OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 22 November 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 22 November 2022

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
33rd Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rosemary Agnew (Scottish Public Services Ombudsman)
Lynsey Cleland (Healthcare Improvement Scotland)
Daren Fitzhenry (Scottish Information Commissioner)
Paula Fraser (Voices of Experience Scotland)
Scott Heald (Public Health Scotland)
Beth Lawton (University of Strathclyde)
Ken Macdonald (Information Commissioner's Office)
Suzanne McGuinness (Mental Welfare Commission for Scotland)
Dr Kenneth Meechan (Society of Local Authority Lawyers and Administrators in Scotland)
Kevin Mitchell (Care Inspectorate)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 22 November 2022

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the 33rd meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from David Torrance.

Under agenda item 1, do members agree to take item 3 in private?

Members *indicated agreement.*

National Care Service (Scotland) Bill: Stage 1

The Convener: The next item on our agenda is further consideration of the National Care Service (Scotland) Bill. We will take evidence from two panels today.

Before we start, I thank everyone who took part in our informal evidence sessions last Monday in Aberdeen and yesterday in Dumfries. I think that members who participated in those sessions would agree that they were extremely helpful. We will make sure that some of the things that we heard in those informal sessions make their way into our scrutiny of the bill and into our questioning of witnesses and, ultimately, the minister.

With our first panel, we will focus on the data and information sharing aspects of the bill. Two of our witnesses are joining us remotely and four are attending in person. I welcome to the meeting Daren Fitzhenry, the Scottish Information Commissioner; Paula Fraser, development officer at Voices of Experience Scotland; Beth Lawton, chief digital and information officer at the University of Strathclyde; and Ken Macdonald, head of ICO regions at the Information Commissioner’s Office.

The two witnesses who are joining us remotely are Scott Heald, Public Health Scotland’s head of data driven innovation, and Dr Kenneth Meechan, who is head of information as well as the data protection officer for Glasgow City Council and is representing the Society of Local Authority Lawyers and Administrators in Scotland, otherwise known as SOLAR.

We move to questions. I will start with Daren Fitzhenry, whose office made a late submission in relation to the provisions in the bill that would impact on the Scottish Parliamentary Corporate Body’s independent office-holders. Daren, will you explain your concern about those provisions?

Daren Fitzhenry (Scottish Information Commissioner): Yes. Thank you, convener. It relates to the provisions in section 15 and the ability to make regulations concerning complaints. Section 15(5) contains quite an expansive definition of the authorities in relation to which ministers are given the power to make regulations. In essence, the definition relates to many of the office-holders, including me. Ministers are given Henry VIII powers to impose duties, but also to remove functions from the bodies.

My concern is that there does not appear to be in either the bill or any of the accompanying documents a clear rationale for why the Scottish ministers should have any power to alter the primary legislation that relates to my office and my post in relation to the national care service. Other office-holders, particularly the Scottish Public Services Ombudsman, will have their own views. From my perspective, however, there does not seem to be a clear rationale as to how freedom of information should be affected in relation to complaints. I would certainly be concerned if there was any desire to remove the function of freedom of information in relation to the complaints process in this system when it exists for the complaints processes in other systems.

The example that is given in the policy memorandum relates to the SPSO, which is where I think the focus lies. In the absence of a clear rationale or driver for the inclusion of other office-holders, I am concerned about that. If the intent is to alter the legislation in relation to the SPSO, I suggest that it would be safer for the powers to be restricted to that office-holder. The SPSO will have its own views on whether that would be appropriate. However, I respectfully ask that the committee has regard to the importance of preserving the independence of my role and the application of freedom of information in relation to all aspects of the bill in determining whether the current definitions are appropriate, given the extensive powers that are potentially available to ministers under that provision.

Sandesh Gulhane (Glasgow) (Con): Can I be absolutely clear? Do you feel that the Scottish Information Commissioner needs to be taken out of the bill completely and that you should not have been included in the first place?

Daren Fitzhenry: My concern is purely about section 15 and regulations for dealing with complaints. On the face of it, I cannot see why any regulations under that section should require any alteration of the powers, duties and functions of the Scottish Information Commissioner. In the absence of a clear rationale for that, I submit that my office should be removed from the ambit of that section. There is a wider discussion to be had on whether it is appropriate for such powers to exist in relation to any of the office-holders. However, I do not see clear applicability or any suggestion as to how the powers may be used in relation to my office.

Sandesh Gulhane: Would the Henry VIII powers basically give ministers the option of doing anything that they wanted?

Daren Fitzhenry: The powers would give ministers the ability to change the primary legislation in so far as it related to those complaints processes.

The Convener: During the pandemic, freedom of information was one of the areas in which there were emergency powers because of the deployment of staff to other areas. I do not want to ask you to speculate, because you say that you do not know what the rationale is, but is there maybe something that relates to that?

Daren Fitzhenry: I do not see that link, to be honest, because the provision relates purely to dealing with complaints. It refers to regulations to

“make provision about the handling of ... complaints”

within that system. As it is bounded by that purpose, I cannot see what regulations would be relevant to freedom of information unless there was a desire to remove it from the ambit of such a system, and I would respectfully submit that that should not be done. There are exemptions and exceptions that apply to whether it is appropriate to release information, and we apply those throughout to many authorities that have complaints procedures.

The Convener: We will make sure that we raise that point with the minister and get clarity in relation to your concerns and questions.

Paul O’Kane (West Scotland) (Lab): Good morning to the panel members. I want to focus on the idea of having a single electronic record for health and social care. That has come up time and again, not only in our scrutiny of the bill but more broadly in our work, including in many of our inquiries. Many people feel that having a single record is important, particularly so that people do not have to repeat their stories and explain their issues time and again.

What are your views on the benefits or otherwise of having a single electronic record? Is there sufficient data in the system to deliver such a record?

Beth Lawton (University of Strathclyde): There are undoubtedly benefits for the individual citizen and at the public health level in the holding of a single health record or the ability to access the data from a single place. That point about access is key. We do not necessarily need to have one system that holds all the data for everyone, but we need to have a way in which that data can be collated so that there is no need for repetition, as you said. Citizens should be able to present the information only once. They should not need to go through it every time on their journey through the health and care system.

From a population health perspective and for research, it is important to be able to access an individual’s information from the beginning to the end of their journey through the system, and to have the information held in one place. In Scotland, we have the beginnings of platforms that allow for that. For example, we have the national digital platform, so there is no need to start from scratch. We can build on existing systems.

I can speak about my experience in setting up the integrated care system in Sussex. All the various entities that are involved in health and social care—including the national health service, charities and social work in councils—will have their own systems, and the danger is that it will be very difficult to unpick some of them and to move information from the organisation's system to a central platform for everything, because the links will need to be kept.

From a digital perspective, my preference, should I be asked for it, would be to build an information aggregation point so that information can be extracted from those systems and held centrally. The national digital platform might provide a basis for that. Building a system from scratch would be a little like what happened with NHS England's national programme for information technology, and we might not want to recommend that approach.

Ken Macdonald (Information Commissioner's Office): I am here to represent the United Kingdom Information Commissioner's Office. Our interest is in data protection in particular, so there are people who are better qualified than I am to talk about the architecture of such systems. However, we support anything that improves health and social care services for individual patients as long as it is done proportionately and securely and that everything starts from the perspective of privacy by design and default. In other words, the privacy of the patient or service receiver should be paramount, and the system should be built around that.

Under the UK general data protection regulation, it is a requirement to start from that premise. As long as the system was developed with the patient in mind and there was interaction with organisations that represent patients in order to get their views on where the dangers and privacy risks would lie, we would support the development of such a system.

Daren Fitzhenry: I come at the issue from the perspective of freedom of information, so my key interest relates to non-identifiable social care data. Having more accurate records, one version of the truth and a consistent system makes it easier to create and, I hope, disseminate reliable non-identifiable health and social care data that can be used to judge services, improve them and hold authorities to account. I would certainly have no negative comments about a system that enabled that.

Paula Fraser (Voices of Experience Scotland): Many of our members have expressed frustration and anxiety about the need to repeat their stories, which was mentioned earlier, and are in favour of having a consistent integrated record. However, even members who are in favour of such a record have concerns about it. They have concerns about the IT system working properly, about things being recorded consistently by the various services and about having access to their records. They have repeatedly found it really difficult to access their records. They have needed to ask for them over and over again, and sometimes they do not receive the information. They want to have informed consent in relation to particular parts of their records.

However, a lot of our members have really deep concerns about any possibility of mental health records, in particular, being part of that consistent record. At the moment, those records are closed. Many of our members are very concerned about the possibility of their mental health records being available to everybody across the NHS and social care. Part of that is to do with the stigma and judgment that many of our members have experienced from staff and the possibility that that data could end up being shared more widely. They are really worried and, because of those concerns, many of them are saying that the sharing of mental health records absolutely should not happen.

09:15

Scott Heald (Public Health Scotland): I agree with the other panel members. We definitely see benefits to having a national care record. As Beth Lawton said, there are definitely advantages at the public health level. With regard to service planning and how services are organised, I agree with Beth in that I am not sure that there should necessarily be a single record or system, but the ability to bring data together is really important. There is a need to think about the IT infrastructure that lies beneath that. Scotland has lots of experience of record linkage, which could come to the fore as we join things across the system.

In response to the question about whether we have all the data available, I would argue that, at the moment, the data is fragmented. Particularly in social care, I am not convinced that we currently have all the data that we would need to feed into a national care record. We also need to think about data standards and definitions and how we can ensure that we all record things in a consistent way, because that will be really important.

Touching on secondary uses of data, I add that it is really important that bodies such as Public Health Scotland can access the data that is held in national care records so that we can do the work that we need to do on population health and service planning.

Dr Kenneth Meechan (Society of Local Authority Lawyers and Administrators in Scotland): It is a double-edged sword. The inquiries that have taken place into failures in the social care system have always said that one of the most important things that professionals in that field can have is the chronology of service users' interaction with significant life events. That is one of the most important things for the protection of children and vulnerable adults, and having a single record would clearly assist with that chronology. Similarly, to pick up a point that Beth Lawton made, there would be efficiencies in avoiding people having to tell us their stories again and again.

The downside is that we could not overestimate the effort that would be involved in the creation of a single record. In my organisation, we are currently replatforming the primary care system that we use to manage social work service users, and simply replatforming that one system has proved to be a massive project. Integrating and pulling together all of the many different systems that are used across dozens or probably hundreds of agencies is a massive task. Also, once you have done it, you will be left with an enormous dataset that will require a vast amount of management in order to ensure that people's access rights within it are appropriately federated.

On the point about access to mental health records, some professionals absolutely need visibility of those records, but most of them would not. Even within a single organisation, the level of information that a child protection social worker will need to have access to will be totally different from the amount of information that the home carer who goes out to provide home services will need. There is a vast amount of complexity in ensuring that access.

We have had a centralised NHS for 70-something years, but we still do not have a single integrated health record. The idea that we would be able to integrate the social care records, particularly in the five-year timescale that is indicated in the policy memorandum, is not realistic, and there are a lot of dangers associated with going down that path.

Paul O'Kane: I will pick up on Dr Meechan's point about what is said in the bill and in the policy memorandum. Concerns have been raised that much of this will be dealt with in secondary legislation and that the bill does not provide clarity on what process will be used to gather the data and develop the platform. Dr Meechan referred to the enormous amount of data that would have to be managed.

Do the witnesses have concerns about the issue being dealt with in secondary legislation?

Beth Lawton: Yes, I have concerns because, when we talk about building something such as an enormous data source, we have to think about what we want to get from it at the end. The danger is that, as the bill is written, the end stage that is expressed is at quite a high level, and we need to have the nuts and bolts. The information professionals with whom I work would think about what the end state looks like and would then work back from that in designing the system. At the moment, there is not enough detail in the primary legislation to be able to envisage that. There are an awful lot of unknowns. My concern is not about whether we should have such a system; it is that the end state is not clear enough for us to work out how things might be affected. My concern relates not to the direction of travel but to the lack of clarity, given that the end point will be left to secondary legislation.

Ken Macdonald: Under article 36(4) of the GDPR, there is a requirement to consult the UK ICO before developing legislation that involves the processing of personal data. Therefore, on each regulation that ministers produce, they should consult us—preferably at least 12 weeks before the regulation is laid in Parliament—so that we get the opportunity to properly scrutinise it from a data protection perspective and to work with officials to see where improvements might be needed. There is also the requirement to undertake data protection impact assessments for processes that involve very sensitive information—special category information. If any high risks are identified that cannot be mitigated, we have to be consulted.

Therefore, protections are built in to the legislative and development processes. We work with the Government and the relevant bodies to try to make the systems as secure as possible.

Emma Harper (South Scotland) (SNP): Good morning. The primary legislation says:

> "The Scottish Ministers may by regulations provide for a scheme that allows information to be shared in order that services can be provided".

Working back from that, we need to ensure that all data will be secure. Ken Macdonald talked about co-design and about the ICO being part of the process of developing legislation. My understanding is that the co-design process will come from the primary legislation when we start thinking about how we will manage and secure people's data.

