen Watt: I am introducing three instruments covering cross-border issues. Two relate to cross-border transfers and the third relates to cross-border visits. The overall aim is to amend the regulations to reflect the changes in the 2015 act and, in the case of the cross-border transfer regulations, to improve their operation.

The 2015 act introduces a requirement that regulations relating to the cross-border transfer of patients detained or otherwise in hospital should make provision for the named person to appeal against a decision to transfer a patient from Scotland. There are also changes in the 2015 act that allow certain persons to act where there is no named person. Those changes are reflected in these regulations, and certain other appeal rights and notification requirements are introduced, which are based on feedback from stakeholders under public consultation.

The 2015 act also allows for provisions in all three sets of regulations to be extended to patients who are subject to measures in other European Union member states. There is currently no process under the regulations for transferring a patient to Scotland from outwith the United Kingdom. That would include a situation in which somebody from Scotland who is taken unwell and detained under mental health legislation while on holiday in an EU country wants to return home to Scotland. By extending the provisions, we aim to fulfil the intention of the 2015 act in providing parity of treatment under the law for patients who are subject to measures in other EU member states. Similarly, changes to cross-border visits legislation will extend the ability of a patient to undertake an escorted visit—for example, to visit an unwell relative—to patients who are subject to measures in other EU states.

In addition to that, there are adjustments to the process that applies when the Scottish ministers make a decision to grant a warrant to transfer a patient from Scotland, which include introducing a fast-tracked transfer process for cases in which the patient and any named person agree to such a transfer. That change is based on feedback from stakeholders that it would be of benefit to any patient who agrees to a transfer, is eager to transfer quickly and does not intend to appeal the transfer. It will avoid unnecessary delay when the patient is in agreement with the proposed move.

I have set out the most significant changes in the regulations. The bulk of the changes relate to the transfer of patients detained or otherwise in hospital. Corresponding changes have been made, where relevant, to the regulations concerning the transfer of patients who are subject to community measures. The changes across the regulations, in particular the cross-border transfer regulations, will improve the effective operation of those regulations to the benefit of individuals who are transferring.

The Convener: Thank you very much. As there are no questions from members, we will move to item 4, which is the formal debate on the affirmative SSI on which we have just taken evidence. I remind the committee and others that members should not put questions to the minister and that officials may not speak in the debate. I invite the minister to move motion S5M-05951.

Motion moved,

That the Health and Sport Committee recommends that the Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017 [draft] be approved.—[*Maureen Watt*]

Motion agreed to.

Mental Health (Cross-border transfer: patients subject to detention requirements or otherwise in hospital) (Scotland) Amendment Regulations 2017 [Draft]

The Convener: Item 5 is the third instrument that we are looking at today. I invite the minister to make an opening statement.

Eleanor Stanley (Scottish Government): These regulations were covered in the earlier statement.

The Convener: As there are no questions from members, we will move to item 6, which is the formal debate on the affirmative SSI on which we have just taken evidence. I remind the committee and others that questions should not be put to the minister during the formal debate and that officials must not speak in the debate. I invite the minister to move motion S5M-05950.

Motion moved,

That the Health and Sport Committee recommends that the Mental Health (Cross-border transfer: patients subject to detention requirements or otherwise in hospital) (Scotland) Amendment Regulations 2017 [draft] be approved.—[*Maureen Watt*]

Motion agreed to.

Mental Health (Cross-border Visits) (Scotland) Amendment Regulations 2017 [Draft]

The Convener: Item 7 is the fourth instrument that we are looking at today. Did you also cover these regulations in your statement, minister?

Maureen Watt: Yes.

The Convener: As there are no questions from members, we move to item 8, which is the formal debate on the affirmative SSI on which we have just taken evidence. Members should not put questions to the minister and officials must not speak in the debate. I invite the minister to move motion S5M-05752.

Motion moved,

That the Health and Sport Committee recommends that the Mental Health (Cross-border Visits) (Scotland) Amendment Regulations 2017 [draft] be approved—[*Maureen Watt*]

Motion agreed to.

The Convener: Thank you very much. I suspend the meeting to allow a changeover of the minister's officials.

10:06

Meeting suspended.

10:06

On resuming—

Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017 [Draft]

The Convener: Agenda item 9 is to consider the fifth instrument that we are looking at today—the draft Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017.

The minister is joined by Scottish Government officials Innes Fyfe, who is the team leader in the mental health and protection of rights division, and Lindsay Anderson, who is a solicitor. I ask the minister to make a brief opening statement.

Maureen Watt: The final instrument that is subject to affirmative procedure that I present today relates to an amendment to the Mental Health (Care and Treatment) (Scotland) Act 2003. The provision will help to clarify that nurses are able to use the power to hold patients for up to three hours to allow an examination to take place, if the patient is in hospital for treatment as part of a community payback order. The Mental Health (Scotland) Act 2015 act will simplify the nurses' holding power in order to support practitioners and to help patients to know their rights in such situations. The power is available in respect of patients who are in hospital by virtue of a probation order with a mental health treatment requirement.

The community payback order was introduced by the Criminal Justice and Licensing (Scotland) Act 2010 and has largely replaced the probation order. The mental health treatment requirement is rarely used by the courts when making community payback orders. However, it was considered helpful to put it beyond doubt that persons who are in hospital for mental health treatment by virtue of a community payback order can be detained in that way.

To be clear, the instrument does not extend the reach of the nurses' holding power provision; it simply clarifies it to reflect that probation orders have been largely replaced by community payback orders.

Alison Johnstone: Community payback orders were the result of legislative change arising from the Criminal Justice and Licensing (Scotland) Act 2010, so why has there been such a delay?

Maureen Watt: The 2015 act's provisions that simplify the nurses' holding power are due to come into force this month. The power is

described as being available in respect of patients who are in hospital by virtue of a probation order with a mental health treatment requirement. As I have said, the community payback order was introduced by the Criminal Justice and Licensing (Scotland) Act 2010 and has largely replaced the probation order. Although the law operates in such a way that the holding power can be interpreted as covering the new community payback orders, it was considered that it would be helpful to state clearly in the legislation that persons who are in hospital for mental health treatment by virtue of a community payback order could also be detained in that way.

Alison Johnstone: What training and training materials will be made available for mental health officers when the regulations come into force?

Innes Fyfe (Scottish Government): The regulations represent improvements that support practitioners. There are no wholesale changes, such as might have been seen with the introduction of the 2003 act. Officials have been working with the Scottish Association of Social Workers and Social Work Scotland on implementation of the 2015 act, including through the instruments that we have been debating, and they have been providing content and information to support updates to local training, which is the best environment in which to introduce the changes to practitioners.

Alison Johnstone: Thank you.

The Convener: There are no other questions, so we move on to agenda item 10, which is a formal debate on the affirmative SSI on which we have just taken evidence. I remind the committee and others that members should not put questions to the minister during formal debates and that officials may not speak in the debate. I invite the minister to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017 [draft] be approved.—[*Maureen Watt*]

The Convener: If no members wish to contribute, the question is that motion S5M-05949 be agreed. Are we agreed?

Motion agreed to.

Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Amendment Rules (SSI 2017/172)

Mental Health (Conflict of Interest) (Scotland) Regulations 2017 (SSI 2017/174)

Mental Health (Patient Representation) (Prescribed Persons) (Scotland) Regulations 2017 (SSI 2017/175)

Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2017 (SSI 2017/176)

The Convener: Item 11 is also subordinate legislation. We have four instruments that are subject to negative procedure to consider. Does the minister have any comments to make on the instruments?

Maureen Watt: No.

The Convener: Do members have any comments?

Members: No.

The Convener: The Delegated Powers and Law Reform Committee has not yet considered the instruments. The Health and Sport Committee will therefore consider them again at our next meeting following that committee's report on the instruments.

I thank the minister for her attendance this morning. I suspend the meeting to allow for a change of panel.

10:12

Meeting suspended.

10:15

On resuming—

Integration Authorities' Engagement with Stakeholders and Draft Budget 2017-18

The Convener: Agenda item 12 is an evidence-taking session with the Cabinet Secretary for Health and Sport on integration authorities' engagement with stakeholders and the draft budget 2017-18. I welcome to the meeting the Cabinet Secretary for Health and Sport, Shona Robison, and I welcome from the Scottish Government, Geoff Huggins, who is director of health and social care integration, and Christine McLaughlin, who is director of health finance.

I invite the cabinet secretary to make an opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): I thank the convener for the invitation to speak to the committee today.

I welcome the committee's interest in the integration of health and social care and this opportunity to discuss in more detail integration authorities' engagement with stakeholders and the budget-setting process. That process is important, not least because integration authorities now manage more than £8 billion of resources that used to be managed separately by national health service boards and local authorities. It is a big amount of money, but it is also a limited amount, and we recognise that it needs to be used more effectively and efficiently. By that, I mean that we need to shift resources towards more preventative activity, reduce reliance on reactive hospital-based care and provide the right care at the right time and in the right place, which will, I hope, be in the patient's home as often as possible.

That said, integration should not be seen as being just about budgets; it is also about improving outcomes for people. That is why I want to focus in particular on stakeholder engagement. It was at the heart of our legislation on integrating health and social care, the aim of which was to put service users at the centre of things along with service providers to ensure that their voices are heard and that they are fully involved in decision making and in planning.

We should recognise that integration is still at a very early stage and is still evolving. We have seen a lot of progress in ensuring proper engagement of key stakeholders instead of their having tokenistic involvement, although we acknowledge that we still have some way to go. I think that that has been acknowledged in earlier evidence-taking sessions. For example, the Coalition of Carers in Scotland noted that it had

"seen a lot of improvements and best practice development"—[*Official Report, Health and Sport Committee,* 25 April 2017; c 3.]

and, in the same meeting, Voluntary Action South Lanarkshire highlighted its involvement in strategic commissioning.

The strategic planning group in each integration authority, along with locality planning arrangements, is where engagement is particularly important, because those who know best how services should be delivered are those who receive the services and those who provide them. Their empirical evidence must be supported by data that must be readily available and accessible to stakeholders. We are working with NHS National Services Scotland on further developing a link to the health and social care data set known as "NSS source", which I understand my officials have demonstrated to the committee and which will be key in informing future decision making.

Clearly, open sharing of data will require trust between and across sectors, and we are already seeing where that approach can work—for example, in the improvements to home care in NHS Highland, where the local Scottish Care representative co-chairs the strategic planning group.

I am happy to take questions.

The Convener: Thank you very much.

Alison Johnstone: Thank you for joining us this morning, cabinet secretary. I very much appreciate the tone of your opening statement, because it is clear that there is still work to be done on stakeholder engagement. For example, Amy Dalrymple of Alzheimer Scotland told us that she attended a meeting of an umbrella group of organisations and spoke to a chief officer of a health and social care partnership, and said that when she suggested the important contribution that third sector organisations could make

"The response that I got was that it would be very welcome if we were to help to communicate why certain decisions had been made"—[*Official Report, Health and Sport Committee*, 25 April 2017; c 25.]

instead of their being involved in the decision-making process. Andrew Strong of the Health and Social Care Alliance Scotland said:

"At the IJB governance level, the relationship between the statutory sector and the third sector, the independent sector and people who use supporting services is inherently unequal,"

and went on to mention

"the nature of voting rights and the number of people on the boards."—[*Official Report, Health and Sport Committee*, 25 April 2017; c 21.]

