OFFICIAL REPORT
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Wednesday 10 May 2023

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CONTENTS

Scottish Parliament

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[The Deputy Presiding Officer opened the meeting at 14:00]

Portfolio Question Time

Rural Affairs, Land Reform and Islands

The Deputy Presiding Officer (Annabelle Ewing): Good afternoon. The first item of business is portfolio question time, and the first portfolio is rural affairs, land reform and islands. In order to get in as many questions as possible, I would appreciate succinct questions and answers to match.

Question 1 was not lodged. Question 2 is from Jamie Halcro Johnston, who joins us remotely.

Ferries (Impact of Disruption on Island Communities)

2. **Jamie Halcro Johnston (Highlands and Islands) (Con):** To ask the Scottish Government what discussions the rural affairs secretary has had with ministerial colleagues regarding how the Scottish Government analyses the impact on island communities of disruption to ferry services. (S6O-02197)

The Minister for Transport (Kevin Stewart): I am working with the Cabinet Secretary for Rural Affairs, Land Reform and Islands and other ministerial colleagues to understand the impact of ferry disruptions on island communities. However, that requires not just ministerial engagement but dialogue with our local authority partners. That is why we took the decision to re-establish the islands transport forum, which is chaired by myself, through the islands strategic group. Furthermore, the First Minister's policy prospectus, which was announced on 18 April, included a commitment to publish a new rural delivery plan within the lifetime of this Parliament. That will cover the issues that are critical to Scotland's island, rural and coastal communities, including transport.

Jamie Halcro Johnston: The minister will be well aware of the serious disruption that Scotland's island communities have endured for far too long, with cancellations, reduced sailings and emergency timetables, often at very short notice, becoming an everyday occurrence for many. Residents often cannot leave their island or get home; island businesses cannot operate and get the supplies that they need or deliver the services that they have promised; and booking trips or stays on our islands is becoming a gamble that is not worth taking for some potential visitors. All of that is a result of 16 years of chaotic mismanagement of our ferries network by the Scottish National Party.

When will the Scottish Government finally accept responsibility for the increasing carnage that its lack of investment in new ferries is causing, and when will it look seriously at compensating islanders and island businesses for the total mess that Scottish ministers in Edinburgh have caused?

Kevin Stewart: I recognise the impact that delays and disruption have regrettably had on our island communities. The Government and I are committed to investing in our ferry services, and we will deliver six new major vessels to serve Scotland's ferry network by 2026—that is a priority for the Government. Although I am sympathetic to the calls to support businesses through compensation, our focus rightly has to be on building resilience in the ferry network. That includes the current chartering of the MV Alfred to support CalMac services and proactively working with NorthLink on potential additional capacity on services to Orkney. We will continue to do all that we can to increase the resilience of the fleet and to add to it so that our island communities are better served.

Liam McArthur (Orkney Islands) (LD): The Minister for Transport will be well aware of the disruption to ferry services across the Pentland Firth following the grounding of the MV Pentalina earlier this month. I thank the minister for his engagement with me on that issue. I know that Serco NorthLink has been working hard to identify how freight and passenger demand might be met while the Pentalina is unavailable, but I remain concerned about pinch points on particular sailings and a loss of connectivity to and from the smaller isles in Orkney. I therefore again ask the minister to look at increasing the number of return daily sailings between Stromness and Scrabster to four while that remains the only ferry route across the Pentland Firth.

Kevin Stewart: I am grateful to Mr McArthur for his engagement with me on the issue. We will continue to look at the pressures on that crossing. As Mr McArthur is aware, because I wrote to him on the subject, thanks to NorthLink we have already increased the number of crossings on a Sunday. NorthLink is gathering intelligence and looking at other points of pressure with a view to adding to the services. I can assure Mr McArthur and Orkney islanders that we will continue to look at all the information that we have and act accordingly. Once again, I say that I am very grateful to Mr McArthur and to Orkney Islands Council, with which I will meet directly after this question time, for the intelligence that they have provided.