The Convener: Are you directing that to Beth Lawton?

Emma Harper: It is for either Beth Lawton or Ken Macdonald.

The Convener: Beth Lawton made the initial point about working back. I am happy to bring her in and then Ken Macdonald, if he wants to come in.

Beth Lawton: I am a little unclear about the question.

Emma Harper: The primary legislation will state what we want to achieve and, from there, we will work back towards what the secondary legislation will need to include. Part of that is about co-design with people who matter and those who know how a co-design process can be taken forward. The co-design part relates to Ken Macdonald's comments and the working back part relates to Beth Lawton's comments.

Beth Lawton: Yes. I absolutely agree with the issue of co-design. As I said, it is really important to get an idea of what we want. There will be many parties who would have an interest in the change and would need to be brought on board to make it successful because, as well as building the technical capability, we need to build the culture on information sharing at an organisational level. We also need to build data literacy because some of the parties that would be involved are not used to sharing information outside their organisations. In a way, the mechanics will be easier than the cultural shift but they will not work unless we get the cultural and digital literacy.

Ken Macdonald: Our role in relation to co-design is to ensure that the system is compliant with data protection law. That involves working closely with people. We have been engaged with the Government in the development of the initial, high-level proposals and we hope to continue to engage with it prior to any formal consultation, as required under the law.

On the general co-design, I referred to the data protection impact assessment—DPIA. It is essential to engage with all stakeholders, not only current service providers but the beneficiaries and patients—that relates to concerns that were raised earlier—to ensure that they are properly and adequately dealt with in the final formulation of the regulations.

Scott Heald: I will build on what Beth Lawton and others said. There is a need to have clarity on the end point and the stages to deliver that end point, so we need to work back and think through how we get there.

A really important point is that we need to be clear on the data that we are looking to bring into the national care record and whether it exists at the moment. I do not think that it will all be available at the moment and work will need to be done to develop it. We need to think through what investment might be needed, particularly in local authorities, in IT to capture consistently the data that will be required for that. We have well-established systems in the health service but the systems are less mature in local government, so there is definitely work to do on that.

The point that was made earlier about detailed standards and definitions will be important so that, when we bring things together across the country, we are consistent. It is a mix. We should be excited by the ambition because it is an opportunity to build on Scotland's data estate in a way that we have not done before. It will be really important to have clarity on the end point and work back to understand how realistic it all is.

Paula Fraser: Our members are really positive about being involved in the co-design stages but they are sceptical about how much involvement they will get to have in that and are worried that they will not be represented well enough. They were also worried by how quickly the bill was introduced without any co-design elements happening beforehand.

Paul O'Kane: Is the timescale realistic? I think that the intention is that the national care service should exist by the end of the parliamentary session. We have heard that there are big challenges with being able to deliver it, not least around whether the data is available, what the infrastructure will look like and how we will upskill people.

My question has two parts. First, is the timescale for implementation realistic? Secondly, are there concerns about the cost? I heard that being mentioned. We will come on to questions about finance, but are there concerns about how much delivery could cost? Beth Lawton, could you answer that?

Beth Lawton: It seems to be me only—sorry.

It will take a considerable time to see the full value of a system such as the one that is proposed. It does not go in overnight. I would think that it would take a minimum of five years, depending on the resources that are available. Finance will come into that. However, you should be able to build it in an agile fashion, so you would not necessarily have a big bang and, at the end of five or eight years, have a grand unveiling; you would build it incrementally and deliver the benefits the same way.

I think that implementation will be expensive and will not directly release all of the money suggested, but we would see indirect benefits from having the integrated data structure. It would provide information to help us plan and take a more proactive approach in managing health. At one of the previous committee meetings, Harry Burns talked about salutogenesis—the idea of creating the right environment for health to flourish. Having that data to hand will enable that and enable us to take a more proactive view of health and care in Scotland. Of itself, because of the early intervention and prevention, that would generate savings.

09:30

The Convener: I want to bring the discussion back to the Government's other drives and digital strategy with regard to health. I think that we have got into the situation in our discussion today of saying that the National Care Service (Scotland) Bill is what will introduce a single interface that links records but, in fact, an awful lot more is going on in Government on that. It is not the national care service that has prompted that work; the Government has been working on it for several years and it comes up time and again in the committee, in relation not just to the national care service but to every aspect of health and care.

A few of you have been in front of us before talking about that point in general. Can we put it into that context? There is a wider strategy to make that interface work for all health and social care systems, not just as part of the bill.

Beth Lawton: With the right architecture, we could be talking about something more like the citizen data systems in Finland and Estonia, where every citizen has, in effect, a secure locker of their own information that they can use to interact with all Government bodies, be that in relation to health, social care, driving licences or banks. They grant access to that information but it is independently verified. That approach could provide a more holistic benefit for Scotland than having a health and care system in one place.

The Convener: You mention some reserved areas, so I can imagine that, constitutionally, that might not be possible. The idea of a single patient record—I do not think that anyone is really calling it that; it is more of a single interface that enables access to all the relevant systems that hold all the data—is not just in the bill, but is part of a wider strategy.

I see Paula Fraser nodding.

Paula Fraser: On the system in Finland that Beth Lawton talked about, our members mentioned that they would want to have something a bit more like a personal data store so that they could give consent for certain parts of it to be viewed. However, it would be person centred so that they would be the ones who had access to it and they would not have to make freedom of information requests about their own records.

Dr Meechan: The personal data store is a good idea but we have to be careful, given that we have regulatory functions here. There are social work interventions that are compulsory. We have to be careful when applying the concept of a personal data store in that area.

I will respond to the previous point on what is in the bill as opposed to the policy memorandum. I think that Ken Macdonald mentioned data protection impact assessments. The data protection impact assessment that accompanies the bill covers only the framework, under which no personal data is exchanged, so it does not tell us anything or give us any opportunity to engage in the wider privacy debates that the proposals should engender at this stage in the development of the plans.

We can see that the long-term journey under the framework legislation is towards having a single, unified health and social care record in some form. Whether that is one great big data bucket or some form of federated interconnection between different systems is a debate for another day. However, we still need to have a debate early on about the wider privacy implications of how we do that so that, to pick up Ken Macdonald's point, privacy by design can be baked in from the outset and not done as different elements.

I appreciate that the co-design process will highlight things as we move forward but we are missing the opportunity now to have the wider privacy and data protection discussion on the wider proposals. The data protection impact assessment does not address that but it should.

Scott Heald: Convener, I go back to your point about the wider all-in data strategy. There is an ambition to—[*Inaudible*.]—how we do things in the health and care system—[*Inaudible*.]—to modernise IT and our ways of working.

I cannot comment on the costs of the data aspects of building the national care record but it is important that, in that context, we also think about the economies of scale that we will get from modernising how we do things. There is a challenge there. The balance between carrying on doing things in a clunky overlapping way and doing them in a more joined-up way will be really important.

The Convener: I cannot hear Scott Heald clearly. Perhaps, if broadcasting colleagues turn off the video the next time he speaks, we might be able to hear him more clearly, which would be better.

Sandesh Gulhane: I am an NHS general practitioner and I cannot access the NHS hospital data system. When I was doing adult psychiatry, I could not access the IT system for the children's service, which was in the other building.

We have significant issues with accessing information within the NHS. We have been working on that for a very long time and have spent an awful lot of money but we do not even have access to each other's information. That is a patient safety issue on many occasions.

Although I absolutely accept that it is important that we have shared patient data, if we have not got that right in the NHS for a long time, what confidence do the witnesses have that we will get anything that enables us to talk to each other within the next decade? It has not happened in healthcare.

The Convener: Sandesh, remember that we are talking about the National Care Service (Scotland) Bill, not the wider aspect.

Sandesh Gulhane: Yes, absolutely.

The Convener: We should always be bringing it back to the bill.

Sandesh Gulhane: Convener, it is important that we understand the context, which is that we have been working on that issue in healthcare for a long time. We want to introduce something new with the national care service—shared data—which is basically what we wanted to do in the NHS, but given that that has not happened, what confidence do the witnesses have that it will happen in the national care service?

Beth Lawton: You are right: the NHS struggles with that. My NHS experience is in England rather than Scotland, but the same premises arise. Because of necessity and because it was the only technology available, there was an overreliance in the NHS on monolithic systems that purported to do everything and did not share information. There is now considerable movement—again, I speak from my NHS England experience, not NHS Scotland experience—towards increased interoperability and the movement of data between systems, but that is not yet perfect. The direction of travel is there but I agree that there is still a long way to go.

In setting up the infrastructure to support the implementation of the bill—and the desired way of working as that flows through—we have the opportunity to develop something from scratch and build it in at the beginning. Therefore, we could consider interoperability and fire standards, for example, at that point rather than trying to retrofit them. That would give us more of an opportunity for success. However, I do not want to make claims that it would be easy. It would be difficult because there are many moving parts.

The Convener: Emma, you have some questions. If you could direct them to particular witnesses, that would be great.

If any of the witnesses wants to come in on something that they have been asked, even if they have not been named by the member, they should signal to me and I will bring them in.

Emma Harper: My question is about data security and the public's need to be aware and trust absolutely that their data will be managed in a way that does not reveal personal information, especially if we are using it to monitor and collect information on how the national care service is working and how records are exchanged so that people do not have to repeat their stories over and over.

What needs to happen for the public to trust, in relation to the retention of their information, that only the specifics that are required will be shared? I put that first to Paula Fraser, who is in the room, and then to Scott Heald.

Paula Fraser: There is a lot of distrust among our members about how data is stored and how it is shared. A lot of members have talked about that even in the current situation. Sandesh Gulhane mentioned records not being shared between different services and the trouble that that causes.

Our members are worried about confidentiality and access to their own data. I am not sure what would give them confidence in the system, other than their having the ability to access their data and to say, in relation to different parts of it, "I give informed consent to this area being shared with particular services." That would obviously be very complicated to do, but our members have talked about the idea of informed consent and being able to feel that their human rights are being respected, especially in relation to mental health records. For certain areas, some members have talked about the idea of allowing access only to bullet points about their mental health record, rather than all the details.

Those are the sort of suggestions that have been made, but it is very difficult to say what would make members feel that they could trust that their information was being handled securely and that would give them confidence in the confidentiality of the records.

The Convener: After we have heard from Scott Heald, we will go to Kenneth Meechan.

Scott Heald: I think that my video is now switched off. I agree with all that has been said. A key aspect will be engagement with the public on all—[*Inaudible*.] A fundamental aspect of—[*Inaudible*.]—the information governance framework that underpins it all. That needs to be done at the start, and people need to be clear about how it will work and how it will impact.

[*Inaudible*.]—the examples that were given about understanding things from a citizen's perspective. [*Inaudible*.]—not having to explain the story multiple times will be one benefit—[*Inaudible*.]—work, but also being really clear about how that sensitive data will be handled and how it will be used.

We can build on the experience that we already have. A body such as Public Health Scotland has access to confidential data. We have really strict frameworks around how that is managed and accessed. There is something about having a narrative with the public and through the groups that have been described—[*Inaudible.*]—understand how it works. We would have the information governance framework and there would be engagement with the public at the start of the process so that people would be involved in how everything would be set up and managed.

Dr Meechan: A lot of the issue relates to work that we already do in the transparency sphere on data protection. Most of the players in this area are public authorities. From a GDPR perspective, we are told that, for public authorities, consent is probably not the way to go, simply because there is a power imbalance between a big public authority and an individual service user. However, the fact that a body is not using consent as the legal basis in relation to data protection does not mean that it should not be transparent, open and up front with people. In the local authority sphere, we have put a lot of effort into telling people what we will do with their information in relation to the different interactions that they have with us.

That gets complicated, because there is quite a complicated ecosystem of information sharing out there. There are proposals in the bill to facilitate information sharing, but I am not sure that they take us a huge step forward.

09:45

The public bodies that deliver services in the areas covered by the bill have identified that they can already lawfully share information with the people with whom they need to do so. We have those information-sharing agreements, including with Public Health Scotland, and the pandemic actually helped to accelerate progress in that area. A lot of that is already in place.

There is a consultation in relation to social care data, but part of the problem with that consultation is that it almost creates an expectation in the minds of people who are reading it: a service user who reads that consultation paper would probably be left with the feeling that they have—or should be able to have—more control over their data than the legal framework actually gives, or that the ability to deliver services actually requires. Therefore, we have to be careful.

We need to be transparent, but the problem with those consultations is that, at the moment, we have no idea what a national care service is going to look like, so we do not know who will be the controller of that data. One of the fundamental difficulties that we have in engaging with the process at this time is that we are pinning the tail on a donkey that has not yet been drawn.

The Convener: Emma, do you want to come back in?

Emma Harper: I think that Daren Fitzhenry might want to come in but, before he does so, I will pick up on the fact that things are happening right now. For example, Badger Notes for maternity services enables women who are pregnant to have real-time access to the information in their pregnancy care record. The clinical portal is another part of what is being developed to enable access to care records that the patients do not necessarily get to see but the clinicians do. There is work in progress, which can be built on. I am interested in how we can use that as a way to measure how we implement a future safe and secure data care system.