Is local co-production achievable if, as organisations such as the Health and Social Care Alliance are suggesting, the relationship is "inherently unequal"?

Shona Robison: As I said in my opening statement, there are examples of good practice; Alison Johnstone has highlighted examples of not-so-good practice. We are still at a fairly early stage in the life of the integration authorities and we are seeing good practice across a number of fronts in many integration authorities, but it is fair to say that others still have some way to go on that journey—certainly in terms of the level of engagement.

Good practice has put stakeholders at the centre of planning and decision making. Stakeholder engagement should certainly never be seen as just a method of communicating decisions that have been made by others. That is not in the spirit of what was intended. I would be the first to acknowledge that the situation is still work in progress.

The Health and Social Care Alliance is an important partner in working to build the capacity of communities and third sector organisations on the integration agenda. When Parliament passed the legislation on integration, it considered carefully some of the structural issues. For example, there was a long debate about the voting rights of individual board members. The conclusion was that it was proper for voting rights on use of such significant public budgets to be held only by board members who are publicly accountable—in other words, elected council members and non-executive members of health boards.

That is important, but it should not mean that the role of stakeholders is limited to acting as a communication channel for decisions that have been made by others. That is not the intention or the spirit of the legislation. As the legislation lays out in considerable detail, it is extremely important that integration joint boards engage fully with stakeholders and partners. That was made very clear. It is also important that third sector partners, which can be a disparate range of organisations, organise themselves effectively to engage in the process. A lot of work has been done, a lot of support has been provided and a lot of resources have been put in to ensure that that is the case.

In summary, it is work in progress, but there are some really good examples of good practice. We want to roll out that good practice to help to address some of the less-than-good practice.

Alison Johnstone: Claire Cairns of the Coalition of Carers in Scotland said that there are other barriers to being fully involved in the process, some of which are to do with cash, transport and access to meetings. She said:

> "we hope that carers would get all their transport and replacement care costs reimbursed, but that is not always the case. Some carers use their own direct payments when they attend meetings, and that reduces the short breaks that they get for themselves".—[*Official Report, Health and Sport Committee*, 25 April 2017; c 3-4.]

Those are other issues that are preventing people from being fully involved. Where should resources and support come from to enable stakeholders to participate fully in local service planning?

Shona Robison: Funding is available for third sector interfaces, as we call them—I think that about £8 million has been provided to the end of March 2018.

We expect the integration authorities to ensure that those who participate in the process can do so without detriment, and I would be concerned if that were not the case. We would certainly want to pick that up with the Coalition of Carers, because people are giving of their time and, if they have responsibilities that make it more difficult for them to do that, they should not be disadvantaged.

Geoff Huggins might want to add to that.

Geoff Huggins (Scottish Government): We can certainly pick that up with the chief officers. We can work to understand how they are engaging with people in a meaningful way and can act on that basis.

As the cabinet secretary said, more than £8 million is available for third sector interfaces to March next year, and a further £4 million is available to September. Beyond that, we will need to look at how we take that forward.

Can I say something on the first question?

The Convener: I am sorry—what are the £8 million and the £4 million for?

Geoff Huggins: Those moneys are to support third sector interface organisations to provide local support to the third and voluntary sectors to engage with integration.

The Convener: Thank you.

Geoff Huggins: A number of those who commented on engagement were national organisations. We have seen the challenges that national organisations with a Scotland-wide remit face in engaging with 31 integration authorities, given what that means in practice. Each chief officer has had multiple applications from many of the organisations to spend time on engagement.

In commissioning local services with local providers, whether those are voluntary or independent, chief officers have to put themselves in a different place by forming strategic

partnerships and engaging in different ways to deliver on policies such as the living wage commitment, as we have seen in our work on that area. The experience may be variable, as you say. In particular, the experience of local third and voluntary sector organisations might be different from that of the nationals but, again, that is just part of working through integration.

A key component of integration is the localisation of the agenda—the idea of building services in communities rather than simply building a national idea of what a service is and then rolling it out. The needs of different communities and individuals are very different. It might be helpful to get under the skin of the local experience a bit more, because those experiences will not always be the same as the national experience of an organisation such as Alzheimer Scotland, which is well connected, or the Health and Social Care Alliance Scotland.

Tom Arthur (Renfrewshire South) (SNP): I have a quick supplementary question. Cabinet secretary, you referred to integration authorities evolving, which I think we all recognise they are. We took evidence some time ago in which it was noted that the lead agency model in the Highlands took five years to bear fruit. How long do you expect the move to genuine co-production to take?

Shona Robison: We want it to happen as quickly as possible. In reality, some integration authorities are already co-producing in the true sense—we have seen a lot of evidence of good practice, some of which has been shared with the committee—while others are still on a journey and will take longer to get there.

Our role and the role of the ministerial strategic group that oversees integration is to share best practice and to push the agenda. We can do that in several ways, including through the provision of guidance and resources, data sharing and extolling the benefits of co-production, but inevitably not all partnerships will move at the same speed towards achieving that aim. The short answer is that it will be done as soon as possible.

Geoff Huggins may want to come in on that.

Geoff Huggins: The other issue is that different challenges require different solutions. For example, I looked at Glasgow's plan for this year. It is considering the implementation of an assess-to-admit service for Glasgow hospitals whereby people will be assessed at the point at which they present, which will probably not involve co-production other than with staff.

At the same time, however, in some of the work that we are seeing on the ground to tackle isolation and loneliness and to improve people's access to a wide range of services including leisure and recreation services, a different type of conversation is taking place about how people live their lives. We need to think about that when we apply the idea of co-production rather than see it as the solution to everything. Chief officers—slightly more of them across the rural landscape—are trying to tap into the assets and capabilities in communities and are thinking about how they can use those to support people instead of simply looking at another statutory or independently delivered service. They are thinking differently about how to meet people's needs, and we are seeing a mix of things out there.

The Convener: I have a question on timescales. Time is a flexible phenomenon these days. A generation used to be a long time, but that is no longer the case.

You said that the new authorities are still at a very early stage of development. However, we have had two years and then a year of shadowing. What timeframe do you think we need to get all the different integrated authorities up to speed in developing alongside stakeholders?

10:30

Shona Robison: A lot has been achieved in a relatively short space of time, as a new organisation has brought together two large organisations and different cultures. Think about what has been achieved on, for example, the big issue of delayed discharge. About a third of partnerships have got delayed discharges into single figures, which is an enormous achievement in a fairly short space of time. That is a hard data measurement. Reports will come out in the autumn that will show progress across a number of the key outcomes, of which that is one. The reduction of the number of unscheduled hospital admissions is another.

Other things might not be hard data outcomes as such, but we would want to see them captured in the reports—for example, the progress that has been made on things such as the level of co-production and the meaningful involvement of stakeholders in shared decision making.

The issue is how we measure success. The hard data measurement of success will be measurement against the outcomes. However, although a range of other things about the culture and the way in which integration authorities go about their business are not as hard edged, they are just as important. I understand that we expect some of those things to be captured in the reports that will come out in the autumn—is that right, Geoff?

Geoff Huggins: Yes, we expect to see that.

When I have been out talking to chief officers and senior managers, it has been interesting to

see how they are thinking about the community and primary and social care landscapes. I have had conversations with a couple of chief officers about their thinking on how a range of different services that are provided by different professionals operate across the landscape.

When I was out a few weeks ago, I asked a chief officer who had previously done the job that they were doing to co-ordinate the landscape. The answer was that nobody had done it, as a social work department managed the social work component, a primary care commissioner managed primary care and a community health commissioner managed the community health aspect. In effect, they were operating down lines in the provision of services. The change is not particularly visible, but we should see the fruits of it as time goes on.

The idea that the chief officers and senior managers are thinking across the landscape about how the different services interact and that they can bring together teams that operate differently because they are no longer subject to the single silo way of seeing things is quite exciting and interesting, but it is not visible unless you get under the skin and talk to people about how different things are. That different way of thinking about things might be covered in a line in a report, but it is of fundamental importance.

The Convener: There are undoubtedly huge financial pressures on the new authorities. Given those financial pressures, it is clear that, when they make decisions about services, there will be significant service change. How do you envisage public consultation and public engagement happening during that period? Is it fair that those organisations are starting their journey with such financial pressures on them? They will bear the brunt of any kickback from the community, although they largely cannot do anything about the budget that they have been handed.

Shona Robison: The total budget under the control of integration authorities covering social care, primary care and unscheduled hospital care is £8.29 billion, and health boards are required to maintain funding at 2016-17 levels. There is also the additional £107 million funding for social care. The global budget is not insignificant—it is a big resource—but the important thing is how it is spent.

On shifting the balance of care, we have been clear with integration authorities—as they have been in their own discussions—about how to make the best use of the collective resources so as to keep people out of hospital by building up community health services with a change in how our services are delivered. For the first time, real inroads are being made into developing services whereby people can avoid ending up in hospital for unscheduled care, which is a very positive development.

The integration authorities are starting life with a significant resource, although I would be the first to acknowledge that, in the financial climate that we all live in, the issue is to ensure that every part of the public sector makes the best use of resources. The aim is a more efficient and effective way of spending resources to keep people out of hospital when they do not need to be there, and we have the best chance of achieving that aim through the new world of integration.

Not everything will be in the domain of major service change. Some changes are about doing things in a different way, developing the community services that are demonstrated to work and have an evidence base to show that they work and prevent people from ending up in hospital. As I say, that is not necessarily in the domain of a major service change.

Where there is major service change, the processes for that are well laid out, and we would expect the public to be fully engaged with that change. We would also expect the public to be fully engaged with some of the new developments. For example, some of the services that are working to keep people out of hospital have come about through the engagement of local communities and the people who receive the services, and we know that they work very efficiently.

One such service is ELSIE—the East Lothian service for integrated care for the elderly. It has been very effective at triage, with people avoiding going anywhere near an acute hospital because of the services that are provided in their home. There has been a lot of public engagement in the testing of those services to ensure that they meet people's needs and are effective, safe and of good quality.

The Convener: The committee's problem lies in identifying whether there has been a shift in the balance of care and whether the actions that are being taken are efficient. It is proving difficult for us to find evidence on that. We have heard about it time and again from different authorities that tell us anecdotally what they are doing, but it is extremely difficult to get them to put figures on things.

Shona Robison: I accept that that is difficult and that it is difficult to achieve such a shift. We have been talking about it for many years and, as I said, our best chance of achieving it is through the integration authorities. We have set ourselves ambitious targets for the percentage of spend on community services, which means that the growth in spend will be greater in community health services than in acute services.

There are annual performance reports, and it has been agreed that data will be released to show the shift in spend so that that will be more visible. The resources that the Scottish Government has allocated are going in a direction of travel that will help with the momentum of that, as money is going into primary care, social care and mental health at a higher rate and a faster pace than it is going into acute services.