Scotch Beef

3. **Bill Kidd (Glasgow Anniesland) (SNP):** To ask the Scottish Government what it is doing to help ensure that quality Scotch beef is available in supermarkets in Scotland. (S6O-02198)

The Cabinet Secretary for Rural Affairs, Land Reform and Islands (Mairi Gougeon): Scotch beef is an iconic product, and I am pleased to say that it is available in each of the main grocery retailers in Scotland as well as in the vast majority of our independent high street butchers. Whenever I meet retailers, the sourcing of Scottish produce, including Scotch beef, is always part of the agenda. In addition, Quality Meat Scotland regularly meets retailers and their Scotch beef suppliers to promote and align marketing campaigns on Scotch beef. It is, of course, important to our agriculture sector that our supermarkets stock not just Scotch beef but Scotch lamb and specially selected pork.

Bill Kidd: It was recently reported that Scotbeef had lost the contract to supply Aldi with beef. Scotch beef is a product of unparalleled quality that everyone should be able to enjoy if they wish, so does the cabinet secretary agree that, although Aldi stocks other Scotch beef products, it is vital that, during the on-going cost of living crisis, discount retailers continue to provide as wide a range of products as possible and give people affordable access to the best of Scotland's larder?

Mairi Gougeon: I absolutely agree that Scotch beef should be available to everyone from all walks of life. I know that, over the years, Aldi has strongly supported Scottish produce and its supply across Scotland, including by offering Scotch beef to its customers. My understanding of the situation is that a change in suppliers has resulted in a temporary reduction in the availability of Scotch beef in Aldi. However, Aldi remains committed to sourcing Scotch beef. It is in the process of acquiring a new contract, and it will have Scotch beef back on its shelves as soon as possible.

Finlay Carson (Galloway and West Dumfries) (Con): With support from QMS, the Scottish beef industry delivers the highest standards of production and of animal welfare and wellbeing. That results in the production of the highest quality of beef, with a carbon footprint that is significantly below the global average.

Last month, the Climate Change Committee spelled out its belief that Scotland will need to slash dairy and beef numbers by 29 per cent and 26 per cent respectively to meet the net zero targets. Will the cabinet secretary rule out any cut to red meat production and assure me and the farming industry that she has a practical and achievable plan to meet the legal climate change targets and protect livestock farming in Scotland?

Mairi Gougeon: That is exactly what we are trying to do. I give that assurance to Finlay Carson, as I have done previously when his colleagues have raised with me the issue relating to a reduction in numbers. We know that we produce livestock well in Scotland, and there will continue to be a role for that into the future. That is why our vision for agriculture and our agriculture reform programme route map make clear our commitment to enabling the producers of high-quality food to deliver on our shared outcomes for biodiversity recovery and climate adaptation and mitigation, and it is why we continue to support those sectors.

Edward Mountain (Highlands and Islands) (Con): I remind members of my entry in the register of members' interests, which shows that I am part of a family farming partnership, and we produce beef.

Farmers have a duty to reduce their emissions in order to achieve net zero. I completely agree with that, but one measure that is needed in order to do that is keeping livestock on the farm after they are ready for slaughter. That happens with beef cattle, many of which are ready at 11 months but cannot be sold as Scotch beef until they are at 12 months. Will the cabinet secretary address that issue with QMS?

Mairi Gougeon: I am happy to raise the matter with QMS and to discuss it with Edward Mountain if he would like to do so.

Mental Health (Farmers and Crofters)

4. **Alexander Stewart (Mid Scotland and Fife) (Con):** To ask the Scottish Government what discussions the rural affairs secretary has had with ministerial colleagues regarding actions to tackle mental health problems amongst farmers and crofters. (S6O-02199)

The Cabinet Secretary for Rural Affairs, Land Reform and Islands (Mairi Gougeon): I regularly engage with farmers and crofters to discuss actions on the range of challenges that they face and, in turn, I raise those points with relevant ministers. In the case of mental health, that is the Cabinet Secretary for NHS Recovery, Health and Social Care and his team.