Daren Fitzhenry: We have been discussing access to personal data, but there was an earlier comment in relation to the non-identifiable care data that is coming in and exploring issues such as efficiency and numbers. There is an important point to be made about access to that as well, when we are looking at trust in a system and how well a system works for the public, including patients, and everybody else.

One concern that I have with the bill as it is currently drafted is that, although the care boards would be made subject to freedom of information duties, the architecture of the bill allows for the contracting out of services, including services that are currently dealt with by local authorities. My concern is that, if that is done and the freedom of information issue is not considered in relation to the providers of the care as well as to the overarching care boards, there is a real risk that information rights could be lost in relation to access to that non-personal data and important non-identifiable social care data. The value of that was seen during the pandemic, when people were hungry for that data, to see how care homes were performing, how the system was holding up, and whether loved ones would be safe. I do not think that we should forget that. My concern is that, as currently drafted, the bill seems to deal with freedom of information and those access rights as an afterthought, to be picked up later, by way of a section 5 order, rather than addressing those issues in the body of the bill.

Gillian Mackay (Central Scotland) (Green): Due to the scale of change that is required—for example, the upgrading of legacy systems—Stirling Council has suggested that there should be a phased launch of the information-sharing system. Do the witnesses have concerns about the capacity of some local authorities—and, potentially, the NHS—to complete that work in the suggested timeframe? Do you have any other issues that you want to raise about capacity and the workforce that is available?

Beth Lawton: That is a real concern. The incremental approach would probably be the most productive one. We are all aware that there is a national shortage of qualified and experienced IT staff. My colleagues across industry and the public sector in Scotland are all reporting the same thing: there are not enough skilled staff to go around. That would be a significant problem for bringing in people for a central project; it would also be a problem within various local authorities not only for keeping their business-as-usual activities running but for undertaking significant enhancement. It is very definitely a concern.

That said, if your resources are more limited or likely to change over time, building incrementally is a much more sustainable way of doing it. You can move things according to what is deliverable in the next sprint, or you can deliver something and then pause if need be. The approach that is being suggested is definitely worth exploring.

Scott Heald: In terms of capacity—[*Inaudible*.]—particularly in local authorities, certainly my experience of collecting data from social care—[*Inaudible*.]—has been that it is—[*Inaudible*.]—very fragmented, but I think that there are opportunities to think about how we—[*Inaudible*.]—the underlying infrastructure—[*Inaudible*.]—to any national care records. As Beth Lawton said, we need a phased approach.

I wonder, though, whether there are opportunities for economies of scale. I imagine that that is something that the national team—[*Inaudible*.]—as Beth Lawton said, building incrementally in sprints. [*Inaudible*.]—opportunity then for the national team to work in local areas to provide additional capacity for—[*Inaudible*.]—to allow that to happen.

The important—[*Inaudible*.]—underlying—[*Inaudible*.]—system, particularly local authorities, varies across the country. There is a lot of inconsistency, so something will need to be tackled around that before we crack the national care records wholesale.

Dr Meechan: I would not underestimate the resource demands that are involved here, particularly given that budgets in the rest of the public sector are increasingly constrained. Vacancies are almost impossible to fill. That is the case more generally, even without getting into the specific skill shortages that you might find in the IT sector.

The reality is that, even if everybody who is involved decided that we wanted to have a big bang, the approach taken would end up becoming incremental simply because of the size of the supertanker that we are trying to turn around. There are a lot of moving parts. As co-design develops, we should remember to involve the information elements of that as we go along.

This really is a huge piece of work. As I mentioned earlier, I do not think that the five-year timescale for the information element is realistic. That would be a big ask at normal times. At the moment, with budgets as constrained as they are, and as staffing resources become increasingly scarce, I simply do not think that it is achievable.

The Convener: We have touched on GDPR already, but a couple of colleagues want to come in specifically on that subject. Sandesh, do you still have questions about that? I believe that Stephanie Callaghan has some questions, too.

Sandesh Gulhane: My question is directed to Kenneth Meechan. SOLAR has expressed concerns about the impact of the proposed measures on the rights of data subjects. Could you expand a bit on what you said in your submission about that?

Dr Meechan: That was particularly in relation to people exercising their subject access rights using data protection legislation to see what information we hold about them. There are some exemptions to those rights. You do not have an automatic right to see everything that is in your file. In a social work file, for example, there will almost certainly be information about a lot of other individuals, which you are probably not entitled to see.

At the moment, if someone puts in a request to a local authority, social workers who are familiar with the case go through the file to identify what should definitely be going out to the person because it is about them. Social workers will also be able to identify what can go out to a service user because, even though it is about a third party, the service user already knows that information. That means that the social workers do not need to worry about redacting that chunk of the file. Those decisions are taken by people who are familiar with the individual.

As you centralise the records, if you were to create a huge monolithic data tank of all service users in the care sector, it seems unlikely that those decisions and the interpretation of a request for information would be managed by somebody with knowledge of the case. You would probably end up with a much more bureaucratic application of the rules.

With some social work records, particularly for people who have been in the care system, there is sensitivity around the information and it needs to be handled with care. Very often, we would handle that by inviting the person in for what is almost a counselling session. It is not a case of just handing over a pile of records and that is it; it is about taking the person through the records to make sure that you are not causing them harm in the course of them exercising their rights.

The further you take the data away from the front-line staff, the harder it is to make sure that you are getting the balance right.

Sandesh Gulhane: I think that all of us on the committee, and most patients, would be keen to ultimately arrive at a place where the patient holds their own data—their own records. That would be an ideal scenario.

What safeguards do you think need to be put in place? You mentioned lots of things in relation to moving data to a more centralised location. I will put that question to Kenneth Meechan first, but I would also like to hear from Ken Macdonald on that same point about safeguards.

Dr Meechan: We already have a lot of safeguards built in through the UK GDPR and the Data Protection Act 2018. That is reinforced by the fact that the organisations that are dealing with that have been dealing with that level of sensitive information for a long time. I am not saying that mistakes do not happen—we all know that they do happen and will continue to happen, unfortunately.

The safeguard is to be transparent with people and to ensure that the right people have access to the information. If you have a huge centralised database, one of the most important safeguards that you will need is to make sure that you have got—[*Inaudible*.]—federated access. Just because you can access a system for one reason does not mean that you should have access to everything that is in there; you should have access only to the information that is relevant to the function that you are carrying out.

To go back to the resource issue that was raised previously, managing that level of federated access across the number of staff who are involved in the care sector is a big ask.

However, if we are going to do this properly and we are going to have privacy by design and by default, that needs to be baked into the process. When we are going through the co-design process, we need to ask who is the actual controller of the information and who has access to it. We need to make sure that that is factored in and that we have the appropriate resources to manage that properly.

Ken Macdonald: I would not disagree with anything that Kenny Meechan has said on that. Safeguards need to be built in from the start. We must ensure that the staff who are dealing with the subject access request understand the individual, understand the relationships and understand the dangers that there can be to others when certain information is released. If we are talking about social care, there could be child protection issues, for example.

Ready access to your record, as you are suggesting, Dr Gulhane, would not protect those other individuals—the third parties. We have to bring people along in the process. The social workers—the data controllers—have to be transparent with the service users and there has to be an understanding by the service users that there are other issues to consider, such as the legalities of access and so on.

10:00

The UK Information Commissioner, John Edwards, who came into post in January, is looking at the way that we deal with certain sectors, and we are putting a lot of emphasis in our work on raising the awareness of the rights of those who have unmet needs.

During the co-design process that we have spoken about previously, and in our consultations with the Government as it takes forward its proposals, I can see our having a big role in supporting users in that regard. I hope that we will engage with Paula Fraser and colleagues in other organisations, to help them with that, too.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): This is for Ken Macdonald. What role should the third sector and voluntary organisations—and services such as those for housing and homelessness—have in relation to information sharing? Does the bill allow them to fulfil that role or might changes to it be needed?

I would also like to hear your comments about the voluntary sector and other services that are outwith the scope of the bill, such as housing and homelessness services.

Ken Macdonald: Most of the detail on that will come through in the regulations. Obviously, the third sector has a major role to play in the delivery of social work services and other care services, so people in that sector cannot be ignored. It is for partners to ensure that organisations are properly trained and aware of their data protection responsibilities, and that they have good strong data sharing agreements between them so that they know what they can share, when they can share it and with whom they can share it.

A strong framework and infrastructure should be built in before the point of delivery. That should be done working with partners, patients, service users and advocacy groups to ensure that there is an effective system of data exchange.

The Convener: I assume that the goal is to implement a single interface that allows all people managing someone's care to access the systems and information that is contained in them, such as when a person is transitioning from a clinical setting to a care setting.

I want to bring in the perspective of those who are in the care sector right now. Yesterday, when we were in Dumfries, people in that sector told us that, currently, they have to put multiple entries of the same information into different systems or that they have to access multiple systems, which is taking away from the time that they can spend with their clients. Do any of the witnesses have views on how we can help the workforce with the goal of having a single interface and on how that could be manageable?

One of the reasons why that comes up time and again is that—Sandesh Gulhane mentioned this from the health perspective—the workforce cannot access certain systems in which there is data and information that they require. People who work in social care also say that they spend much of their time having to log in to different systems to report on things or to get information, which takes away from the job that they are supposed to be doing.

I see that Beth Lawton is nodding. I know that I am rambling a little bit, but you get my point. From the perspective of those on the ground, what would need to be implemented to reduce the red tape around that?

Beth Lawton: I was nodding along as you spoke, because my previous role was in mental health, in Sussex. Part of my role involved setting up the integrated care service there, and we had exactly the problems that you mentioned. Social work staff would enter their data in council systems, mental health practitioners would enter their data in NHS systems, and charities, which were very active in the sector, might have had in a back office three stand-alone computers that did not connect to anything at all. I absolutely recognise what you are referring to.

There is no easy answer. The ideal situation would be to have, in the first instance, common data standards so that people collect the same data. We find that each organisation has its own set of data—they are all slightly different—so it becomes more difficult to aggregate them. Therefore, it would be helpful to agree data standards and to have a culture of sharing.

In Sussex, we typically found that one organisation would say, “Oh no, we can’t share that information with you because of GDPR”, so our staff had to enter data in two separate systems that were controlled by two entities. Therefore, we must build that culture of data sharing and understanding of it, and we must build the common data definitions. Then we can look at aggregating the data as part of the wider system that we were talking about. However, on the basis of three years’ experience of that down south, I know that there is no quick fix.

The Convener: Does anyone else want to come in on that? Dr Meechan—you indicated in the chat box that you want to come in, but I do not know whether that was in relation to my question.

Dr Meechan: I want to come in on your question and on the previous point about third sector engagement. During the pandemic, the role of many smaller third sector agencies in providing vital support came to the fore in a way that had not happened previously. However, that also highlighted some weaknesses in information governance.

We have been working on that by—how can I put it?—addressing the bureaucratic parts of data protection. In Glasgow, we have now agreed on a model, which we are happy to share with others elsewhere. We have agreed on that bureaucratic part of data protection up front with the umbrella organisations, such as Glasgow Council for the Voluntary Sector.

Those organisations went off, got lawyered up—if I can use that term—and agreed a framework with the council under which all their members can happily enter specific data-sharing agreements in relation to the work that they are doing. In that way, we are happy that we have addressed the information governance aspect, which helps to facilitate joint working in that area.

On the point about joint services, health and social care have been moving more closely together to the point that, in some areas of practice, it is recognised that you cannot work in isolation. Addictions work in particular and some aspects of mental health work require both clinical and social care interventions to ensure that things are done properly. We recognise that by saying, “This is an area where we are jointly controlling that data.” Therefore, it should not matter into whose computer you input the data.

When someone representing an organisation is entering data, that organisation controls the data. You should recognise that in what you say to your staff. If a council employee is doing things with that data, rather than saying, “I’ll only put this on that organisation’s computer, even though I work for the council”, it should be recognised that the council has a role there. We have been trying to do that, and it is increasingly becoming the norm in fields such as addiction and mental health that more than one agency controls the data.

The Convener: Stephanie, you have questions on ownership of data, so now is a good time to bring you in.

Stephanie Callaghan: Dr Meechan’s last point is really interesting, and I would like to hear some more detail on that. If my understanding is right, there is consensus on individuals’ owning and controlling their data. That is to do with consent, choice and setting limits, and the approach to that must be person centred. Should that be stated in the bill?

Paula Fraser: Yes, from our members' perspective, that should be stated in the bill. However, many of our members say that absolutely no mental health records should be shared at all, regardless of the option to access those themselves or whether the approach is person centred. Therefore, I must state that the view from some of our members is that they do not want that to happen at all with mental health records. In general, our members want that in the bill so that they know that it is absolutely guaranteed, in a sense.

Ken Macdonald: I absolutely understand what Paula Fraser says, but I have a concern about the language that might be used. The use of the term "person centred" might send the wrong signals. As Kenny Meechan mentioned earlier, there are times when we have to say, "We can't ask for your consent on this—we are the local authority and you need our services." There is a power imbalance, so we have to be careful with the language that is used.