Christine McLaughlin (Scottish Government): I acknowledge that, as the convener said, it has been difficult to get the evidence to show the shift through clear, straightforward reporting. We are doing a lot of work with the NHS and the integration authorities to work out how we can start to see the shifts coming through—and not just in funding and the direction of funding. The feedback is that there is now more clarity about the direction that the cabinet secretary mentioned, and we need to see that flow through in expenditure.

From 2017-18 onwards, we will examine closely spend in the acute sector, in primary care and in community care. That will involve looking at areas such as prescribing so that we can understand the situation when we start to see the shift and can assess whether it is happening at the level that we would expect it to happen on an annual basis.

I agree that much of the current evidence involves what people say is happening, but I expect to have more clarity from 2017-18.

The Convener: Much of that is assertion.

Christine McLaughlin: It is asserted through funding, if I can put it that way.

The Convener: It is an assertion that the shift is happening, and it is an assertion that it will make things better and more efficient. We do not have evidence that the shift is actually happening.

Christine McLaughlin: We have some evidence. If I can clarify—

The Convener: Just a moment. Probably all of us around this table—in fact, probably all of us in this Parliament—think that shifting the balance of care is the right way to go. The problem is that we do not have evidence to show that it is working.

Christine McLaughlin: We have set up a couple of things to enable us to make it work. Doing things such as giving direction on maintaining spend is more than just making an assertion. Maintaining spend on health and social care integration means that we expect it to flow through in the financial year. How that needs to be managed to deliver the shift in the balance of care means that some shifts will be required in the current year. It is more than assertion: that is happening. Money is being put into primary care and investment is being made in new models, and that money will be spent in those areas—it will not be spent in the acute sector.

There are sufficient building blocks to enable the shift to take place. Through 2017-18, we will see the extent of expenditure in those areas and the exact value of it. That is not just an assertion. There has been enough of a shift in the direction of funding, and that is what I am trying to distinguish.

The Convener: The money can be shifted, but we do not know whether it is being used more effectively.

Shona Robison: We have set the ambition that, by 2021-22, we expect more than 50 per cent of front-line spending to be on community health services. You are right, however, in saying that budgets can be set—we see the budgets that are being set this year moving in that direction—but we need to track the actual spend. That is the bit that needs to follow, and we are acutely aware of that.

Donald Cameron (Highlands and Islands) (Con): I return to the vexed issue of care home closures and public engagement. I know that Mr Huggins will be aware of several closures in Argyll and Bute, where feelings ran so high that a petition on the closures came first to the Public Petitions Committee and then this committee. We are all well aware of the issues: often there is a sense that decisions are predetermined, that consultation is superficial and that information is lacking.

To be fair to the IJB, I think that it will take lessons on board, but there remains a gap between the buzz words of “locality planning” and “co-production” and what is actually happening on the ground, where the fact is that there just is not the public support that we all want for the changes, if they are right, correct and need to be made.

A witness who gave evidence to this committee spoke about a real culture change. My fear is that although of course integration will take time, things are moving very slowly. How do we achieve the culture change that must happen?

Shona Robison: I will answer this with Geoff Huggins, who has been far closer to the issue than I have and has spent a fair bit of time in Argyll and Bute meeting those who have been directly involved.

Even if an integration authority believes that what it is putting forward is the right thing, it is important that that is explained properly and that time is taken to go out and properly consult, not just say, “This is what we’re doing. Take it or leave it.” More important than that is that time must be taken to demonstrate what the new replacement

services actually are. To be honest, health boards have not always been as good at doing that as they could be, so integration authorities need to look at best practice for demonstrating what new services will look and feel like for those who receive them.

It is right that the integration authority has taken more time to look at the proposals. Clearly, there are difficulties with service provision in the care home sector in that area.

Geoff, do you want to say a little bit about your involvement?

10:45

Geoff Huggins: We are talking particularly about some of the services in Campbeltown, are we not?

Donald Cameron: And Dunoon.

Geoff Huggins: Campbeltown is particularly interesting. What we have there is a care home that is significantly underoccupied. When I was last here talking about it, something like 12 or 13 of its 30 places were occupied. There were significant issues with the home's ability to have appropriate staff in place because of issues with recruiting in the area and the poor ratings that the home had received previously.

In other circumstances, the care home operators would probably have simply given notice to quit and indicated that they intended to close the home, which would have passed the problem to the integration authority, which would have had to find housing in the area for the 12 or 13 people in the home. That was clearly undesirable for all parties, because it would have required the people, who were from Campbeltown, to be moved away to receive care elsewhere. The integration authority in that space stepped in to have a conversation about how it could find a solution that better met the needs of the people in Campbeltown.

That is the point at which things became difficult. The solution that was initially seen as desirable was to find 17 more people to go into residential care in Campbeltown and occupy the home, making it value for money. Now, in the same way that we have a desire to shift the balance from hospital to community, we have a desire to shift the balance from residential care to care at home. In that context, the idea that we would simply increase the amount of residential care that is being offered in an area was not particularly desirable.

We have worked through the process with the partnership, but some of the public expectations were not in the same space as the expectations from the Parliament of more community care. In that case, there was an expectation of more residential care, and that had to be worked through.

We have identified a solution. With the assistance of the council, the council leader and the local member of the Scottish Parliament, the partnership worked through the process to identify how to resolve the issues in Campbeltown and find an appropriate solution that meets the needs of people who live there while not requiring people to transfer externally.

The change that we had was that, rather than simply having a notice to quit, there was a process that resolved the situation. There was some trickiness, in that people had different views, but that is part of the process. I do not think that effective and constructive engagement will mean that every time that something happens, people will say, "That is great. We're doing it." There will continue to be a need to work through different views. We have to be careful not to say that working through different views and perspectives means that engagement is not working. In the end, engagement has worked in Campbeltown.

Donald Cameron: To be fair, a temporary resolution was achieved over the course of a year.

I was actually more interested in a slightly higher level. This demonstrates to me that engagement with communities has to be meaningful, and I do not think that it has been in these cases. What happens is that the public hear that their local care home is closing and there is a media campaign and so on. That does not work for anyone, to be frank. I am interested to hear about the lessons that can be learnt from such experiences and how we effect the culture change that we all accept requires to take place.

Shona Robison: The main thing would probably be earlier engagement. Sometimes things happen. Sometimes a care home, or whatever, will find itself in difficulty and that can have a range of knock-on effects and triggers.

It is about trying to have early engagement when there is a foreseeable problem, and to do it in a way that is not about dealing with a crisis. The process that we have just been talking about took time, but it was important to take that time to reach a better solution.

Whether it be the private, public or voluntary sector, it is important to have early discussion about potential issues and problems in a way that is not about responding to a crisis.

Geoff Huggins: The other thing that came out of the experience was a move away from seeing the change process as being about individual components of the overall service. The more general conversation that we have been having

with Argyll and Bute is about thinking about how services are applied across geographies. When we are talking about a unit or particular component of the service, the community and the public do not get the full picture of how a range of changes will effectively provide a better, more cost-effective, sustainable or deliverable service over time.

Part of the learning that we have taken from Argyll and Bute was about the context—for example, the home that we are talking about was one of two homes in the area. Some of the issues also related to how more people might be employed to work in the care-at-home sector rather than in the residential sector, and also about the quality and nature of training and upskilling in the area. A series of things took the solution from being simply about the one particular property to being about the wider environment. We are using that learning elsewhere.

Another issue was the importance of earlier engagement with elected members, including MSPs, because, to be fair, they are the ones who will tend to have the impetus to campaign to retain something. That appears to be something that is common across the piece, and there is a challenge around making the case against such campaigns in that situation.

Donald Cameron: With regard to changes in medical or clinical care, should medical professionals have a greater role in stakeholder engagement? Would that be helpful?

Shona Robison: I think clinical voices are really important in explaining why decisions are made on, for example, patient safety grounds. The best voices to explain that are the clinical voices. When service changes are proposed, clinical voices—not just medical voices but the voices of everyone who will be delivering the services across the piece—are an important component of that because they can explain how services will be delivered in a different and, in many cases, better way. For example, if a service is to be delivered in the community through primary care or community health services that had previously been delivered in a different way, it is important that the public are assured about the quality of that service, and those who will be delivering the service are often the most powerful voices in terms of explaining what that will look and feel like. We do not always use those voices as well as we could. It is important that those voices are heard, along with others.

The Convener: This is where I think that some of the problems arise with regard to the realistic medicine agenda, because I think that some people in the community might be willing to put up with a lesser service that is local, rather than a centralised service that is better in the eyes of clinicians. From the point of view of patients and the public, that approach is also realistic medicine. That is part of the dilemma of the agenda that is being put forward.

Shona Robison: Those tensions are inevitable. I argue strongly that, often, the services that are being developed will be of better quality, and that that should always be the driving force. Again, it depends on the kind of service that we are talking about. If we are talking about a procedure that someone receives once or twice in a lifetime, the arguments are different from those about a procedure that somebody needs on a weekly basis—you can see the difficulties involved in someone having to travel further, for example.

What the realistic medicine approach says, alongside the national clinical strategy, is that we have the opportunity to deliver a lot of services more locally if we get the approach right, with a lot of services being delivered within primary care and community health services in a way that avoids people having to travel to the hospital. For example, a lot of diabetic care that people previously had to travel to hospital to receive is now delivered within the local community health services. There is a two-way process, but we have to explain the rationale and what the service will look like far better than we do at the moment.

The Convener: We have a number of questions on budget issues, so we will move on to that. Colin Smyth will ask the first one.

Colin Smyth: Local authorities set a balanced budget by a certain date and identify specifically where savings will come from for the year ahead. Obviously, a large part of what previously went into council budgets now goes into the budgets of IJBs.

A number of IJBs have still not set a budget for the year ahead, and a number have set budgets with savings targets but no detail on how they will meet those targets. Is that satisfactory? Why are IJBs having difficulty in identifying their savings if they are simply efficiency savings?

Shona Robison: I reiterate that we are talking about a total of £8.2 billion of resources being at the disposal of the integration authorities. Sometimes it is important to focus on the pot of money that is to be spent rather than just on the efficiency savings that require to be made.

I will make a couple of points about the budget-setting process. First, it is a lot better, as a lot of progress has been made on last year in terms of timeframes and the number of budgets that have been successfully set. Some issues remain. For example, for the six partnerships in the NHS Greater Glasgow and Clyde area, there remains a legacy issue—of, I think, £7.8 million of non-recurring funding—to be resolved from 2016-17.

To put that in some context, I note that those authorities have about £2 billion to spend between them, so they are looking at £7.8 million out of £2 billion. The issue remains, but it is being resolved. There are positive discussions and I am confident that, with support from the Scottish Government, the authorities will deliver a resolution very soon.

The only other one is the Fife partnership, where there are issues around the set-aside budget. Again, those are being worked through and I am confident that they will be resolved. That is a significant improvement from 2016-17, when 11 of the 31 IJBs had agreed a budget by the end of April. We are now in a position in which they have all done that, bar the seven that I mentioned, and those seven are working through the issues that they have to work through.