We also have to be careful—dare I say it?—about not sharing data. Beth Lawton said that we cannot share because of GDPR; I know that she was quoting someone else, and not saying it herself. There is normally a way through the data protection legislative framework to allow sharing. It is a matter of seeking the right advice, and that is an educative part of our role.

I also smile at, and take exception to, Kenny Meechan's description of the bureaucracy around data protection. I would call it good information governance—it is necessary, and it is key to the whole framework.

Scott Heald: To build on that point, we need to be really careful about the balance between—[*Inaudible*.]—the need for us to share data for things such as service planning, understanding pathways and so on.

It comes back to the point that I raised earlier about having a dialogue with individuals on—[*Inaudible*.]—to be used for those purposes. When people make the kind of carte blanche statement that they do not want their data to be shared, that is risky, because there are reasons why it is really important that they share data, and there is an ability to understand what is happening across—[*Inaudible*.]

The Convener: Stephanie, do you have any more questions on that issue?

Stephanie Callaghan: To come back to what Paula Fraser said, I realise that people are concerned about mental health information in particular being shared. However, that is one of the key areas in which we talk about people experiencing trauma as a result of having to repeat their story over and over again. It is implicit that they should be able to share that information when that is helpful to them. How do we get the balance right, so that human rights are respected, too?

Paula Fraser: I do not know whether I have an answer to that, but our members have definitely talked about the retraumatising effect of having to tell their stories over and over again. Interestingly, much of the time, what they are talking about falls within mental health services, where their records have not been shared or details have not been recorded properly. It is there, rather than outwith mental health services, that they find that they have to retell their story. I see what you are saying, but I am afraid that I do not have an answer.

Stephanie Callaghan: I appreciate that point, because I know that, for some people, sharing details or too much information on traumatic experiences with someone with whom they are not happy about doing so is also a traumatising experience. Do the other panel members have any comments on how we get the balance right?

Ken Macdonald: I wonder whether anybody is flagging up certain pieces of information on the record. I do not know any of the scenarios well enough to give a proper example, but I go back to the health scenario that we have discussed, which is a rough parallel. We often see cases in which people dispute what the doctor has said on the record, but, as colleagues here will be aware, it is essential that the doctor's initial diagnosis is retained. People want us to say, "Scrap it," and we say, "No—make a note that it is disputed," because, ultimately, in the patient's medical history, it is essential to know what the initial diagnosis was and whether the doctor was correct or wrong.

10:15

That is not a direct parallel, but I wonder whether there could be something in the mental health area so that the patient can say, "I'm not happy. I understand that you might have to keep it and that you might have to share it, but please note my concerns," and the issue is flagged up in that way.

Dr Meechan: On the point about control of the data, one of the important things that can also cause trauma is that you need to know whose job it will be to fix issues when you get things wrong. However securely we build a system, we should not be naive enough to think that there will not be mistakes at some point. Unfortunately, things will go wrong. That is when we have to be in touch with Ken Macdonald's colleagues down in Wilmslow to notify them of data breaches. We need to bear that in mind when we are designing the system.

I can give a couple of examples that I am aware of. Our local authority managed to lose rather a lot of data in relation to the housing of sex offenders in the community. The data found its way into the hands of *The Sun* newspaper when it was at the height of its "hang a paedophile from the nearest lamp post" campaign. The data breach in that case involved the emergency rehousing of a lot of those offenders. A massive multi-agency task force had to be mobilised to deal with that.

On a smaller scale, there were home carers going out to people's houses who had a piece of paper with the combination for the key safes on it. That piece of paper blew out the window of a van, and the data breach response was that we had to send tradesmen out to about 20 people's houses to change the combination of the key safes. That is the sort of situation where, again, it is really important for us to know who the controller of the data is, because one of the important things the controller has to do is to make things right when they go wrong.

The Convener: A couple of members want to come in on this theme.

Emma Harper: I have just a quick thought. Yesterday in Dumfries, one of the people round the table said that we should move away from talking about person-centred care and talk about relationship-centred care, which is based on trust between, for example, a person and their carer at home or in a care home. What are your thoughts on the language that we use? Of course, we want a person-centred approach, because the situation is very dependent on what data is shared and who is allowed access to data, such as the combination for a key safe, as Ken Meechan was talking about. Can I have brief thoughts on person-centred versus relationship-centred care?

Paula Fraser: I am not sure that I have an answer on that. Our members talk a lot about person-centred care, but they also mention that, as you say, the term is often bandied about, and it might not be doing what it is supposed to be doing. The term "relationship-centred care" might be a good description if you are talking about what happens between a clinician and a patient, as long as it is not taking away any of the rights of the patient. Language is important, but it is also quite difficult to decide on. I am not sure that I have a good answer on that.

Evelyn Tweed (Stirling) (SNP): To go back to what Paula Fraser said about co-design, we know that people want a shared record, in whatever form that takes. The Scottish Government consultation showed that 86 per cent of people wanted that and they wanted it to be shared across platforms. However, Paula also said that people were anxious about what co-design would look like—what it would mean and whether they would have enough time. Would it be helpful to have further guidance from the Scottish Government about what it would look like, in order to offer reassurance that there will be time to have those important conversations about control of data, mental health issues and what might be shared and in what circumstances?

Paula Fraser: That would be very useful, as would knowing that there will be enough time to carry that out properly and have everybody who should be consulted, consulted properly.

The Convener: We now have questions on monitoring and evaluation. Emma Harper and Evelyn Tweed want to come in on that topic. If anybody else wants to pick up on any of the aspects that we have mentioned before we round off this panel session, please let me know.

Emma Harper: We have talked a lot about personal data, but now we have a couple of questions on the monitoring and evaluation of the national care service.

I am interested in whether the bill as introduced has suitable information on the monitoring and evaluation of care as it is delivered. Should anything be added, or will the framework legislation allow the service to be monitored and evaluated in the way that we intend?

Daren Fitzhenry: To go back to my earlier point on freedom of information, the openness and transparency that freedom of information can provide to the systems would allow for increased accountability and monitoring—particularly if it is tied in with information standards—which would mean that we have a consistent approach between bodies, as I mentioned. For example, it would mean that different care boards could be compared like with like.

Although care boards would be captured under freedom of information to enable that sort of analysis, the tier below is not captured in the bill. For example, if person A's care was provided by a local authority or by another public body such as a care board, that person would have access to specific information but, if person B was in a care service that was provided by a contracted-out service, that person would not have the same rights to information. We are looking for the consistency that is promised by the system, but there is a risk that the architecture, as it relates to freedom of information rights, will create inconsistencies. I am concerned that having a section 5 order to remedy that later on is asking for a period of time in which there will be inequalities.

Emma Harper: It is interesting to talk about the release and sharing of information and the whole minutiae of regulations that allow freedom of information requests and monitoring and evaluation to be out there and shared to allow us to compare how one board is doing versus another.

We talk a lot about self-directed support, which works really well in some places but does not work well in others, so we need to be able to monitor that. Do you think that there should be something more detailed about data monitoring and evaluation of the system, such as on unmet need, in the bill?

Daren Fitzhenry: The piece of monitoring and evaluation that I am particularly interested in is the availability of information to the public, so that they can raise questions and concerns and make informed decisions, and that is where freedom of information comes in.

The bill is an opportunity to consider that as part of the process and build it in from the get go—while it is dealing with all the other data considerations in the system as whole—rather than view it as an add on. My concern is that, for the system to work properly, it is helpful for Parliament and the committee to consider all those issues at the same time and build them in rather than dealing with them later. Certainly, it is interesting to consider how that would work with information standards and whether, in itself, that will help to create consistency across the various service providers.

The Convener: Evelyn, do you have a question?

Evelyn Tweed: Emma has helpfully covered mine.

The Convener: Okay. We will move on to the final question, which is from Gillian Mackay.

Gillian Mackay: The governance structures and the way that information is stored and what is stored where and by whom are not particularly clear for many people. Do the witnesses think that that is the case? What work would you like to be undertaken as part of the construction of the NCS to ensure that everyone knows their rights and responsibilities?

Ken Macdonald: I referred to the legal responsibilities that organisations, Government and the partners will have. It is essential that they consult us—in fact, it is obligatory—and I hope that we would be able to assist them on their pathway to getting it right.

The Convener: Scott Heald, who is online, wants to come in. It might be on an earlier question, but I will bring him in, anyway.

Scott Heald: I—[*Inaudible.*]

On the points about monitoring and evaluation, one of the really important things about development of a national care record relates to the uses of the data once it is established. In relation to all the issues about unmet need and health inequalities, it is important to build in at the start how the data will be used once it is there. The fundamental part at the start is to talk through how the data will be used.

The answer to the question about the multiple agencies is that there has to be a multi-agency approach, because there are a lot of players in this space. On the specific question about whether the approach is clear at the moment, it is safe to say, certainly from my perspective, that it is not clear. However, important work would need to happen at the start, before it kicks off, about exactly who is involved and what role they will have within that.

The Convener: We have reached the end of our time with our first panel. I thank you all for your time. I now suspend the meeting for 10 minutes, so that we can have a break and allow our panels of witnesses to change over.

10:27

Meeting suspended.

10:40

On resuming—

The Convener: Welcome back. Our second evidence session will focus on the bill in relation to regulation and quality improvement.

I welcome to the committee Rosemary Agnew, Scottish Public Services Ombudsman; Lynsey Cleland, director of quality assurance, Healthcare Improvement Scotland; Suzanne McGuinness, executive director of social work, Mental Welfare Commission for Scotland; and Kevin Mitchell, executive director for scrutiny and assurance, Care Inspectorate.

I will go to Kevin Mitchell first. To what extent could the bill as drafted improve the regulation of care and support services?

Kevin Mitchell (Care Inspectorate): I thank the committee for the opportunity to give evidence. The Care Inspectorate welcomes the bill, particularly the aspiration to improve the quality and consistency of social work and social care services and thereby the outcomes and experiences of people, which is what it should all be about. We also welcome the underpinning principles of the national care service that are included in the bill.

We recognise that it is a framework bill and, as such, does not have the detail that some are perhaps looking for. However, we also understand that further detail will be forthcoming in due course, not least through draft regulations, consultation co-design and co-production.

Although we recognise the potential of the bill and the very laudable aspirations, in our experience, structures or changes to structures will not on their own deliver change or high-quality, seamless services for people, particularly for those who need those services the most. How the legislation is interpreted, implemented, and implemented consistently will therefore be crucially important. Equally crucially important will be how the national care service is led, managed and resourced.

We know from our scrutiny evidence that, above all else, it will need a strong shared vision; strong collaborative leadership; strong and effective partnership working; good multidisciplinary working where relationships are key and have the potential to break down any artificial barriers that might exist; robust quality assurance; and adequate resourcing.

To go back to the convener’s original question, we see the potential, particularly for the most vulnerable. We also welcome the recognition in the bill of the importance of independent scrutiny and assurance aligned to a quality improvement approach. In that respect, we think that the Care Inspectorate is well placed to carry that out. We already do that across a wide range of social work and social care services for babies, children, young people, adults and older people, and we have a strong record of working across complex structures.

We are confident that we can continue to do that and deliver independent scrutiny and assurance and support improvement effectively, whatever the structures that are in place. We certainly look forward to further discussions about the detail of the bill and its enabling powers in order to achieve all that.

The Convener: Social care is already a very highly regulated sector. You may be aware that we have been doing some local outreach work. We were in Dumfries yesterday, where I spoke to somebody who manages an independent care home about the burden of inspections, and multiple inspections, in relation to staff capacity. She put it to me that they did not want another layer of inspections on top of that. Are you involved in the review of inspections at the moment? What would be your response to that?

10:45

Kevin Mitchell: I assume that you are referring to the independent review of inspection, scrutiny and regulation that is being led by Dame Sue Bruce. We welcome the review and look forward to engaging with it, and we have already met Dame Sue Bruce and Stuart Currie.

When we go into any service, we are very conscious that the inspection will be a distraction. However, we take our responsibility to provide independent assurance very seriously, as we do our statutory duty to further improvement in social work and social care. When we go to do our inspections, we are very clear that we will support improvement. We regard every visit, contact and inspection as an opportunity to do that in the service. Our statutory responsibility is to provide independent assurance of the quality of care as well as the safety, protection and wellbeing of people who are sometimes among the most vulnerable, whether they are children, adults or older people. When we go into a service, we will seek to deliver all that, and we always regard our inspections as something that we are doing with people rather than something that is being done to them. We engage in professional dialogue, signpost and try to identify good practice.

However, no matter how you package that, sometimes some people will feel that the inspection process is a burden. Sometimes the views of the inspection process may correlate with the outcome of the inspection. Services are overwhelmingly rated as “good” and “very good”, and we do not often receive complaints when we report the outcomes of the inspections of those services.

The Convener: To be fair, they were talking about the amount of inspections, rather than any kind of outcomes. They were hoping that the national care service would not be adding another layer of inspection on top of what they already have to do in that regard.

Kevin Mitchell: I suspect that what they might have been alluding to—and I am only guessing—is that we would only seek to carry out inspections relative to an assessment of risk. We take an intelligence-led, risk-based approach to inspections, although we also want to look at services to identify good practice, so we need to strike a balance. During the pandemic, an enhanced role for oversight groups in health and social care partnerships developed. Those groups have been helpful in many respects, and we liaise very closely with them. On many occasions, we have been told about potential overlaps and some inconsistencies in how those groups approach the oversight role in different areas. Some services perceive those groups as providing a secondary form of inspection, rather than supporting improvement. That might be what people have mentioned.

I do not want to speak negatively in any way about the oversight groups, because they have done some very good work and we have worked very closely with them. However, I know that some people feel that, rather than offering support and guidance, they come in and more or less repeat what we have done. That might be the source of some of the tensions that have been made known to us. I would not like to say how widely that view is held, but what you have said sounds similar to other views that have been put to us.

The Convener: I will bring it back to views on the ministerial oversight aspects of the bill and how that might relate to the regulation of care in mental health services. I will come to Suzanne McGuinness first.

Suzanne McGuinness (Mental Welfare Commission for Scotland): The commission welcomes any and all measures to improve quality and consistency across social work and social care. We previously submitted our views on the bill, and we felt that ministerial oversight of mental health services is set out quite broadly. We would expect greater emphasis on parliamentary scrutiny of ministerial powers, or for that to be made more explicit in the bill.

As the committee will be more than aware, mental health services are a complex landscape. We are currently working our way through the final report of the Scottish Mental Health Law Review. There is a lot in there, and there is a clear crossover between what the NCS hopes to achieve and what the Scottish Mental Health Law Review hopes to achieve. We would ask that those two combine as we progress with the national care service.

The Convener: I have a question for Rosemary Agnew on another very specific issue that relates to our previous panel. The SPSO was mentioned in the oral evidence that was given by the Scottish Information Commissioner. What is your feedback on that aspect of the Scottish Information Commissioner’s submission with regard to the Scottish Parliamentary Corporate Body and office-holders?

Rosemary Agnew (Scottish Public Services Ombudsman): Thank you for the opportunity to give evidence. I start with an apology—if I confuse the committee, it is because a lot of the information in the bill as drafted is quite conflicting in places. We have tried very hard to unpick it in specific ways.

There are, in fact, three issues relating to ministerial powers in section 15 of the bill. The first issue relates to being a parliamentary office-holder. We have concerns about the impact of the bill on office-holders. I know that the SPCB has also written with its concerns. It is worth taking us back to the Public Services Reform (Scotland) Act 2010.

When it was last proposed that the Government be able to make changes to parliamentary supported bodies by secondary legislation, which is what this bill is doing, it was accepted that it was not appropriate to simply use an affirmative procedure to do so. Instead, protections were added to the Public Services Reform (Scotland) Bill to make it clear that secondary legislation would be for limited purposes only, and the super-affirmative procedure, specifically designed for that, was introduced. That reflected the importance of the independence of the status of office-holders—not just me but the other parliamentary bodies.

This has an added dimension for the SPSO because, since that time, the United Nations has endorsed the Venice principles. They are a bit like the Paris principles but they relate to ombudsmen. Those principles ask states to ensure the independence of ombudsman schemes. Although we fully support the purposes and intentions of the bill, which Kevin Mitchell set out, we have a concern that the ability to change our powers in that way would undermine our independence. Admittedly, it would have to go through some sort of procedure, but it would be using secondary legislation to alter what is already complex legislation. We are not sure that that would be appropriate.

There are also some very specific impacts of section 15 in relation to complaints and ministerial powers, which I am happy to cover now, unless they are related to later questions.

The Convener: Please continue.

Rosemary Agnew: The second area where section 15 comes into play is in relation to our powers as a complaints standard authority. I have tried to set out what the current situation is and what the bill might change.

We were given complaints standard authority powers through an appropriate parliamentary process in 2010. That means that the SPSO sets complaints-handling standards for bodies under our jurisdiction, monitors complaints-handling performance, and supports and drives learning and improvement in relation to both complaints handling and getting public bodies to use complaints to learn for themselves what is good and poor practice. We accept that it is not ideal, but we have seen significant improvements because of model complaints-handling approaches.

Under our powers, we expect a complaints process to meet model complaints requirements and the principles that have been laid before, and approved by, Parliament. All local authorities, health and social care partnerships, IJBs and health boards broadly apply that system. There are a few local differences but, in effect, the process is the same. The national care service would be established under the legislation as a function of the Scottish ministers, which means that it would come under the SPSO's jurisdiction. Therefore, in theory, it is also under our jurisdiction for model complaints handling.

Section 15—this is where we come to what might transpire—would, in effect, make ministers a model complaints standards authority for the national care service and, potentially, social services, because it would give them the equivalent power to issue complaints procedures for those areas. My view is that that is incongruent with the powers that Parliament has already given to the SPSO, and it runs the risk of creating different systems for different parts of public services.

It is difficult to say in detail what the impact would be, but I go right back to one of the fundamental aims, which is to make the service easier, simpler and better for complainers and service users. Therefore, ideally, we want a service that does not result in complaints, and I do not think that it would be helpful to further complicate an already complex landscape.

On the final area where section 15 might come in, my primary powers are linked to the body that delivers the function, so my powers apply because the body is delivering the function and it is in my jurisdiction. There could be an unintentional consequence of reducing the accountability of some of my primary functions. That relates specifically to our ability to consider the merits of some decisions. Under the social work powers that we were given in 2017, after significant consultation and through the super-affirmative procedure, we are able to look at the merits of professional decisions that are made by social workers and social services. However, those powers are linked to the accountable body—in that case, the local authority. It is the same with regard to health services, where the powers are linked to the health board.

However, if those functions were moved to the national care service without any saving provisions in the bill, we think that it would end our powers in relation to the merits of decisions. To put it simply, we do not think that we would be able to challenge professional social work decisions in complaints, because of the way in which the bits of the legislation interact. Again, that would be a very retrograde step with regard to the creation of an ombudsman that is, in effect, a one-stop shop. There are also likely to be unintentional consequences of complexity with regard to how complaints are handled and where they go.

The Scottish Government has confirmed that our understanding is correct, but we are also concerned that it might have a similar impact with regard to some health-related complaints—if only health functions are transferred—and for whistleblowing complaints, because, since April 2021, I have also been the independent national whistleblowing officer. We have not been able to assess exactly what the impact would be, because we do not have as much detail on that.

We have been able to work positively with the Scottish Government, and it has said that it would use its section 15 powers to reinstate the social work-related powers. However, in my view, that would be to do things in the wrong order. The co-design that is going on is a great way to involve lived experience in the design of the service. I presume that some of that will relate to complaints.

However, given that our powers were confirmed through primary legislation or the super-affirmative process, we are still concerned about the appropriateness of the Scottish Government being able to change primary legislation to suit what it wants to see coming out of complaints. We would much rather be part of the co-design in order to make the complaint systems that we have better, instead of introducing something completely new.

11:00

The Convener: That is very helpful. What you have said will inform our questioning of the minister on that issue.

We move to questions from Emma Harper on the national social work agency.

Emma Harper: Good morning, everybody. Our papers contain information about the establishment of a new national social work agency. I would be interested to hear the panel's thoughts on the proposed creation of a centralised quality improvement body in the form of a national social work agency. Do you welcome that, or would you prefer an alternative approach to be taken? If so, what would that be? Let us go to Suzanne McGuinness first.

Suzanne McGuinness: I understand from my colleagues that the social work profession across the board is fully supportive of a national social work agency. It is really important for the social work profession to gain parity of professional recognition with integration partners across the board. Regardless of whether we have an integrated national social work agency or a stand-alone body, what matters is that we gain parity.

The commission is fully supportive of a national social work agency, which we think offers an opportunity for social workers to operate in the way that we are trained and intended to operate. That involves using our professional social work knowledge, skills and values to best effect through relationship-based practice within communities. That is a shift away from the current evolution of the role towards being gatekeepers.

It would be helpful for the role of the chief social work officer to be aligned with the national social work agency, and for that to be included in the bill.

Kevin Mitchell: I am not a social worker, but I have worked very closely with social workers at a strategic and operational level for almost all of my 45 years of public service. Although the detail is unclear, the Care Inspectorate recognises the potential benefits of the proposed creation of a national social work agency, particularly in promoting the value of social work and supporting improvements in learning and development opportunities for social workers and, indeed, social work managers. We feel that that could help to attract more entrants to the profession and to improve retention.

Care would have to be taken to ensure that there was no duplication of functions that are already undertaken by other bodies, such as the role that the Scottish Social Services Council plays on standards of education and training.

The Care Inspectorate also welcomes the bill's tone in recognising the unique task of social work, which is very closely aligned to, but not necessarily synonymous with, social care. Social work and social workers make a unique contribution to any multidisciplinary approach to delivering health and social care services. Social workers have particular skills, knowledge and experience and a strong set of social justice-based values, which, in my experience, are not always well understood. They often work with the most difficult and complex of cases, which involves balancing conflicting needs and views and making professional judgments in the most difficult of circumstances, such as on child and adult protection, or in managing high-risk offenders.

I suppose that, in totality, children and adults do not live in isolation from each other; they live in families and communities. Although there are arguments for and against the inclusion of social work services, children's services and justice services in a national care service, the critical point is that we do not disaggregate them. We know from our scrutiny evidence that services delivered by adult social work services—drug and alcohol treatment, for example, or justice—can impact on children, and vice versa. Whatever decision is made, it will be important to look very carefully at the issue before any of those services are disaggregated.

Whatever structure is put in place for a national care service, we hope that social work, social care and the staff therein are valued, with social work staff, in particular, being valued and represented at all levels of the service. The national social work agency must be in addition to—not instead of—that representation and must be able to consolidate progress in a number of agencies that work with social work.

Emma Harper: This might be a question for Lynsey Cleland, too, but I want to look at the issues of quality and education that have been mentioned and which have been raised in previous evidence-taking sessions. Yesterday in Dumfries, we heard that some of our carers are doing percutaneous endoscopic gastrostomy—or PEG—tube feeding. These really complex skills must be valued and, as a former nurse educator, I think that it is important that we measure and monitor such things and ensure that people are able to deliver these complex forms of care.

We also heard yesterday that older skilled and experienced care workers might retire early instead of undertaking mandatory training. Have you heard about that issue? Have you experienced it at all? Is there some plan to ensure that older experienced people who might not want to achieve the required levels can continue to work in whatever capacity, given that they already demonstrate a lot of those skills?

Lynsey Cleland (Healthcare Improvement Scotland): On the broader point, I think that the skills mix across health and care professions is really important. We need to ensure that those skills are maintained and that on-going skills development and training are delivered in an achievable way that meets the needs of service providers. It is important to strike that balance as we move forward, and we need a wider consideration of the workforce with regard to the skills and resources that are needed across the health and care spectrum.

With regard to broader considerations around quality improvement and some of the key conditions in that respect, an important issue is the interplay between the professionals providing care and the systems and structures within which they work. From our perspective, the quality improvement framework must be consistent and connected across health and care, with consistency of language, methodology and approach, as that helps to ensure that the people who use the services, no matter at what point in their care they are, have an integrated experience.

From our improvement support work across both health and care, we think that it is vital that the individuals who provide such support have the skills and experience, that it has been co-designed and that it has been tailored to the specific needs and issues that have to be addressed.

Kevin Mitchell: We certainly recognise the staffing pressures at the moment on health, social work and social care. Indeed, there is not a day goes by when we are not faced with them in our day-to-day work.

It is also important to acknowledge that, across the health and social care sectors, staff demonstrate huge levels of professionalism, commitment and dedication. It is true public service—it is a vocation. Those staff need to be valued and recognised, and they need reward packages that recognise what they do.

With regard to the staffing pressures that we are all aware of, work is being done to attract younger people and new entrants to those professions. However, I will pick up on an important point that Emma Harper made: in health and social care—indeed, in social work—we need to retain people who have high levels of experience, that has sometimes been acquired over many years, to train, mentor and support people who come into the profession. That is hugely important.

I cannot speak to the demographics, but we could provide some information from a social work or social care perspective, if that is of interest to the committee. Anecdotally, we know that those challenges exist, and we know of, and hear of, people leaving social work and social care earlier than might have been expected. Again, we can only guess about those cases—there could be many reasons for that. It might be related to what people have gone through during the pandemic or a number of other things. However, there is no doubt that a considerable effort must be made to recruit and retain high-quality staff because ultimately, those staff are crucial in delivering high-quality healthcare, social work and social care. Without the staff, we would not be able to deliver that care that we would all hope to receive if we were ever unfortunate enough to need it ourselves.

Emma Harper: Page 3 of the policy memorandum says that the creation of a national social work agency is part of the plan, but that is not in the bill. It seems pretty significant to create a national social work agency—if that is what is proposed—so does that need to be in the bill?

Suzanne McGuinness: Yes, I absolutely agree that the national social work agency should be in the bill, along with the clear role of leadership and accountability that the chief social work officer in each partnership area brings. That leadership role must not be undervalued in any way.