The public sector as a whole, including local authorities and health boards, is used to delivering efficiency savings and has done so for many years. We are asking the integration authorities to deliver 3.5 per cent efficiency savings. Again, I note that we expect them to use the opportunity to reform and deliver service changes in terms of both shifting the balance of care and how they prioritise and resource services to shift that balance, keeping people out of hospital and reducing unscheduled care admissions to hospital. We are confident that the plans that the integration authorities are developing will deliver that direction of travel.

Colin Smyth: Cabinet secretary, you made no reference to those IJBs that have set budgets that include savings targets, but have no detail whatsoever as to how they will meet even part of those targets. They simply have figures in their budgets. Why are those IJBs, having set a budget, unable to identify savings, if they are simply efficiency savings?

Shona Robison: Some of the savings that the integration authorities will deliver will be in-year savings, and they will work through those as they progress. Christine McLaughlin is closer to the finance officers who are working through those budgets, so she can say something about that, but we are confident that the integration authorities will deliver those savings, some of which will be in-year savings.

Christine McLaughlin: One factor is that the NHS does not treat the years as being entirely stand-alone. It is a rolling programme of savings. If we look at the history, even over the past three or four years, we see that there is always a component of one-off savings as well as the efficiency savings that Colin Smyth mentioned, which arise when people make changes to a service, and which they will have on a recurring basis. Typically, that has run at anything from a quarter to a third of the total savings.

The situation is not new and, if we look at the history, we see that health boards have been able to achieve those savings in-year. However, it is in the nature of the way in which services and budgets are defined that there can be swings, with in-year pressures in some areas and other areas where the actual expenditure improves on the budgets that were set, given that the budgets are targets that people set at the beginning of the year.

It is important to see it in that context. I do not think that any integration authority is in the position of having no plans to back up the savings that they have identified. However, it is not uncommon for savings not to be completely and fully identified at the beginning of the year. Of itself, that is not an indicator that there will not be balance, but it does mean that more in-year work will be needed to identify the savings. We focus our efforts on understanding the extent to which there is a level of risk with those unidentified savings. We also work hard on looking at where national or regional actions can be taken, beyond the boundaries of an individual integration authority, NHS board or local authority.

11:00

Colin Smyth: Can we look at the process that IJBs follow when budgets are set? The theory behind the budget setting process is that IJBs agree a strategic plan, identify what resources are required to meet that plan and align resources to outcomes. However, what happens in practice is that local authorities and health boards decide how much they will give to the IJB and then the IJB decides what it is going to spend that money on. Is that a satisfactory process? How would you improve it?

Shona Robison: The process has improved over the past year. A lot of work has been done through providing guidance on the issues that were raised concerning the budget setting process last year, and Christine McLaughlin has worked very closely with finance officers to get the budget setting process more into the former than the latter approach.

Christine McLaughlin: There is definitely evidence that integration authorities are more engaged with the NHS boards and local authorities through their chief officers and chief finance officers as part of the budget setting process. Because we set a clear direction at the beginning of this financial year about the need to maintain spend, that took away a lot of the negotiation that there was in the first year. It was one of the most positively received steps in the development of the 2017-18 budget, because it removed the negotiation about taking off an efficiency saving before handing over a budget to

the integration authority. We said very clearly that we expected the minimum spend to be the same in cash terms as it was in 2016-17, and my view is that that took away a lot of what we saw in that first year.

Geoff Huggins: The other thing that we are seeing is the interdependencies between integration authorities and the residual NHS services. The expectation in 2017-18 is a reduction in unscheduled care; that is clearly signalled in the delivery plan. However, we do not want the integration authority to take decisions without proper and full discussion with the residual health board. We cannot simply say to the chief executive of NHS Lothian, "By the way, we are going to give you 20 per cent less this year. Can you just get on and sort that out? We are not going to tell you how to manage your demand." They have to work through the complexities of their interdependencies, because the decisions that are made by the integration authority have implications for the NHS board in respect of other services that are provided within a hospital. Also, they need to have confidence that, if there is an intention to reduce attendances or admissions, it can be sustained across the year. Resolving all those issues before the start of the financial year is probably beyond either boards or integration authorities; it requires a continuing conversation through the year. It is important to see it in that way.

We are still working through the process of moving beyond seeing resources as continuing to be earmarked on the basis of their historical source or what they were previously allocated for. We had a conversation the last time that we came to the committee about the expectations from different interests—for example, that money that used to be spent on pharmacy will continue to be spent on pharmacy. As part of the process of change we are seeing conversations that go beyond simply finding an efficiency, which is doing something faster or cheaper, to deciding what we might do less of or where failure demand can be taken out of the system. We are also seeing different styles of solution going into the process.

Where we are this year in respect of efficiencies is not that different from where we were last year—

Colin Smyth: It is a problem.

Geoff Huggins: —but the consequence was that, during last year, the efficiencies were delivered. We reached the end of the year in the financial state in the integration landscape that we had wanted to reach. That shows that, rather than artificially pretending that all the issues can be resolved before the financial year starts, resolving some of the issues and continuing to work through the others has been an effective methodology.

Colin Smyth: I think that it is fair to say that a lot of the savings, which were made very late in the day, are non-recurring savings.

I want to return to my initial point. In what way do you see improvements being made? For example, an issue that was raised was that it was okay to put in a figure for savings without identifying when those will be made, because the budget is decided annually. Why do we not allow IJBs and local authorities to have three-year budgets? The Government sets a three-year budget, so it has certainty and it can set out the budget over a longer period. Why are we not moving in that direction?

How else do you see the budget process improving? You talk about giving IJBs more certainty by defining by how much local authorities can cut the budget allocation to them and where the £107 million, for example, goes to. Does that mean that you see more central direction being given to IJBs on how they set their budgets?

Shona Robison: On three-year budget setting, we will continue to have discussions about how we can give longer-term certainty. To be blunt, there have been challenges because of the whole Scottish budget setting process. The allocation from the United Kingdom Government was late, which had knock-on consequences for the Scottish Government's budget setting timeframe. That had a knock-on effect on those who receive resources.

Your point about looking to a longer-term timeframe is not unreasonable. That is something that we would want to do; it is an issue that we continue to discuss with partners.

Christine McLaughlin: We are moving to a longer time period. Part of the guidance is about moving to a rolling three-year cycle with integration authorities, which is not dissimilar to the situation in the NHS. It is similar with local authorities, too—they set a rolling budget for a longer period, although it is always the first year that is their real target budget, with the expectation that years 2 and 3 would be refined as they go. That is the direction in which we are headed. Part of the balance concerns the extent to which the Scottish Government can make clear assumptions about the high-level funding that is available. The way that we do that with the NHS is that we agree on a reasonable set of assumptions, to which it works.

It is not unreasonable to have a three-year rolling budget for integration authorities, but we all need to recognise that there will be changes to years 2 and 3 as the budget process moves forward. The more we see of that approach, the better it will be for everyone.

We have good working relationships with the integration authorities, and not just with the chief finance officers; we take feedback from them. It is in our gift to give more or less direction, when it is helpful to do so. I would like to hear back from the integration authorities about what they consider to be obstacles to good, longer-term planning and on the areas in which there could be improvements. We will take on board those views as we develop the budget for 2018-19.

Nothing really significant has been raised with me, other than the extent to which we can give greater certainty about funding from the Scottish Government. We will continue to work with integration authorities on the basis of reasonable assumptions as we go through that process.

The Convener: This will be your final point, Colin.

Colin Smyth: The cabinet secretary will not be surprised that it is on the issue of the living wage. Are we yet in a position in which people who carry out sleepover shifts are being paid the real living wage, or are IJBs and local authorities simply adhering to Her Majesty's Revenue and Customs guidance on the national living wage?

Shona Robison: We have given a commitment that, during this financial year, sleepover rates will be paid at the real living wage level, but work is on-going—as I am sure that you are aware—on some of the related complexities with service providers. Some of the service providers have made the point that we need to take time to enable them to make what are, in some circumstances, fundamental changes to how services are delivered. They were concerned about services potentially falling over if that time was not taken.

That is why, along with the Convention of Scottish Local Authorities and the service providers, we have taken a cautious, planned and careful approach to delivering the living wage for sleepovers, which will be delivered during 2017-18; we want to ensure not only that the move does not impact on service providers but, more important, that it does not impact on the service users who rely on the services.

Do you want to add anything, Geoff?

Geoff Huggins: Yes. The work that we have done on the living wage and on sleepovers has revealed a lot that we had perhaps not been aware of about the structure of the system and the differentials in different areas of the country. For a start, we had not been entirely aware of the number of people who were subject to sleepovers or the structure of their care packages. As a result, some of our work with partners, chief officers and others has been on whether in some places the service models are actually the best that can be used, whether sleepovers are being used inappropriately or whether they can be used to deliver a better quality of service. We have therefore put in place a change programme that is looking at appropriate service models and the use of technology, and which is seeking to ensure that those for whom sleepovers are the most appropriate approach get a quality service in that respect.

As we have worked through the implications of paying the £8.45 rate for sleepovers, certain questions have arisen. For example, we think that it might be more difficult to recruit people to do work during waking hours if we are prepared to pay people £8.45 an hour to be available for sleepovers. That could lead to recruitment issues. Again, we are working through with providers our understanding of those challenges, but the problem is that, each time we think that we have resolved an issue, some other challenge develops.

Nevertheless, we will continue to do the work. We have said that we will come back with outcomes later in the year. We will look for a result that meets the commitment in question and the needs of provider organisations and people, but which works within the integrated landscape and the wider social care reform process.

Shona Robison: We have put resources aside for this, and we have left the door open for additional resources to be provided if the current resources are shown not to be adequate in meeting the commitment that has been made. Those discussions are on-going.

Colin Smyth: I presume that, if we are being realistic, the £10 million that has been allocated will not be sufficient to pay the real living wage.

Shona Robison: That work is on-going, but we have said that if it is not sufficient, more resources will be made available. Part of the work that Geoff Huggins has described has focused on the financial costings. The £10 million was a starting point based on certain assumptions, but as Geoff has said, the complexity that has arisen as more work has been carried out on the issue will guide us as to whether those assumptions were or were not accurate. However, the door has been left open for additional resources to be provided, should they be required.

Geoff Huggins: I think that that was part of the reason for the structure of the arrangement for 2017-18. When we tried to unpick the data to identify the marginal cost, things became quite complex not just because of some of the initial work that had gone into meeting HMRC requirements, but because of different expectations with regard to the structure of the service and our ability simply to cost and evaluate the difference between what had almost been single-payment packages of perhaps £35 to £40 a

night and what those would have been when converted to an hourly rate. When we came into this year, the data looked distinctly fragile with regard to our ability to say, "It will cost this amount to deliver the 2016-17 service in 2017-18 at a sleepover rate of £8.45 an hour." There are so many moving parts that it is actually quite difficult to assess the full cost. In practical terms, it might be that the allocation for 2017-18 is sufficient, but that will make 2018-19 difficult in turn.

The Convener: When you have done that work and achieved a result, can you write to the committee to advise us of that?

Shona Robison: Absolutely.

The Convener: That would be helpful.