The Mental Welfare Commission's view is that the role of the chief social work officer, along with the national social work agency—whatever that will look like—should be in the bill. Specifically from a mental health perspective, the chief social work officer acts as the proxy decision maker for people who are, sadly, unable or no longer able to make some decisions for themselves—adults with incapacity—and we would not want the significance of the role that local authority guardianships can play in people's lives to be lost. Therefore, to make that explicit, it is important that the national social work agency and the role of the chief social work officer are in the bill.

Sandesh Gulhane: Kevin Mitchell, can you explain the Care Inspectorate's opposition to the national social work agency?

Kevin Mitchell: I do not think that anything that I said earlier—unless I have got it wrong—suggested anything other than the fact that we see the potential benefits of such an agency.

Sandesh Gulhane: I thought that your submission expressed some opposition to it. Am I mistaken?

Kevin Mitchell: The collective view of the Care Inspectorate is that, although it is difficult to comment when we do not have the detail, we certainly recognise the potential benefits of promoting social work.

11:15

The only qualification that we put on that is to say that, if such an agency were to be created, it would be important to ensure that there was congruence, rather than duplication, with the roles of bodies such as the Scottish Social Services Council. I highlight that issue, but it is not in itself a reason not to create a national social work agency. We just want to ensure that roles and responsibilities are aligned with the new structure and existing structures, if existing structures remain, so that services that are working together are not at odds with one another when it comes to their individual roles and remits.

We have been clear that there are potential benefits. As the consultation continues, with co-design and, no doubt, further engagement with Government officials—we have already had some engagement—we will be able to comment on the detail. I can certainly see that the approach might create opportunities, for the reasons that I gave earlier.

The Convener: Thank you. We move on to questions on mental health support and protection.

Gillian Mackay (Central Scotland) (Green): Good morning, panel. What risks are attached to separating social work functions, with some falling under the national care service and others remaining with local authorities? Could the approach create additional barriers and undermine provision of an holistic person-centred social work service?

Suzanne McGuinness: On the risks of social work functions sitting in different structures, the commission would strongly support a congruent and coherent structure, under which things move together. We cannot break things up; if we break things up we might end up with more of the same, when we are seeking improvement.

You asked about barriers. To have social workers being commissioned from a local authority into a national care service and a local care board would leave the social work profession in an exceptionally challenging position: it would undermine and dilute the profession. That is a key barrier, if we are talking purely about risks in relation to social work functions.

There are social workers who are trained as mental health officers, so we need to ensure that the mental health officer role sits alongside the role of social work colleagues, with everything moving together under the NCS.

Gillian Mackay: What opportunities are there for the national care service to improve mental health support and protection?

Suzanne McGuinness: There are such opportunities with a national care service, but as colleagues have highlighted in this meeting—and, probably, in previous meetings—there is still a lack of detail.

The final “Scottish Mental Health Law Review” report has been published, as I said, and we are awaiting the Scottish Government’s views on the review’s recommendations. There are opportunities for the national care service to look at the human rights enablement approach that is described in the report.

We also request that, for people in Scotland, cognisance be taken of the United Nations Convention on the Rights of Persons with Disabilities, and of the International Covenant on Economic, Social and Cultural Rights. There is a clear crossover between what it is hoped a national care service will achieve and sections 25 to 27 of the Mental Health (Care and Treatment) (Scotland) Act 2003, in the context of economic, social and cultural rights. I will put it politely and say that, right now, sections 25 to 27 are not fully realised for individuals who come under the 2003 act.

The commission fully supports early intervention and prevention, which the NCS could realise. That is another opportunity. The Royal College of Psychiatrists approached me before this meeting. Although early intervention and prevention are at the heart of social work, we agree with the college and the Scottish Mental Health Law Review group that there should be no loss of focus on individuals who are affected by severe and enduring mental health issues and who are at greatest risk.

It is a real balancing act. The national care service alignment that is being taken forward, along with the “Scottish Mental Health Law Review” and its recommendations, could ensure that mental health gains parity with physical health. Everybody in the mental health world feels really strongly about that. In answer to your question, there are opportunities for the national care service in respect of mental health services.

The Convener: Carol, you have questions about that.

Carol Mochan: I would like clarification of whether there are hurdles that Suzanne McGuinness feels could be overcome to get mental health into the bill, and whether she feels that we will not be able to get mental health services in the bill.

Suzanne McGuinness: Are you talking about having mental health services included in the bill?

Carol Mochan: Yes.

Suzanne McGuinness: Sections 27 and 28 of the bill talk about transfer of services. The “Scottish Mental Health Law Review”, the Mental Welfare Commission and colleagues in the Royal College of Psychiatrists agree that there are wide-ranging powers, but there is concern about what that actually means. Under schedule 3 of the bill there are local authority duties, but it is really difficult to say what that means.

Some concerns are about the complexity of the landscape. The Royal College of Psychiatrists is concerned about the transfer of mental health services from the NHS to local care boards or specialist care boards and what that would look like. We call for co-design by all stakeholders in order to ensure that mental health services sit in the right place. There is no argument about having clear pathways for individuals in respect of mental health, or about improving current pathways. There is a raft of work going on, as the committee will be aware. I do not know whether that answers your question.

Carol Mochan: Yes, it does, but some of the legislative stuff really needs to be worked through before we can be comfortable that people will be protected and that things will be happening as they should.

Suzanne McGuinness: I absolutely agree; we have been really clear about that. Again, I draw your attention to the “Scottish Mental Health Law Review”. There is a raft of background information there about honing what is required. I absolutely call for clarity and detail in the bill about what is meant by transfer of mental health services and transfer of local authority duties under mental health legislation, capacity legislation, adult protection legislation and so on.

The Convener: I will stick with you, Carol, because I think that you have a question or two about joint inspections.

Carol Mochan: Yes. We took evidence about inspections yesterday from people who work in the field. We know about the importance of going in and seeing how services are performing. There was talk about joint inspections during the pandemic. What were the benefits of that? In relation to the bill, would it be beneficial to look at who is inspecting services, and how and why?

Kevin Mitchell: I am happy to take that one. Just by way of context, if you are not already aware, I point out that the Care Inspectorate has a long and strong track record of joint inspections with Healthcare Improvement Scotland, Education Scotland, His Majesty's Inspectorate of Constabulary in Scotland, HM Inspectorate of Prisons for Scotland, HM Inspectorate of Prosecution in Scotland and the Mental Welfare Commission for Scotland. We have worked successfully with three of those bodies—HIS, HMICS and Education Scotland—for more than 10 years.

I have alluded to the fact that we also have a strong track record of working across complex structures. The Care Inspectorate is confident that we can continue to deliver independent scrutiny and assurance that supports improvement in whatever structure is in place and with whatever services are within the scope of a national care service.

On Carol Mochan's specific question, perhaps you were alluding to the situation during the pandemic. We welcome the proposal in section 43 of the bill that Healthcare Improvement Scotland may, for a fee, assist the Care Inspectorate in carrying out an inspection of a care service. We note from the financial memorandum that it is proposed that that measure would be used only in extremis or in exceptional circumstances. I suppose that that arises from the pandemic when, during the main period, which was around April 2020, Healthcare Improvement Scotland agreed to a request from the Care Inspectorate for mutual aid and support. Initially, that focused on case holding, but HIS began to join us on inspections and, up to April 2021, it joined us on about a third of all the inspections of care homes for adults that we undertook.

I reinforce the point that, whether it is in the context of the specific proposal in section 43 on exceptional circumstances or in general terms, we certainly have a long history of joint inspections with a significant number of partner scrutiny bodies, and we envisage that that will potentially be required more. That will greatly depend on what services are within the national care service.

The issue also relates to the earlier conversation about mental health services and community health services. For example, adults in care homes still rely heavily on community health services and services that are delivered by GPs. Therefore, there are discussions to be had about how those collective approaches might work in a new model of inspection.

That is why we welcome the independent review of inspection, scrutiny and regulation by Dame Sue Bruce, which I suspect will look specifically at that. It will not necessarily look at us, at Healthcare Improvement Scotland or the Scottish Social Services Council, but it will look at the existing scrutiny approaches to see how they need to be developed in the context of a national care service. We are very much up for those discussions and, if we can help Government officials or the committee in any way, we will be happy to do so.

Lynsey Cleland: I echo Kevin Mitchell's comments on the strong working relationship that Healthcare Improvement Scotland and the Care Inspectorate have, and the relationships that we have with a range of other partner agencies. Healthcare Improvement Scotland undertakes a range of assurance activities across the NHS and independent healthcare services, and we work in partnership with, essentially, the organisations that Kevin Mitchell listed. We are keen to build on that collaboration so that we continue to ensure a consistent and connected external and internal assurance approach to support on-going improvements in care.

It is incumbent on all the scrutiny and assurance bodies to continue to draw on the intelligence that is available to us in considering where to target our assurance activities in order to ensure that they are done in a co-ordinated way. That might mean joint activity or being aware of where other organisations have a footprint so that services do not feel that several organisations are turning up on their doorstep in quick succession. We are working closely on that and will continue to do so. We welcome the clarity that the bill will bring on other areas in which we can continue to build on the collaborative work that we already have in place.

My final point is about the importance of ensuring that scrutiny, assurance and improvement support for health and social care services are very much joined up to reflect the complex pathways of care that people experience.

Suzanne McGuinness: The Mental Welfare Commission for Scotland is neither an inspectorate nor a regulating body—we work with individuals to safeguard and promote people's human rights in the mental health and capacity context.

On that point, I ask the committee to look at "Scottish Mental Health Law Review", which discusses inspection and scrutiny in the context of mental health. It makes recommendations for the Mental Welfare Commission, in particular regarding expansion of the commission's role. The Scottish Government is still considering that, so we will see what happens further down the line.

11:30

Colleagues in the commission would agree on the need to work collaboratively and, from our point of view, to provide expertise in the field of mental health, as required. For example, through David Strang's recommendation, we are currently chairing a recently developed group on mental health and learning disability. Key to that is co-ordination and communication across regulation and inspection bodies, with the key partners, in particular in those fields, sitting around the table. I just wanted to highlight that point.

Carol Mochan: I have one small question about something that has been raised with us. Sometimes HIS charges fees for its inspections. I want to get a wee bit of understanding of where that comes from, and whether it would continue in the national care service.

Lynsey Cleland: I clarify that we do not charge fees for our inspections. The provision in the bill concerns our being able, if we were asked to support the Care Inspectorate in inspection of care services, to charge that body for the cost of that.

I give the example of our provision of support in care home inspections during the pandemic, when we drew on our expertise in infection prevention and control. We did that by redeploying existing inspection staff and drawing on their experience, knowledge and skills to support the work. We were able to do that because some of our other inspection programmes had been paused.

Again, it would very much depend on the nature of the ask. If short-term support was requested, we would probably deploy staff and pause or rephase existing work programmes. Considerations around potential resource costs would arise if long-term support was requested. That would require us to think about how we could deliver the support in conjunction with the range of inspection and assurance functions that we currently carry out.

The Convener: Stephanie Callaghan has questions on the role of the SPSO. We dipped into that a little with Rosemary Agnew, in response to my questions on earlier evidence from the Information Commissioner's Office, but if you would like to ask your questions, that would be great.

Stephanie Callaghan: I think that we dipped into it quite a lot, in fact. Rosemary Agnew went into detail in her earlier responses to my questions on complaints. I have a couple of small points to raise; I am not sure whether you will be able to answer these questions.

First, chapter 3 of the bill is about creating a charter. Would you expect that to be limited to principles or to include rights and responsibilities—for example, on waiting times and complaints, similar to what is in the Patient Rights (Scotland) Act 2011?

Secondly, should ministers have a duty to ensure that advocacy services are available for people with disabilities or people who have other needs, similar to what is in the Social Security (Scotland) Act 2018?

I direct those questions to Rosemary Agnew first, and I am happy for others to come in after her.

Rosemary Agnew: I was involved in development of the charter for the Social Security Scotland. I broadly support the concept of charters. A charter is almost like an emotional or social contract between a public body and a service user, and it works both ways.

In practice, in a complaints-handling environment, we do not often need to refer to the charters, because they relate more to overall principles of service. I would be wary of including in a charter too much detail on timescales and numbers. An example is the treatment time guarantee that is set out in health regulations. Something like that is almost a hostage to fortune if the charter includes too much detail and the landscape or the structure changes. With regard to principles, however, I think that a charter is a very good approach.

Advocacy is something that I feel strongly about professionally and personally. We tend to think about groups of people needing advocacy, and we use the general term "advocacy" for all sorts of things, but it is about supporting people at a point of vulnerability. That could be any of us; something traumatic could happen to me tomorrow, and I would need support.

The advocacy issues that I see relate to inconsistent access to advocates; access depends on where you live and what services you want advocacy for. Advocates can perform various functions; they can have a purely supportive role or they can represent people.

The principles that we—dare I say it?—advocate are about easy access to advocacy at the point of need, whether that is to access complaints or simply to interact with the service. What type of advocacy would be appropriate? Who puts the person in touch with an advocate? When a person is trying to deal with something really traumatic in life, the last thing that they think is, “Where do I go for an advocate?”

There is a responsibility on public bodies in that respect, but we also have to think about the support and training that advocates receive, because in professional terms a well-trained advocate can make a huge difference for an individual. Very often, the people who are advocating are relatives, friends or charities who might not have the same background, so some thought has to be given to what we mean by advocacy and how we give people consistent access to advocacy.

Kevin Mitchell: I will answer in the context of complaints in relation to the charter and advocacy. We need to be mindful that the Care Inspectorate already has a unique statutory responsibility for complaints about regulated care services, which are distinct from social work, health and the other services that are delivered in the integrated landscape.

Our view about the regulated care service complaints process as it stands is that it is working well. We regard every complaint as an opportunity to improve the care that people receive, because that is what it is about. How complaints are dealt with by a provider can tell us a lot about that provider. Intelligence from complaints that we receive is crucial to our wider role of scrutiny and improvement support. We cannot and would not stress enough the importance that we attach to retaining that link and to being able to quickly and effectively gather intelligence through dealing quickly and effectively with the complaints.

Members might be aware that we deal with about 6,000 complaints a year. That number has risen steadily from 2,800 in 2011; that general increase might indicate that there is greater awareness of our complaints process for regulated care services, and greater awareness among people about the standards of care that they and others should expect to receive.

I will relate that to the question about the charter; I am old enough to remember the creation of the children’s charter. We think that the charter of rights that is proposed in the bill could be helpful to people who use services, to their families and to carers, in helping them to understand their rights in terms of care and support. It could also help them to know their rights and what they should expect in social work and social care, including how to make a complaint. There is certainly mileage in that.

We acknowledge that for people who use services, for their families and for their carers it is likely to be challenging to make a complaint about integrated services in which a number of health, social work and social care services work together. It might be that that is what the bill seeks to address; we are not entirely clear on that. Regardless of that, it is important that the route for making complaints, like our complaints procedure, is based on the complaint-handling guidance and model complaints-handling procedure from colleagues in the SPSO, so what was said earlier is relevant.

We note that there is provision in the bill for regulations to be made for advocacy. It would be important to consider that in relation to complaints, particularly for people with communication difficulties.

Suzanne McGuinness: We welcome section 13 of the bill, which is about advocacy. In our previous submission we included a clarifying definition. We are talking about independent advocacy. The definition of that is set out by the Scottish Independent Advocacy Alliance. It is about giving people

“the right to a voice”

and about human rights being

“recognised, respected and secured.”

Equally, the bill could be an opportunity to fill gaps in specialist advocacy. I know that we are not yet anywhere near knowing where children’s and young people’s services will sit, for example, but should we get to the point at which we have clarity on that, we know through our work that there is a dearth of specialist advocacy services for children who are detained in non-specialist wards. Next week, we will publish our children and young people monitoring report in which we highlight that. Therefore, I make a call that, if we can, we have the bill make a difference in delivery of advocacy services. One of the key points that Rosemary Agnew made was about the need for well-trained advocates who can support people and navigate them through what is a really complex landscape.

Rosemary Agnew: I will pick up a couple of points. The first relates to children and young people. We all anticipate the United Nations Convention on the Rights of the Child being incorporated into Scots law. That includes children’s right to having their opinions heard. Advocates will be a crucial part of that.

Kevin Mitchell made a point about advocates in a complaints context. Often, by the time an issue becomes a complaint there is emotion, stress and worry. In particular, by the time it reaches stage 2 or reaches us, there is also a breakdown in relationships. Advocates can play a vital role in helping to rebuild relationships because they can be realistic with complainers and—as Kevin Mitchell said—help people to articulate issues much more constructively.

I reflect on some of the excellent work that the patient advisory service does in the NHS. Often, when we examine a complaint that has been brought by a representative through the patient advisory service's provision of support, it is easier for all parties to focus on the underlying issues.

I cannot emphasise enough what my colleagues have said.

The Convener: We now want to talk about the transfer of services. Paul O'Kane has questions on that.

Paul O'Kane: I will explore the notion of social work being within the scope of the NCS. That was not included in the Feeley report. What are your thoughts on why it was not? What is the potential impact of transferring those services into the national care service?

I will start with Suzanne McGuinness, if that is possible.

Suzanne McGuinness: Do you mean the context of transferring the entirety of social work into the national care service?

Paul O'Kane: Yes. I am going to come on to talk about what a separation might look like. However, if, as envisaged, we were to transfer criminal justice services, for example, what impact do you think that would have?

11:45

Suzanne McGuinness: I think that there needs to be a consultation across the board on criminal justice services and children's services. It would be remiss of me to make any comments about that in the absence of consultation through the Mental Welfare Commission for Scotland. However, there are pros and cons, and the social work profession becoming fragmented would be a risk if we do not come together. In the absence of detail, it is difficult for me to have a full, informed view on that.

Paul O'Kane: Sure. I presume that the Care Inspectorate pointed to those services not being included in the Feeley report. Kevin, will you comment on that?

Kevin Mitchell: The focus of the Feeley review was clearly on adult services but, as it happened, there was consideration of whether or not children's services should be part of a national care service. It is clear that consideration needs to be given to whether children's services, as well as justice services, should be included.

We welcome the current public consultation before there is any transfer of services. As we understand it, the bill, as it stands, proposes to give ministers the powers to transfer quite a broad range of services, including social care, social work and community health functions. It seems to us that all of that needs careful consideration.

We know that there are arguments for and against the transfer of children's services and justice services but, as I said earlier, we would caution against the disaggregation of those social work services. I point to the example that I gave earlier. Children and adults do not live in isolation from one another. Services that are provided to adults, such as justice, mental health and drug and alcohol treatment services, have an impact on children, just as not providing them has, and services that are provided to children have an impact on the adults who care for them, just as not providing them has. Social work is connected across people's lifespans, it is connected to social care in the round, and it needs very careful consideration.

There are very particular arrangements for child protection and adult protection, and they also require careful consideration. We know that, at a strategic level, the chief officers play a key role in the strategic overview of child and adult protection, and many of them now have responsibility for public protection. Collectively, the chief executives of health and social work and the local authorities take the strategic lead in both child and adult protection and, indeed, the management of high-risk offenders in the community. None of that precludes consideration being given to the responsibilities being transferred, but I think that all of that requires careful consideration.

In our inspection experience, the chair of public protection groups at the most senior level often rotates between the chief executive of the local authority, the health board and the police commander. Again, none of that necessarily precludes those services being included in the national care service, but all of it requires careful consideration. Alcohol and drug partnerships fall into that consideration, as well, of course.

Above all else, we would advise against the disaggregation of social work, because that could have potentially detrimental effects, whatever the structures might be.

Rosemary Agnew: I will pick up on some of Kevin Mitchell's themes from a complaints perspective. We see some of the issues between transitions, such as transitions from child to adult services, and we see that the complexity comes when different agencies are involved. When we look at where the issues currently arise, the argument that Kevin Mitchell has made for keeping services together and coherent is difficult to argue against.

When I was preparing for this meeting—I did prepare—I reflected on the fact that we are in danger of focusing on service when, actually, people are at the heart of the matter. If we focus on which bit of the service we put here and which bit we put there, we are perhaps in danger of missing people's life journeys and the number of times and ways that they will interact with the care service and the mental health service. Perhaps if we look at things in terms of life journeys, that might make some of the congruence that Kevin Mitchell referred to a little easier to comprehend. I must admit that, when we try to put things purely in terms of service, we end up with our heads going round and round.

The Convener: We are all listening to you, Rosemary, and what you have said chimes with what we heard on our Aberdeen visit in particular. Camphill Scotland staff talked about residents in their care who, when they reach the age of 60 or 65, might have to transfer into services that Camphill Scotland could not offer because of their age. Thank you for bringing that up.

I think that Lynsey Cleland wants to come in on that.

Lynsey Cleland: I very much echo those points about the importance of thinking about the journey of care and the connected approach, whether that is between acute services, community services or social care, so that we have a continuum.

Wherever we draw the structural lines, there will be interface issues that will need to be managed. Again, the focus needs to be on ensuring that leadership and governance arrangements are in place to work across structural or organisational boundaries, to the benefit of those who are accessing services.

The Convener: One of the reasons why the national care service has been proposed is to address some of the issues around services not being joined up and gaps appearing. It is good to bring the discussion back to that.

Paul O'Kane: I want to return to the point about the fragmentation of the social work profession. We have heard, and I hear, from social workers a real concern that, if we take social workers out of the local authority context, we will run the risk, particularly in children and family services, that there will be a real disconnect from education, which has a role within child protection as well, and that the link with teams around the child will be lost. Do people recognise that that is a significant risk?

Suzanne McGuinness: There is risk there but, equally, there is the risk of the fragmentation of social work as a profession and what that means. Rosemary Agnew outlined that beautifully in speaking about people's lives as a journey. Social workers do not look at people within just an adult or a mental health context; they look at people in a holistic sense and across the age range. I say that with the caveat that we have not concluded our submissions for the consultations. However, there is potential for the fragmentation and dilution of the social work profession.

Earlier, we talked about a national social work agency and whether there would be a conflict there. I cannot fully answer that question now, but there could potentially be a conflict for social work as a profession.

It is about holding people at the heart, and that is what the social work profession does. I understand that there is a much wider issue in respect of local authorities and a national care service, which I will not open up right now.

There could be a fragmentation of a profession that holds people in the holistic sense, as opposed to just doing part of that. If we have bits here and bits there, would that mean losing the sense of the profession in the way that it works, as people, across the piece?

I reinforce the point about transitions—transitions for children and transitions for adults as they move into older people's services. People turn into an older person at the stroke of midnight on their 65th birthday. For the NCS, we can, I hope, find a way to plug the gaps. That would be helpful.

Stephanie Callaghan: I have a quick question for you, Suzanne. I also sit on the Education, Children and Young People Committee, and we are examining this stuff, too. We have heard about situations involving, for example, a family with a justice social worker, an addictions social worker and a children's social worker, who are each focused on different information. There is then the job of pulling all those threads back together so as to consider the family holistically.

Does the bill present an opportunity to streamline? I do not mean streamline; I suppose that I mean an opportunity to take a much more holistic approach involving social workers working with the whole family. Rather than having three or four social workers, one or two could consider the situation in the round and apply their expertise and knowledge right across it. I do not know whether that happens or whether there is specific training for each strand, which still all need to be kept separate. I am interested to hear what you would say on that.

Suzanne McGuinness: Social workers are trained in all the disciplines from their university graduation. They will have had experience—certainly academically, and most often practically—in each area: children and young people, criminal justice and adults.

I refer back to my earlier response on the evolution of social work, which has been submitted to the committee by other social-work-specific agencies as well as by the Mental Welfare Commission for Scotland. That concerned the shift of social work away from the gatekeepers of budgets, eligibility criteria and the implementation of self-directed support—which comes from what must be one of the best pieces of legislation ever.

Just as an aside, thinking about the implementation gap and the shift in cultures is key. We can have the best NCS bill in the world, with everybody's input, but if the implementation gap is not sorted, along with the shift in cultures, we will end up in the same place. I hope that the NCS will help to push things forward with self-directed support.

To return to the question, with the introduction of a national social work agency—and depending on the outcome of the various consultations—I hope that social work will be permitted to operate within its founding principles, knowledge, skills and values, and that social workers will be permitted to work with people in the holistic sense, both as communities and as individuals, whatever their diagnosis or age.

The Convener: We must move on. I apologise: Rosemary Agnew wants to come in. I keep on doing that to you, Rosemary. I apologise.

Rosemary Agnew: That is all right. I need a flag.

I want to pick up on a couple of things about structures and working together. There is a risk in any structure. One will have positives in one sense, and one will have positives in another sense. To echo something that Suzanne McGuinness said, it might be helpful to think of the legislation as enabling. If we go right back to the user experience, it is a matter of making it seamless at the point of delivery. That does not necessarily mean that one organisation does everything. However, the provisions in the legislation have to enable and reduce the barriers. Even within the current delivery system and the current regulatory system, there are probably things that can be done, such as better information sharing and more enabling of working together. If they were picked up well, they would reduce some of the risk around the perception of barriers at the point of delivery. However, all those things have to be equally well resourced.

12:00

The Convener: We need to move on to talk about Anne's law and advocacy.

Emma Harper: One of the main drivers for introducing Anne's law was the recognition that families and friends were absolutely essential in supporting the health and wellbeing of care home residents during the Covid pandemic. Suzanne McGuinness might want to answer this question because of the health and wellbeing aspects of the introduction of Anne's law, which is about enabling visits to residents in care homes and visits by care home residents—as well as enabling people to go into care homes, it gives residents the ability to go out. Do you think that the aspects in the bill about visits to care homes or outside visits by care home residents are adequate to meet the needs of residents and support their wellbeing?

Suzanne McGuinness: Throughout the Covid pandemic, the commission was inundated with concerns from families about the impact of the policy of no visits to care homes. The commission's view is that everybody has a right to private and family life, which includes visits when a care home is somebody's home. We fully support Anne's law, in relation to both visits to and visits out of care homes. If we do not allow visits out of care homes, we are essentially talking about detention, which is a whole other ball game.