Miles Briggs: I would like to raise a small point. Children's services are not covered by IJBs at the moment, but is any work being done to include them in the future? What impact might there be on such services as a result of the pressures that we have heard about on adult services?

Shona Robison: Some IJBs cover children's services—I think that the figure is about a third. Is that right?

Geoff Huggins: Nearly all integration authorities have children's health services, because by and large they are provided through primary care services, and a third have social care services. It is a mixed rather than a single picture.

Shona Robison: Yes, and I think that we would want to work with the integration authorities and certainly in the ministerial strategic group to look at what have been the benefits and, I guess, the downsides of including children's services. If there are advantages of including children's services and those are clearly demonstrated, we would want to evidence that and look at what lessons there might be for the authorities that currently do not do that. We have not mandated that approach; we want to continue to look at the relative benefits of including children's services.

11:15

Miles Briggs: What sort of timetable are we talking about for that?

Shona Robison: The analysis is on-going. We will look at the annual reports that integration authorities will submit in the autumn and, for those that have children's services, we will do an analysis of the benefits. We will probably do that through the MSG.

Geoff Huggins: Miles Briggs asked about financial pressures. It is instructive that, in the areas where children's services are included, there have probably been additional financial pressures on the children's side, which have then squeezed the services for adults and the elderly. A number of integration authorities where children's services are included have had to find additional resources from elsewhere in the budget to support services for things such as learning disability and autism. We have to see this as a set of issues that flow both ways.

Yesterday, we had a conversation between officials about the integration of children's services. The issue is complex because, although people are generally in favour of integration, many areas are thinking about integration between children's services and education rather than between children's services and health. There is a question as to whether the Parliament or the Government wants to mandate a template or to allow for continued local decisions on the best way to structure that, but with a general commitment to working across boundaries—whether service-level or geographical boundaries—to get better value and be more effective. We are seeing a number of dynamics. It is seductive to see the issue just from our perspective in health, but other people are looking at the question through a completely different lens.

The Convener: On 30 May, we had a discussion about the distinction between efficiency savings and cuts, and Ms McLaughlin will recall the exchange that we had previously on that. In that session, Keith Redpath from West Dunbartonshire health and social care partnership said:

"There may be some aspects of efficiency and doing things a bit better that mitigate some of that, but the reality is that most people would recognise that as a potential cut to the level of service. That is why I used the term 'cuts'."

Katy Lewis from Dumfries and Galloway health and social care partnership said:

"There will be some things that we do that you might want to describe as cuts or budget reductions."

Karl Williamson from Shetland health and social care partnership said:

"as budgets keep getting reduced, we might get to the position where we need to make cuts and reduce services."—[*Official Report, Health and Sport Committee,* 30 May 2017; c 22-3.]

We have discussed the thesaurus that is used by chief officers in Scotland—some say "cuts", some say "efficiencies" and some say "savings". Do you now recognise the comments from those chief officers that cuts are being made?

Shona Robison: Well—

The Convener: Sorry, but I am asking Ms McLaughlin first.

Christine McLaughlin: The overall budget is increasing and not reducing, so there are not cuts

overall to health and social care. That is the point that we are trying to make.

The Convener: Do you recognise what is being said by chief officers who are on the ground operating budgets? They say that they are having to make what they call cuts in their services.

Christine McLaughlin: They are having to move money around the system and the money has to go further than it has before. That is what I recognise.

The Convener: You cannot bring yourself to say that there are cuts in services.

Christine McLaughlin: I have tried to answer your question as transparently as I can.

The Convener: No, I—

Shona Robison: Convener, if all budgets stay the same in every line, there will be no change. Change is required, and that will mean—

The Convener: No one is arguing about change. We are arguing about people being up front with the committee. Senior officers have told us that, on the ground, cuts are being made. There seems to be a gulf between what they are saying is happening on the ground in our communities, which is what our constituents are seeing day in and day out, and what people at Government level and senior civil servants are willing to accept. Why cannot we just accept that this is going on in our communities?

Shona Robison: It is because the situation is not as black and white as that.

The Convener: It is, according to those senior officers.

Shona Robison: Some budgets are increasing and some services are having more money spent on them. If you look at primary and community health services, you will see that more money is going to be spent in primary care. However, there might be other services where there is less money.

If all budgets stay the same and there is no shift of money, you will not see a shift in the balance of care. By definition, some budgets will be reduced and some will increase. Efficiency savings are used, in a way, to drive that change by ensuring that resources are freed up to be invested in the priority areas; otherwise, nothing will change.

The Convener: These are not efficiency savings. We are being told that they are cuts to services.

Shona Robison: Some services will be reduced and some funding for services will be reduced, but other services will have increases in funding.

The Convener: So some services will be cut.

Shona Robison: If we are going to change services and put more money into some services—as per the whole discussion that we have had for the last hour and a half and which everybody has agreed is a good thing—it is clear that other things will have to change and be reduced. You cannot spend the same amount of money on everything and therefore prioritise nothing. Some things will have to change and have less money spent on them so that more money can be spent on other things. Therefore, the priorities of community health services and primary care will see more money being spent on them, but other areas will see less money being spent on them.

The Convener: That will have an impact on people who use the services on the ground.

Shona Robison: People will see their services being delivered in a different way. Fewer people will have to go to hospital because more money is being spent on primary and community services. That is a good thing—people going to hospital less because their services are provided in the community is better for patients. That is why that is the direction of travel. We want to make services better, not worse, but that requires us to keep people out of hospital, in the community and in their own homes for as long as possible. People will receive their services in a different but better way—I do not agree that that will be detrimental to their services.

The Convener: Of course, time will tell on whether it is better or worse.

Shona Robison: Of course.

The Convener: As no one else has any final points to make, I thank the cabinet secretary and her officials very much for their attendance.

11:21

Meeting suspended.

11:25

On resuming—

NHS Governance

The Convener: Agenda item 13 is NHS governance. Today, we are going to look at whistleblowing. I welcome to the committee Sir Robert Francis QC; Cathy James, who is the chief executive of Public Concern at Work; Kirsty-Louise Campbell, who is senior manager of strategy and insight at the City of Edinburgh Council, and Laura Callender, who is the council's governance compliance manager; Robin Creelman, who is a non-executive director at NHS Highland; and Morag Brown, who is a non-executive director, co-chair of the staff governance committee and whistleblowing champion at NHS Greater Glasgow and Clyde. She will need a big business card to get all that on it.

We have around an hour, so I appeal to people to keep their questions and answers short. I will ask the first question. Is the whistleblowing system in Scotland fit for purpose? I am sorry—I should also have said that it is not necessary for everyone to answer every question.

Robin Creelman (NHS Highland): I am happy to kick off. The whistleblowing system is not yet fully developed or fully in place, and to judge it in isolation would be to judge it wrongly. To me, a whistleblowing system is basically a lifeboat for the culture of the national health service. If the rest of the culture is in place, we should seldom require the lifeboat, but we must have the lifeboat.

I am comfortable with where we are. In NHS Highland, we are still refining and making changes to the system, but I am generally comfortable with the direction of travel. I think that our work in the area is very worthwhile.

Cathy James (Public Concern at Work): I agree that this is a journey that the NHS in England and the NHS in Scotland are on. Many of the necessary parts are being put in place, but some progress is quite slow—for example, the national officer role is not in place yet, but it is coming. Thought is being given in Scotland to the structure of that role and to giving it a statutory footing. That is in stark contrast to what is going on in England, where the role has been put in place as a test to find out what best practice looks like. That approach has its problems. Slower progress is being made in Scotland because planning is being done.

The work on whistleblowing will never be finished. It will always need adaptation, review and consideration, which is why it is vital that we have a national role that is responsible for whistleblowing. Otherwise, it will get lost among all the other requirements that are put on local organisations.

The Convener: Robin Creelman talked about the whistleblowing system being a lifeboat. I know from experience of dealing with constituents who have come to me that when some of them have tried to clamber aboard that lifeboat, they have been booted back into the water. Do you recognise that?

Robin Creelman: I recognise that every system can fail, but we must start from a position of recognising the differences between the Scottish and English systems. Whistleblowing really took off in Scotland after the first set of events at NHS Ayrshire and Arran, roughly four years ago. Learning had not been shared and there was a lack of transparency in the system.

As a result of that, Healthcare Improvement Scotland introduced the adverse events programme, which is a national standardised system for dealing with adverse events. That filled a huge gap in the system and it greatly affected the culture. As a non-executive director at NHS Highland, I was very comfortable to see an increase in the number of adverse events following the introduction of that programme, because I felt that it demonstrated a more transparent and open culture, in which people were less afraid to speak up.

We have other things coming in next year such as duty of candour and being open. All those things contribute to the culture of the organisation being to have whistleblowing as a lifeboat.

There is also initial confusion about the difference between what are just grievances and things that really require whistleblowing.

11:30

The Convener: What would be the consequence of adverse events not being investigated? There have been a number of cases: I have one in which serious adverse events were reported but there is a culture of cover up and of not investigating adverse events. The person who reported them was hung out to dry.

Robin Creelman: That is the perfect storm or disaster scenario. Mid Staffordshire NHS Foundation Trust got to where it got to because nobody thought it could happen, so I will never say that it cannot happen in our system—although I would be absolutely astonished if it did.

Adverse events usually initially come out through clinical governance and then, depending on the size of the event, there is a convention of four or five different experts. It is difficult to hush up something like that.

Morag Brown (NHS Greater Glasgow and Clyde): You raised a question about people who have lived through whistleblowing having a harmful or damaging experience. We need to recognise that we are at an early stage of a journey. We will seek to improve our arrangements and support to staff. The national officer role could be of great assistance in that.

We must also recognise that people are concerned about being the subject of victimisation. They are also concerned that something be done about that, so we have to work hard over the coming period to earn the trust of staff and to earn public confidence.

The Convener: On the process, my understanding is that when someone blows the whistle often, the issue goes to the board that they work for and can find its way to the manager on whom they might be blowing the whistle. Is that your experience or does that not happen? Someone in the organisation where the whistleblower works has to investigate.

Robin Creelman: The process is defined in the whistleblowing policy, which contains a range of options for the staff member. The policies are based on the code of practice that has been produced by the whistleblowing commission, which is Public Concern at Work. The initial point of contact can be the line manager or a manager in a different place—it can be one of a variety of people. If it had to be done through line management, the process would be devalued.

Kirsty-Louise Campbell (City of Edinburgh Council): The City of Edinburgh Council has a unique arrangement around governance of whistleblowing disclosures. We have an independent hotline provider that oversees the disclosures and the reports that come in through whistleblowing, and it reports directly to our scrutiny committee. In terms of ensuring that the whistleblowing report or disclosure is taken seriously and the investigation is carried out in full, that is our check and balance.

Alex Cole-Hamilton: Two weeks ago, when we first discussed the topic in committee, there was a heated discussion about the spectrum that lies between raising concerns and whistleblowing. There was a view that, in the majority of cases, NHS staff feel empowered to raise concerns, but whistleblowing feels like a different threshold. Could we have the witnesses' reflections on that spectrum? At what point does it become harder for staff to direct criticism against, say, a colleague or set of practices, over and above the normal day-to-day intervention of "This doesn't feel right—maybe we should do things differently"?