Should the NCS bill be paused or delayed for any reason, we suggest that Anne's law should be included in any relevant legislation in order to avoid its being delayed, because it is fundamental in upholding people's rights and ensuring that they have the right to family life.

Emma Harper: We have talked about advocacy and complaints. Is the bill adequate to be able to deal with that kind of support if there are any issues and we need to look at who is responsible and who is accountable? One of the issues that came up during the lockdown was to do with legal liability insurance. That was a real challenge, because care homes, rather than protecting one resident, were protecting all residents. Does that need further consideration?

Suzanne McGuinness: As Kevin Mitchell is from the care home regulator, he would be best placed to answer that question.

Kevin Mitchell: I do not disagree with what has been said by colleagues up to now. Fundamentally, the issue goes back to what we talked about earlier: people. Connecting with people is a fundamental right and is essential for wellbeing and good mental health. It is fair to say that the pandemic highlighted the need for a stronger voice for people who receive care and their families.

Notwithstanding what is proposed in the bill, the Government has already published two new health and social care standards—which I am sure members are aware of—to put Anne's law into practical effect while the legislation is prepared and considered. We are in no doubt that the two standards, as they are, enable care homes to build on existing good practice in supporting meaningful contact. There is a difficult balance to strike between people's rights and choices and the risk to others, but I think that the standards give that balance. The legislation seeks to enshrine that in law by giving ministers the power to require care home providers to comply with any directions that they make, especially if something as serious as the pandemic were to happen again. Those would undoubtedly also take account of public health requirements.

On balance, we are supportive of the work that the bill proposes to embed "Open with Care", and we think that it is absolutely crucial for visits to include not only visits to care homes but visits out of care homes by residents, because people in care homes are part of communities and care homes are in communities. It was pleasing to see it referred to in the Feeley report and, I think, elsewhere that that should be regarded as investment in communities.

With regard to advocacy, we think that the charter will also give people confidence in their rights. As the regulator, we have already been given a role, and whether it is done through our existing complaints function or other means, we will follow up, as we always do, to ensure that those rights, compliance with the new standards and, if the bill is passed, the legislation are upheld.

Emma Harper: Should Anne's law be extended to other facilities, such as hospitals? I understand that infection control and prevention guidance is important in specific areas, especially if there are outbreaks in other places. Have you considered whether we should extend Anne's law to hospitals?

Kevin Mitchell: I will probably defer to my colleagues, because although there are similarities—you are right to highlight that infection prevention and control is as important in care homes as it is in hospitals—we must be careful, because a care home environment is different. It is not a clinical environment; it is somebody's home. There is a risk that if we do it the other way round, we could potentially overmedicalise a care setting.

On the question of whether Anne's law would be appropriate for a hospital setting, I defer to my colleague from Healthcare Improvement Scotland.

Lynsey Cleland: As you said, there is a range of important considerations around infection prevention and control, particularly in acute hospital environments and particularly where there might be people who are very vulnerable and immunocompromised. At various points throughout the pandemic, NHS services have had to make adjustments to visiting to take account of some of those considerations. For example, when there has been an outbreak in a particular ward, services have looked to restrict visiting in order to contain that outbreak, while recognising the importance of people being able to have contact with family and friends and the vital role that that plays in their overall health and wellbeing, as well as in their recovery, particularly if someone has to be in hospital for a period of time.

During the pandemic, our community engagement directorate did a lot of work with health boards around virtual visiting and the technology, support and guidance that were needed to enable that to happen, so that patients could still have contact with their loved ones if it was not possible to have face-to-face contact. That work involved getting the technology and hardware that were needed to support virtual visiting, as well as work on the general principles and embedding the ethos of supporting people to maintain that vital contact with family and friends.

The Convener: We should be finishing in a couple of minutes, but with everyone's permission, I will extend the meeting by about 10 minutes, because we still have one area of questioning to go—monitoring of the national care service, which Evelyn Tweed will ask about.

Evelyn Tweed: I have rolled my questions into one large question because I knew that we were struggling for time. In evidence, we have heard that 72 per cent of respondents to the national care service consultation agreed that ministers should be accountable for the delivery of social care. Do you agree with that approach? What benefits do you foresee it bringing? Are there any risks that you would like to tell us about? I will go to Suzanne McGuinness first, and then anyone else who would like to come in.

Suzanne McGuinness: On monitoring and oversight of the NCS, we need to establish agreed measures for monitoring. In our submission, we set out that the principles of the bill are too broad, as are—on the face of it—the ministerial powers that are in the bill, albeit that the bill is only at its first stage. Because the principles are too broad to measure meaningfully, I do not think that you could come up with anything tangible with regard to what that would look like in reality.

We would support, and we expect, parliamentary scrutiny and reporting to Parliament on the monitoring by ministers. The commission has a statutory monitoring function under the Mental Health (Care and Treatment) (Scotland) Act 2003, and we monitor reports on adults with incapacity and children and young people. We are more than happy to discuss our experience of monitoring in the mental health context, once the reviews are concluded.

In relation to ministerial accountability and so on, it is important to note that what happens with the national care service will impact on the implementation of the "Scottish Mental Health Law Review" report. In looking at ministers' oversight and monitoring responsibilities, it is really important that those are joined up. We suggest a national care service oversight group that could be responsible for the oversight of delivery. We are talking about an implementation gap and shifting cultures, and we suggest that there is a place for a body that oversees and that is collaborative and cohesive—that is needed to deliver.

We know that public health data is available for monitoring and that the Scottish ministers can access it. Health boards have needs assessments, and data is available in communities and localities. I suppose that I am trying to say that accountability and access to data are very complex, because there are various strands.

As I said, I would expect parliamentary scrutiny overall of the monitoring by the Scottish ministers, if they have responsibility. However, their powers need to be clarified in the bill.

The Convener: Are there any more views on that?

Rosemary Agnew: What Suzanne said.

The question was about agreement, benefits and risks. It is difficult to comment, because there is not a huge amount of detail, but one thing that occurs to us is that monitoring, scrutiny and regulation are very closely joined, and there is a lot of similarity between them. We have already engaged with Dame Sue Bruce in relation to her current review. A lot depends on what she finds and what comes out of her review.

Scrutiny, monitoring and oversight are slightly different things. The SPSO monitors complaints handling and the outcome of that, but it is unclear how that might apply in relation to the powers under section 15 to transfer services. I am probably saying the same thing as Suzanne, but in a different way: there needs to be clarity in the bill about ministers' role. Once that is clearer, that will probably help to inform and enable an appropriate accountability structure. At the moment, I do not have a lot of detail.

Kevin Mitchell: To be honest, we are not entirely clear about what is meant by the reference to "monitoring" the national care service, and we suspect that that is multifaceted, as colleagues have suggested. Clearly, if services are directly provided or commissioned by the national care service, they will require to be inspected and/or regulated. It is difficult for us to provide any detail on changes that might be required, so one of the reasons why we welcome Dame Sue Bruce's review is that we think that it is geared to providing some sense of that.

On our approach, I would simply reiterate our strong track record of working across complex structures and being flexible and responsive to the changing landscape. We feel well placed to do that, irrespective of the structures that are put in place. We have alluded to Dame Sue Bruce's inquiry a number of times. What is perhaps equally helpful is the recent announcement by the Minister for Mental Wellbeing and Social Care of a review of mental health scrutiny and assurance, which will feed into Dame Sue Bruce's work and the wider scrutiny and regulation to inform the national care service development. We welcome that.

The only other thing that remains unclear to us relates to section 3 of the bill on responsibility for improvement. The bill says that the Scottish ministers will put in place

> "arrangements for the purpose of monitoring and improving the quality of the services that the National Care Service provides."

It is not clear what the impact of that would be on our role. I hope that I have outlined how we link targeted and generic improvement support to our scrutiny findings. We would welcome further discussions around that. However, we feel that we would be able to be flexible and responsive, as we have been previously, irrespective of the structures that are put in place and what those provide for.

12:15

Lynsey Cleland: I echo what my colleagues have said and support all the points that have been made. From our perspective, the issue comes back to clarity of roles and responsibilities and being very cognisant, as Rosemary Agnew said, of the interplay between monitoring, scrutiny and regulatory activities and the various parts that they all play. We need to have clear transparency and accountability, and a focus on the impact and outcomes with regard to the quality of care that people receive will be the key consideration in any of that oversight.

In the same way as Kevin Mitchell is, we are keen to continue to play our full part, through our assurance and improvement functions, in supporting the considerations to move forward.

Tess White (North East Scotland) (Con): I am sorry that I was late this morning—I was at another committee meeting.

I have a question for Rosemary Agnew and Kevin Mitchell. Many are concerned that the bill gives too much centralised power to ministers, and we have heard today that it will make the ombudsman function toothless and powerless and that, as Rosemary said, it will make the SPSO unable to do its job. What other conflicts of interest do you foresee?

Rosemary Agnew: What a good question—thank you. Fundamentally, it is partly to do with the drafting of the bill. I know that this might seem as though it comes a bit out of left field, but I want to go back to the point about co-design. I have been reflecting on a really positive co-design experience that we had, working with the Scottish Government. That was in relation to the establishment of the independent national whistleblowing officer function. We worked closely with the Government, which led and hosted events for a whole range of stakeholders. Concurrently, the legislation was being developed and drafted, so there was an outline framework for the legislation. That meant that, by the time the legislation had been drafted, it had been informed by the co-design; it also worked the other way, so they informed each other.

There were huge benefits to that, because it meant that, by the time the legislation came for parliamentary scrutiny, there was a very real example in the whistleblowing standards of what that might look like in practice. At the moment, one of my concerns is about the timing of the co-design process and the drafting of the legislation. We are in danger of losing the benefit of the two things happening concurrently if one happens ahead of the other.

That will partly inform whether, as drafted, the powers of ministers—I am thinking about section 15 in particular—are what was intended or whether those powers have been put in place to make it possible to take on board anything that comes out of the co-design process later. At the moment, that is not clear. It is not appropriate for us, as an apolitical body, to say anything about whether ministers have too much power—that is for the Parliament to decide—but I think that, as the bill is drafted, there is inconsistency in where powers sit and how they interact with one another.

If I am to take a complaints focus on this, I do not want it to appear as though I am being negative about what that might mean for the SPSO. However, we in Scotland have created an internationally respected ombudsman service and, as public services ombudsmen, we are recognised as being innovative and as doing a lot of good work. It would be a retrograde step to undo any of that. I would like the legislation to be drafted to enable the two aspects to sit side by side coherently. At the moment, I am not sure that they do.

The Convener: I see that only Kevin Mitchell wants to come in.

Kevin Mitchell: There is nothing much that I can add to that. As I said earlier, we recognise that it is a framework bill and that, as such, the detail that all of us would like to hear more about will come later through consultation, co-design and discussions with officials.

I do not see any conflict for us as the independent regulator. Yes, we may have a role in inspecting and regulating services that are commissioned by the national care service and thereby Government, if the bill comes to pass, but I suppose that that would be similar to what happens with services that are commissioned by the NHS, or akin to the situation in the NHS.

We welcome the strong emphasis on independent scrutiny by an independent scrutiny body such as ourselves. There have been discussions about intervention orders, and I understand that concern has been expressed about a possible overlap between the framework bill in relation to ministerial intervention and the Care Inspectorate’s enforcement powers. We welcome the strengthening of our enforcement powers. It might be wise to look more closely at that issue as more detail emerges. My initial thoughts are that we had something similar during the pandemic when there were emergency powers. We were able to manage and work through those.

The recurring theme in what I have said today is the need for careful consideration as the detail emerges to identify any issues of that nature that might arise. However, we continue to recognise the potential benefits, and we are happy to provide support in any way that we can, whether that is through our existing approaches or, indeed, through Dame Sue Bruce’s work or that of the independent review of mental health.

The Convener: I thank the witnesses and my colleagues for their participation this morning. Our next meeting—

Carol Mochan: Excuse me, convener. If we have finished the evidence-taking session, I wonder whether I might bring up an issue with the committee.

The Convener: Is it in relation to this agenda item?

Carol Mochan: It is in relation to work within the committee.

The Convener: We will have a discussion in private after our public session ends. Is this something that you want to raise—

Carol Mochan: I would quite like to raise the matter now if that is possible.

The Convener: Okay.

Carol Mochan: Thank you, and sorry for interrupting.

Given that we are engaged in scrutiny of the proposed national care service, I thought that yesterday’s reports about a two-tier national health service were quite alarming. I seek the committee’s advice on whether we should seek clarification on some of that, as it very much links in with the work that we are doing. I seek clarity from the committee on that.

The Convener: Thank you, Carol. That is an issue that we can discuss in private rather than in public, because it relates to our work programme. I did not have advance notice of what you were going to say. That would have been helpful.

Carol Mochan: Okay.

The Convener: When we go into private session, we will have detailed discussions on what we have heard today and on any other issues that members want to bring up.

That concludes the public part of today’s meeting.

12:24

Meeting continued in private until 12:45.

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