Sir Robert Francis QC: Perhaps I can speak from my overall experience. As you might know, I am keen to get away from the term "whistleblowing", because it covers a huge range of things, including some that not even well-meaning people would think appropriate. It implies a barrier to speaking up. In an ideal world, everyone should be able to speak up, be listened to and see action being taken, but unfortunately that is, as we know, not the position.

Any division between what one might call speaking up and whistleblowing is likely to be counterproductive, and it seems to me that what we should be looking at is the reaction to someone who speaks up. Does it result in, at one end of the spectrum, victimisation and no action being taken or, at the other, positive end, the raising of the issue being welcomed and investigated, action being taken and the person who raised the concern being thanked? If what happens in one's organisation lies at the former end of the spectrum, alarm bells should be ringing about the culture in it.

That is a general answer. There is, of course, a spectrum, but it is all about speaking up. Some people become victims as a result of speaking up, while others become the champions of the issue that they have spoken up about.

Cathy James: I agree. The terminology is really crucial, and there is a lot of confusion. However, the danger of getting rid of the term "whistleblowing" altogether because of its being fraught with difficulty is that we would end up endlessly entrenching the negative view of it. We were not named "The Whistleblowing Charity" when we were set up 25 years ago; we were named Public Concern at Work because of the sense that to be a whistleblower is to take a risk.

I do not have a view about what the process should be called, but, internally, it should be about a process of escalation in an organisation that is very clearly set out and which people receive training on. In fact, that is what is starting to change. Training around whistleblowing is really gaining momentum in the health sector and the financial sector—which, interestingly, are the two sectors in which there have been huge scandals.

There is also, of course, also an external element to this. Sometimes that is seen as the whistleblowing aspect, while everything that happens internally in an organisation is soft and fluffy and works. However, according to our advice line, that is not the reality. Most whistleblowers try once or twice internally and then give up. If we want to see this as something that is in the interests of the NHS in Scotland, because it shows where the problems are, we need to capture those people, listen to them, act on their concerns and ensure that they are protected.

Robin Creelman: To be honest, I do not think that the terminology matters much. Perhaps I can give a fairly simple example. If, in a clinical setting, a member of staff sees a nurse or doctor not washing their hands, the staff member will normally record that sort of thing on a system known as Datix, which then goes to clinical governance in the health board and is acted on. However, if the member of staff records that occurrence, but nothing happens and the offender still does not wash their hands, day after day, week after week, there needs to be some outlet for raising the profile of that. Currently, that would be whistleblowing.

Alex Cole-Hamilton: Sir Robert talked about the two ends of the spectrum—either being victimised for whistleblowing or being thanked at the end of the process and helping things to improve. It also strikes me that at the more negative end of the spectrum there is the situation that we know from the NHS and other walks of life of complaints that go upwards being met with disbelief or inaction. How can we mitigate the two significant barriers to people taking action and putting their heads above the parapet and blowing the whistle—concern about victimisation, which we know happens, and cynicism about whether they will be believed or even listened to? What is in place to deal with those things just now, and what could we put in place that we do not currently have?

Sir Robert Francis: I will start from a general perspective. If someone raises an issue that is disputed, there must be a process to sort out the facts. You might think that I would believe that, because I am a lawyer. Often when people speak up, the matter immediately descends to the personal level and the question becomes who is to blame for the issue that has been raised, and if there is no one to blame it must be the fault of the person who raised it. We have to get used to the idea that there will be disagreement about what is right and what is wrong. However, we then need to sort out what is right in an authoritative, fair and proportionate manner. Until we do that, we will never proceed very far either in improving the service or in looking after the person who raised a no doubt genuine concern.

We have to recognise that not every issue that staff raise will turn out to be correct, but they must not be discouraged from raising those issues. If it is thought that the staff member is not correct, they should be given a proper explanation, which makes sense to everyone, as to why there is a difference of view.

Alex Cole-Hamilton: Is that the process?

Sir Robert Francis: What happens must depend on the facts, but there must be a process of authoritative investigation. If the issue is potentially serious, it must be investigated by people who have the authority to investigate and are trained to do so. Often, things are looked into in an entirely impressionistic way. When that happens and no action is taken that satisfies the person who raised the concern, we begin to get trouble. The longer such sores are left unhealed, the more likely it is that there will be victimisation and, perhaps even more important, a failure to correct the issue that was raised in the first place.

Alex Cole-Hamilton: I absolutely agree with that, but my concern is a little bit further upstream. I am thinking of the adage, “Culture eats strategy for breakfast”, and my concern is the people who do not get into the process because the culture around them prevents them from having the confidence to raise a complaint, or even intervenes to prevent them from making a complaint or raising something important.

Sir Robert Francis: A way to address that is to ensure that you have mechanisms to collect data about what staff feel about things. The NHS staff survey is becoming a very instructive tool in relation to staff telling the system that they do not believe that they will be treated fairly if they raise a concern, that they are not being listened to, and matters of that nature. The figures can be looked at on the basis of individual organisations. We need to get out of a culture in which 51 per cent is thought to be a good result.

Alex Cole-Hamilton: I agree with that point—those numbers have prompted the committee to take on the issue. However, although we can measure it, I am not convinced that we are actively doing something to address the problem.

The Convener: Would anyone else like to make a brief comment on any of the points that Alex Cole-Hamilton has raised?

Kirsty-Louise Campbell: We introduced our whistleblowing arrangements in 2014 and from our experience the point about culture is absolutely critical. Over that period, we have built a position in which people feel that they can contact our whistleblowing hotline and service and be heard and listened to. If the person’s concern is not a matter of whistleblowing within the policy or legislation, the matter is still investigated and they are given proactive feedback in a positive way. It is the same for people who make a disclosure, whether that is done anonymously or not. Building confidence through the good process that you have put in place allows colleagues and staff to feel that their views are being heard more appropriately.

Morag Brown: Alex Cole-Hamilton asked what we were doing about the problem and the point about culture is very important. I co-chair the staff governance committee and we have recently

established a subgroup to consider culture, because we wanted to address some of those issues and concerns in feedback from surveys and other areas. We are committed to reshaping and refocusing our culture so that one of our core principles is that the NHS is a good, safe place to work. That is very important.

We are developing a plan for our new modular approach to culture. It is also important to learn lessons where that has worked well. We will look at places such as Salford Royal NHS Foundation Trust, where there have been significant improvements and cultural change.

11:45

On whistleblowing, we have taken forward information sharing and encouragement through staff news and inserts in payslips. In the future, we want to extend that through roadshows and further training.

A couple of measures that are well worth exploring are how we share good practice—how we share the good news when people have reported concerns and we have acted on them. That is important. We have heard of two examples of good practice from my review of our whistleblowing cases this year, and we are looking at how we can best share them.

In addition, we need to give consideration to systems and processes that are open and helpful for supporting staff. We need to consider whether a buddy system would be helpful for people whether or not they already have a supporter, because of the impact on the individual who takes a very serious concern through the whistleblowing process.

We are looking at a number of areas, as well as others that we can take forward for the future.

Cathy James: There is a lot of work to be done to review internally. Just looking at the numbers is not enough, because the numbers will not be comparable across organisations. An organisation that has a culture of very high reporting may well not have much end-game whistleblowing. An organisation that has a low number of reports should be questioning why that is, or it might have got the balance about right.

You need to look at the survey work and at what is happening in other incident-reporting processes, and you need to speak to staff and have focus groups. All too often, quite a lot of resource is involved in doing those things. When pressures are on the NHS to deal with all sorts of other priorities, internal review work can go to the bottom of the pile, but it is where you will find out where the problems are, so it needs to be given priority.

Robin Creelman: One thing, convener—

The Convener: Be very quick.

Robin Creelman: Okay. With regard to governance, as soon as a whistleblowing incident occurs, I am notified. I get a monthly statement that covers progress on incidents, who the investigating officer is, outcomes, and good practice and how it is shared.

Alison Johnstone: Sir Robert, your freedom to speak up review referred to an NHS England staff survey in 2013, which showed that only 72 per cent of respondents were confident that it was safe to raise a concern. We had a lower figure here in Scotland. Do you think that things are improved? Would you expect that result to be better now, with the national confidential alert line?

Sir Robert Francis: You are testing my memory on what the result in the staff survey was in March this year. I do not think that it was much better, frankly—the process was still at an early stage.

The impression that I got at the time of my report was that the level of staff lack of confidence in the system was pretty dire compared with some other sectors. That is slightly surprising, but it seems to be the case. A lot of positive work needs to be done.

One issue that I found quite surprising was how difficult it was for me to find examples of good practice, which were seen as being successful, to put in my report. The reason for that cannot be that there were no examples; it is that in the good places, people just shrug their shoulders and think that what they do is a matter of routine, so they do not bother to collect data about it. We need far more leaders at a local level recognising the value of what they hear from their staff. That will encourage not only their institutions, but others.

Alison Johnstone: You suggested that we have to stop people becoming victims of speaking up, and blacklisting has been raised as an issue. What protections would you like to see put in place?

Sir Robert Francis: I recommended that legal protections should be extended outside the particular organisation in which the individual is working, so that people who are applying for jobs elsewhere in the national health service should be protected. They should not be discriminated against when applying for a job because they have a history of speaking up somewhere else.

In response to the draft regulations on that, our national guardian has suggested that such protection should be extended to include all employers. In other words, whistleblowers who are going through the non-NHS world should also be caught within the regulations. Doing that would be

more complicated, obviously, but I think that it would not be a bad thing.

I also recommended that the protection under the Public Interest Disclosure Act 1998 should be extended to trainees and students. That has been done, in part, in the sense that people who are the equivalent of an employer where the trainee is working are covered by the law. It is not clear that the bureaucratic central organisations—Health Education England and so on—are similarly covered. Those are technicalities that apply to England; I do not know whether they apply to Scotland.

Alison Johnstone: There seem to be specific key differences with the City of Edinburgh Council model, which seems to be a positive one. Are members of the panel aware of what is going on in Edinburgh? Should the national confidential alert line have further powers to investigate cases?

Cathy James: The national confidential alert line is an advice line for staff. It is one part of the jigsaw. Edinburgh has a reporting line, rather than an alert line. It enables the individual to report something to Expolink, which is the private company that runs the—

Kirsty-Louise Campbell: It is not—

Cathy James: It has an investigation arm as well, has it not?

Kirsty-Louise Campbell: It is not that organisation. We have an independent hotline that colleagues are able to contact directly. It is run by a company called Safecall. Where there is a major disclosure—for example, an issue that involves a PIDA matter, a breach of health and safety legislation or a matter of significant concern—that independent organisation can step in to investigate and report via the corporate leadership team, chief executive and the scrutiny committee.

Cathy James: The alert line that we run is an advice line, so it is legally privileged. It works on a basis of consent. If the individual wants us to report something for them, we can pick that up on their behalf. However, ultimately, we are trying to help them to report it themselves and give them some independent advice. They are not making a disclosure to Public Concern at Work or the alert line; they are seeking advice in an absolutely confidential space. That is a very different model, and it is complementary to the reporting line service that Edinburgh has.

An investigation line is different from a reporting line, but you probably need both models. I would not say that one is better than the other. In financial services, many organisations are considering having reporting lines as well as advice lines. The advice line is one part of the jigsaw, as opposed to being an exclusive approach that is taken on the basis that one model is better than the other.

Alison Johnstone: That might be why we have a petition before Parliament calling for a hotline rather than a helpline.

Cathy James: The two things are very different, but they are complementary.

Sir Robert Francis: I agree that having both models is a good idea. Other industries, in the commercial sector, tend to have an external hotline to enable someone to speak to somebody in complete confidence, with a better guarantee of anonymity. Whether that is the best solution in the health service depends on various things. You would think that it would be possible to place the service within something as large as the health service in England, but that is a matter of opinion.

Maree Todd (Highlands and Islands) (SNP): I am a member of the pharmacy profession, which is regulated by the General Pharmaceutical Council. Until I was elected last year, I worked for 20 years in NHS Highland. During the time in which I worked as a clinical pharmacist, I saw the culture in the NHS transformed into a much more open one, with much more emphasis being placed on the duty of candour. When I raised that point a couple of weeks ago, one of my colleagues said that that was perhaps because there are now more things to be concerned about, but I do not agree. I think that, because of some of the huge and terrible scandals that have hit the NHS, there genuinely was a culture shift in people's understanding of just how important it is for professionals to speak up when they have concerns.

What will be added by extending the duty of candour to all NHS staff? The professions already have a duty of candour. Are the professions not speaking up?

Robin Creelman: My understanding of the duty of candour, which I think will come in in April 2018, is that, although the legislation talks about a "responsible person", that is not actually defined as an individual. In a specific case, it would be NHS Highland rather than an individual employee who would be the responsible person. It is about members of the public getting total honesty from the organisation that they have an issue with.

Sir Robert Francis: Of course, I recommended a legal duty of candour. There was already, and had been for decades, a professional duty of candour, but I am afraid that that did not help the patients in Mid Staffordshire. I remember that I met a senior consultant who would see me only in the confines of his own home and in secret because he was so afraid of what he had to tell me but, actually, I already knew what he had to tell me, because other people had told me it.

Another point is that the professional duty of candour puts the entire burden on the individual whereas, actually, an organisational response is often required to a particular issue.

We need to be careful in what we are talking about. The legal duty of candour is about candour to a patient on something that has gone wrong. However, I also recommended a duty on the part of the organisation to be open and transparent about its work generally, which is just as important. In other words, we should not be told by the board of a hospital only the good news; there should also be a recognition of any problems that the board needs to solve. If there is that sort of culture among the leadership, it becomes much easier for people elsewhere in the organisation to talk about and raise issues of concern.

Cathy James: I agree entirely. With the advice line, we sometimes see that the duty to report is used against the whistleblower or adds to a culture of silence. When people are a bit worried or, more than that, scared about reporting and there is a bad culture in an organisation, if one brave soul speaks up, others then follow when it is clear that the organisation is listening. However, we have seen cases in which, because of a duty to report that is put into a contract, perhaps in the care industry, individuals have been disciplined for failing to report, in the context of a really bad culture. We have to be careful of unintended consequences, because the duty can be used as a stick. I agree that professionals definitely should have a duty, but we should be careful about imposing that on all staff across the system.

Maree Todd: Thank you—that has clarified things for me. I am interested in the idea of not just reporting to the patient when things have gone wrong but reporting up the way. What system will be in place to collect and gather information? I imagine that, with some of the really bad scandals, people were speaking about the issues and concerns were raised but, somehow, the big picture was not put together.

Sir Robert Francis: That is absolutely correct. In Mid Staffordshire, many staff were reporting incidents and attributing them to, for instance, a lack of staffing, and then the pushback would be to discourage them from using that as a reason. We can seek to deal with the issue only by using some sort of process of audit inspection or oversight because, unless we get under the bonnet of the relevant organisation, we will never find the truth. We need transparency so that we can see not only that the organisation is receiving reports but what on earth it is doing about those reports. That is a board responsibility in most places.

Cathy James: One criticism of the Scottish system is that the number of reports to the advice line is used to consider whether the system is working. That is not what should be looked at. It should be the number of reports going to people on the boards, the number of reports that boards get from their staff and the number that managers are dealing with. Sometimes, that can be difficult to track. It is possible to overbureaucratise the approach. Managers need to have discretion to deal with things, but we need to capture the really good business-as-usual organisational operations. That is why a bit of thinking about how to capture that, how to review, how to structure the review and how to ask staff will pay dividends in the long run. Perhaps the national officer will have some influence in helping boards to do that work. It is not about what is going to an external organisation; it is about what is going to the boards.

Robin Creelman: We get reports to the board quarterly, and we will periodically have a committee session for a deep dive into an individual case to discuss things that cannot be looked at in public.

12:00

Sir Robert Francis: I forgot to mention that our national guardian has started a survey of all the local guardians. She has just received the first set of results; although they have not yet been properly analysed, she has discovered that about 25 per cent of all concerns that have reached the guardians are about patient safety—that is only a fraction of the total level of concerns, one would hope. I understand that she will, in the future, analyse what she hears from the guardians about what has happened about those concerns. I emphasise that she is not a regulator, but she has access to information via the guardian network. That is perhaps less bureaucratic than setting up an inspectorate to get round and look at things.

Morag Brown: Bringing together a lot of information to get the whole picture in a complex and large organisation can be a challenge. Careful consideration about how to bring together incident reporting through our Datix system is important; examples are significant clinical incidents, whistleblowing reports, complaints, ombudsman reports and reflections by committees on individual cases. How to bring together the bigger picture—the work on staff governance and clinical governance, which can then be complemented by specific reviews and surveys—is very important.

Maree Todd: I have a final very quick supplementary question. You mentioned the Datix system, which I was familiar with when I worked in a hospital. I understand that it is not used in primary care, which has a different system. How do the two systems work together?

Morag Brown: My experience is more with the acute sector. Independent contractors have their means and measures to record incidents. We have access to that information through our monitoring of independent contractors for clinical governance. I can ask my colleague who leads on clinical governance to provide information to the committee.

The Convener: That would be helpful.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Morag Brown spoke about the importance of developing an NHS culture in which folk feel able to speak out. The committee has taken evidence from the Scottish Ambulance Service, in which, according to the staff survey, only 20 per cent of staff felt consulted about changes in their work. Nearly half had not had a staff review in the past year. Most importantly, with regard to whistleblowing, only 31 per cent said that they felt safe to speak up, which was the lowest figure of NHS boards nationally. Are panellists aware of any boards that have been tackled about their staff governance when such issues are flagged up in staff surveys? That is quite a specific example—are you aware of any action being taken on those figures?

Morag Brown: Sorry; do you mean action not specifically about the Scottish Ambulance Service figures?

Jenny Gilruth: No. Those figures are quite specific for the Scottish Ambulance Service, but there is quite a disconnect with previous evidence that we took from the service. What is the point of carrying out a staff survey if there is no reaction at the end of it?

Morag Brown: On staff governance, the information from our staff survey, along with other indicators and drivers, prompted us to set up a sub-group to look at how to reshape and refresh our culture. The iMatter survey has had much higher response rates in our area and other areas across Scotland—we had something like a 64 per cent response rate, which is a much higher response. iMatter is a more responsive survey, because it gives more immediate feedback to the team and it allows a team and management to test the temperature of their culture, to reflect on it and work together to change it. The information from surveys helps us with big-picture, large-scale cultural change and it also helps us to manage and create open, discursive team cultures—iMatter is very important to that.

Robin Creelman: One of the challenges for a board is knowing the temperature at the front line. That was touched on in Sir Robert's report. In Highland, we have a thing called the Highland quality approach, which is a full-fat version of lean methodology. It uses phrases such as gemba—it is based on the Toyota working principles. As part of that, the non-executive directors and board members are encouraged to go to the gemba regularly, where they have informal chats with front-line staff and take time to mingle with them and hear what they are saying. That is not the answer, but it helps to give people a feeling of the pressures at the front line.

Jenny Gilruth: Is there capacity to use that as an example of good practice and share it with other boards so that folk can learn from it in developing a supportive culture?

Robin Creelman: I would not claim that we are unique in that regard, although we are probably the ones who have taken it the furthest. We have senior staff trained at the Virginia Mason hospital in the States, and there is an interchange of staff there. We have probably taken it a degree further than others, but I am not suggesting for a moment that other boards are not doing similar things.

Jenny Gilruth: Thank you.

Clare Haughey: Thank you for coming along today. The committee received a written submission that quotes you, Sir Robert, in calling into question the independence of whistleblowing champions who are employed by authorities that the whistle is being blown on. It says:

> "Sir Robert Francis in his 'Freedom to Speak Up Review', following the Mid Staffs inquiry, stated that these appointments should be seen 'by all' as independent, fair and impartial—that they should not be adjuncts to existing posts."

Will the non-execs who are whistleblowing champions with NHS boards comment on how they reconcile their different roles and whether they see any pitfalls in their being board members as well?

Robin Creelman: I think that it is implicit in the role of a non-exec. If I thought that I was a board member to do what the executive board members thought I should do, the whole system would have failed. I am there to form my own views about things and act on them.

Morag Brown: That is right. We are appointed by the minister and we have that independence. We should certainly be able to speak up and challenge, and I think that we do that. However, I can understand why members of the public and people who have had bad experiences could have concerns about that, and why there is potential for public concerns about independence.

I think that the independent national officer can offer some assistance in reconciling that, in that there will be guidance. There will be an opportunity for the independent national officer to monitor and benchmark boards' performance and openness and transparency in relation to

whistleblowing, and to produce national materials and training for whistleblowers. There has been some consideration of whether the independent national officer should become the final, independent stage in the whistleblowing process. There could also be potential in the role, given its independence, to provide a forum for patients and the public around whistleblowing and how it is responded to, and a forum for staff who have concerns or have had experiences in the area that they want to talk about.

Clare Haughey: There may well be potential for that, but I am keen to explore a bit further your role as non-execs who sit on a board. How do you convince NHS staff that you are neutral and that you are not part of the system or culture that they perhaps have concerns about?

Morag Brown: As Robin Creelman said, our appointment process suggests that independence, but it is also seen in how we handle the business. With some of the issues that I have dealt with, or some of the scrutiny, I have raised the level of investigation and highlighted limitations in investigations. I think that we have our own personal integrity in being open and transparent and in challenging systems.

Clare Haughey: How has that message been transferred to the staff on the ground?

Morag Brown: As we said earlier, we have been developing our communications with staff through our various newsletters and roadshows and through the visibility of non-executive directors and senior managers and so on. That is how we convey our openness in the system.

Robin Creelman: I think that you have touched on something that needs to be explained a bit more to staff. According to whistleblowing policies, which tend to be relatively standard across all boards, the whistleblowing champion, who is not named but just mentioned, is not part of the investigatory process at all—they are divorced from it. Our role is to oversee the process. As part of that, I carry out a kind of exit interview with whistleblowers to find out how the system can be improved, but I think that we need to explain things a little bit better to staff and emphasise the independent nature of our view.

Clare Haughey: How long have you been in this role?

Robin Creelman: Just over a year. It is a relatively new thing.

Morag Brown: I think that Mr Creelman is right—we should also explain what we do not do. We do not carry out investigations or take part in that process. Instead, we play an assurance role.

Clare Haughey: And that assurance role has been in place for only a year.

Morag Brown: Yes.

Robin Creelman: The whole whistleblowing thing has been around for only a little over a year.

Clare Haughey: I wonder whether Sir Robert, whom I quoted at the start of my questions, can share with us his opinion on the appointment of non-executive directors at board level as whistleblowing champions.

Sir Robert Francis: I am not going to speak about the situation in Scotland—

Clare Haughey: I was not talking about individuals as such.

Sir Robert Francis: Perhaps I can speak more generally from an English perspective.

When I made this recommendation—and I am choosing my words carefully here—I did not have it in mind that the role should be the same as the role of a non-executive director in a whistleblowing process. When I wrote my report, many trusts had a board director who, as part of their portfolio, had oversight of the whistleblowing process, and what I recommended was the creation of a guardian, because it seemed to me that every organisation needed someone who had the confidence of the staff and the management and who could, when problems arose, unlock the right door to a solution.

I knew that, in different organisations, there would be different solutions, and because this was such a novel recommendation, I did not go very much deeper than that. However, every trust in England now has a freedom to speak up guardian; they come from a wide range of backgrounds—some are non-executive directors—and time will tell whether that approach has worked. The concern that some people have expressed and which I think we have to look at is that a non-executive director has a corporate responsibility to the running of the organisation that, to some, might be seen as conflicting with their role of helping to oil the wheels of the system for challenging the organisation. I am not saying that the situation is impossible, but we have to work it out; however, I would emphasise that the issue of the right person to be a guardian might come down to an individual's personal qualities and how they are respected in an organisation rather than the position that they actually hold in it. As I have said, time will tell.

Cathy James: The model in Scotland was deliberately different in making the whistleblowing champion an oversight rather than an operational role. Because the freedom to speak up guardian is an operational role, they are expected to help and protect the whistleblower, to get the information that is needed and to ensure that the wrongdoing or malpractice is investigated and addressed. The

freedom to speak up guardian is therefore very different from the whistleblowing champion.

Where confusion arises is that, with cases that are perceived not to have been dealt with properly—or which have not been dealt with properly—no one might know where the top of the tree is in the organisation in question. Many NHS staff—indeed, staff in any organisation—will think, "There's a whistleblowing champion; I'll go to them," but if they get told, "No. no, no—we can't deal with you," trust gets undermined very quickly.

There is academic research from all over the world that suggests that it is about trust—it is so hard to build up that trust and so easy to lose it. Whistleblowing systems need to be very flexible and have multiple channels. They must not have barriers. Sometimes the protection of the senior person can create the barrier that undermines the system.

12:15

Clare Haughey: Can you clarify a point? You are whistleblowing champions and there is a perception that you guys are the ones who oversee the process, but I am hearing that you do not oversee it and have no operational responsibility for it, so what is your role?

Robin Creelman: Our role is to oversee the process. The role is clearly defined in the whistleblowing policies—that is certainly the case in the Highlands and Islands and is probably the same for the other boards.

Clare Haughey: So your role is to oversee policy.

Robin Creelman: No, it is to oversee the process.

Clare Haughey: Sorry. What authority do you have if the process is not being followed and how would you know if the process were not being followed?

Robin Creelman: When I am not satisfied with the process, as has happened in a very few cases in the Highlands and Islands, I suggest changes and continue to suggest them until I get general agreement and they are implemented. I discuss any change with the staff governance committee, the chair of staff governance, the chair of the board and then I assume that it is agreed and we do it.

Clare Haughey: The fact that you keep suggesting until it is changed suggests that there is some resistance.

Robin Creelman: At the end of the day it is a consensual change. I keep trying to make my point in the hope that other people will agree and then we change the process.

Clare Haughey: As a whistleblowing champion, what authority do you have?

Robin Creelman: I try to influence change where I see that the process is not working properly.

Donald Cameron: I have questions on two areas. First, Jenny Gilruth mentioned the Scottish Ambulance Service, and one of the most startling figures that I picked up from the papers was that less than a third of its staff feel that it is safe to speak up. Given the importance of the Ambulance Service, does anyone have observations on that?

My other question returns to the legal duty of candour. From a technical point of view, how is that duty to be enforced through sanctions and remedies?

The Convener: I ask everyone to be brief, because we are really up against time.

Donald Cameron: Linked to that point is the fact that one of the most interesting tensions is in the relationship between organisations and individuals in relation to taking responsibility. Cathy James hinted at that. It is as difficult for a board or an organisation to front up to a failing as it is for an individual. Will you explore that as briefly as possible?

Cathy James: There is an absolute lack of accountability for those who have meted out retribution or retaliated against a whistleblower. We rarely see any sanction against decisions that have been made when whistleblowers have been treated badly. If there were the will to take that seriously and do something about it in the senior leadership of an organisation, that would change the perception that nothing changes.

I do not have a magic bullet. Time and again in all the scandals that have hit the public and private sectors, people have seen accountability as being missing. If we never see any accountability, people will endlessly fail to trust the system.

Robin Creelman: The question is so big that it could not be answered even if we had all the time in the day. Another issue is unintentional detriment. If, for all the best reasons and with good intentions, someone raised a whistleblowing concern in a ward setting but it was not proved correct, it is inevitable that the relationship in that ward area would break down. In such cases, the person who raised the concern often has to be moved from the area, even though they did nothing wrong. We need to address that situation. I understand that work is being done in health improvement in England to find a way to make that happen.

Cathy James: A re-employment scheme is being worked on in England. It is very much in its pilot stages, although it is operating.

Sir Robert Francis: Accountability is important. I will say one more thing about culture, which is that it is about people making the right decisions in the interests of their patients and the NHS in general. Victimising a whistleblower or a person who has raised a concern is the absolute antithesis of that.

Sometimes that has happened almost because of legal advice; there is a sort of adversarial culture that we need to get away from. However, when someone at a senior level has been proven to have acted in the way that I just described, there should be a means of holding them to account. Half the problem that we have is that managers in the NHS are not subject to the degree of regulation that registered healthcare professionals are. In general terms, perhaps that needs to be looked at.

Miles Briggs: I will pick up on the question of people who are having a whistleblowing aspect looked into. How many current NHS employees have been suspended, have been signed off because of stress or are on gardening leave and have not had the complaint looked into but are still being paid by the health service? I have been trying to get those numbers but I have had no luck. How many such people are suspended?

Cathy James: I do not have the specific numbers, but we did research on the whistleblower's journey that looked at 1,000 of our cases. In the public sector, and in the NHS and the healthcare sector specifically, more people were suspended, whereas in the private sector, more people were dismissed. We looked at a skewed sample, because people come to us when they are in difficulty with whistleblowing, but we have seen that trend in the statistics. I am afraid that I do not have absolute numbers.

Miles Briggs: Can you provide the committee with a breakdown of those statistics for Scotland?

Cathy James: I suspect that I cannot do that easily, but I will have a go and look at what we have in our system. We are a small charity that advises individuals; we are not a regulator, so we do not collect such data, but I will have a look.

Miles Briggs: Thank you.

The Convener: I would like to raise a couple of issues now that we are at the end. Alison Johnstone mentioned blacklisting. I have been heavily involved in that issue in the construction industry. I am absolutely of the opinion that some form of blacklisting operates in the health service, although not on the formal basis that it did in the construction industry.

I was involved in the case of Dr Hamilton, who provided evidence to us. She had an unblemished record in the health service as a psychiatrist and was well respected until she blew the whistle and eventually lost her job. Despite the huge need for psychiatrists in Scotland and the vacancies all over the place, she cannot get employed in Scotland.

Is that a coincidence? Are you seeing that happening elsewhere? Scotland is a small place. It would take a human resources officer only half an hour to phone round the 13 other health boards and say, "What do you think of this one?" and for someone else to say, "Don't take that." There would be nothing official and nothing written down. The system could easily operate in that way. Is that happening elsewhere?

Robin Creelman: I can honestly answer no, not to my knowledge, but—

The Convener: The second part is important—whether it is to your knowledge.

Robin Creelman: I can speak only for the board that I work in. However, your hypothesis implies a fairly large degree of collusion. Relatively senior clinicians would not be appointed by an HR person. I am not saying that what you described is not happening or dismissing it, but collusion would have to be quite sophisticated, because an appointment panel is usually made up of three or four people. I am not dismissing the possibility, but I would find it hard to believe. I certainly have no personal—

The Convener: The example that I gave is in the public domain, so I am not giving away any secrets. There were a number of vacancies in one health board's area and, when the person I mentioned applied for those vacancies, they suddenly did not exist any more. Such things lead to all sorts of conspiracy theories, but there clearly seems to be an issue.

Cathy James: I think that what you described happens. If someone gets the label of whistleblower, it is the label of a troublemaker. That is why we have always campaigned to have the kind of provision that Sir Robert Francis recommended, which gives people the same rights against discrimination pre-employment as they have when they are employed, so that they can say, "I have not been offered that job." The problem with the current legal protection is that, until someone is in a job, they do not get that right. I think that that has been changed—

Sir Robert Francis: It is on the way to being changed.

Cathy James: It is on the way to being changed in the health sector only. I imagine that that applies in Scotland, because it involves the Public Interest Disclosure Act 1998, which definitely applies in Scotland, although not in Northern Ireland.

I do not see why that provision should not apply across the entire piece of legislation. The legislation protects all workers, so why would the problem be seen to be only in the health sector? It is a problem in all sectors.

Another point is on computerised staff records. Some whistleblowers are looking at how the back end of the computerised staff record is being used in an unofficial way to record information that managers put on their systems. I do not know whether that is happening just in England or what the system is in Scotland, but there is a sense that information that is not covered by a subject access request is sitting in those databases and it ends up being detrimental to people who are looking for a job elsewhere.

Sir Robert Francis: I did not know about the case that the convener mentioned but, if someone with such experience was of colour and did not get a job, there would be at least an automatic question mark about whether there was racial discrimination. I believe that whistleblowing, or whatever you want to call it, should be treated in the same way. If a whistleblower has been refused a job by a public sector organisation, there ought to be a reverse burden of proof. The question would be why that otherwise perfectly qualified individual had not got the job.

The Convener: As a final point, has there been whistleblowing by board members?

Sir Robert Francis: Yes.

Cathy James: We get board members as whistleblowers all the time, not just from the health sector but from all sectors.

The Convener: We are talking specifically about health.

Cathy James: I imagine that this applies to health. I do not have a specific case in mind, but we certainly get whistleblowers who are board members and at senior levels.

Sir Robert Francis: The committee can read in my inquiry report about a whistleblower from the board of the Care Quality Commission who gave evidence to me quite effectively.

The Convener: Thank you very much for your interesting evidence.

12:26

Meeting continued in private until 12:41.

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