The Scottish Government takes the mental health of our farmers and crofters seriously. Over the past financial year, we committed £50,000 to supporting the Royal Scottish Agricultural Benevolent Institution and £50,000 to the national rural mental health forum. We recognise that the sector continues to face significant challenges and we are fully committed to working with it to address those challenges where we can.

Alexander Stewart: Depression and suicide rates for farmers are among the highest of any

occupation. Tragically, those figures are growing and the situation is getting worse. What steps will the Scottish Government take to not only halt but reverse that trend?

Mairi Gougeon: That is, of course, a really worrying trend. I welcome the member raising this important topic in the chamber, which I know we will discuss further during his colleague's member's business debate tomorrow.

Every life that is lost to suicide is an enormous tragedy that has a devastating and long-lasting impact on families, friends and communities. That is why the work of organisations such as RSABI and the national rural mental health forum, and why continuing to support them, is so vital. I cannot direct people enough to the resources that those organisations have available 24/7, such as a helpline and web chat. It is really important that not just I but other members across the chamber highlight those avenues of support to people, so that they know that they can reach out and seek that help and that it will be available to them.

The Deputy Presiding Officer: I have a supplementary from Jim Fairlie.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): I would like to withdraw my supplementary, please.

The Deputy Presiding Officer: That is duly noted.

Lamlash Bay No-take Zone

5. **Mark Ruskell (Mid Scotland and Fife) (Green):** To ask the Scottish Government what it has learnt from the fisheries no-take zone at Lamlash bay. (S6O-02200)

The Cabinet Secretary for Rural Affairs, Land Reform and Islands (Mairi Gougeon): Lamlash bay is an excellent example of the Scottish Government working with a local coastal community—building on the voluntary no-take zone by incorporating it into the south Arran marine protected area—to support the recovery of the maerl beds in the bay.

Since designation, commercially important species such as the king scallop and European lobster have increased in size, age and density. We have continued that approach to MPA designation and management, and we are currently working with coastal communities to develop fisheries management measures for the rest of the MPA network.

Mark Ruskell: The Arran no-take zone has seen tourism grow while scallop and lobster numbers have increased four-fold. Given that economic success, how does the Government plan to continue to work with the Community of Arran Seabed Trust—COAST—to collect further data on the impact of that internationally recognised no-take zone?

Mairi Gougeon: Our monitoring strategy sets out how we intend to monitor MPAs and how we will continue to monitor the related surveys that we do. Many partners, including NatureScot, are involved in that work; we work with them to gather the evidence and to assess the overall condition of the sites.

NatureScot has recently launched a community-led biodiversity monitoring project to try to support community groups and individuals who want to participate in the monitoring of our marine protected areas. COAST has provided a lot of valuable evidence to NatureScot and the Scottish Government about the seas around Arran, which we very much appreciate.

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): In another no-take zone—Broad bay—we know that marine biodiversity is almost non-existent. Leaning on evidence from one example such as Lamlash bay while ignoring another is no way to go about policy making. Furthermore, more work needs to be done to establish the effectiveness of the current MPA network.

Does the cabinet secretary agree that we should not rush into imposing new, un-evidenced marine protections simply to appease the Government's Green coalition partners and that we should, instead, seek to understand the protections that already exist?—[*Interruption*.].

The Deputy Presiding Officer: Could we hear the member who has the floor?

Mairi Gougeon: We will, of course, consider the examples that the member has raised, as well as other examples that we know exist across the world, when we look to develop that work.

It is important to remember that we have carried out a consultation, which I believe received more than 4,000 responses. It is vital that we fully consider each of those responses. I know that a lot of feeling exists around this subject and that other organisations have expressed concern. We want to listen to those points of view in a careful and considered way before setting up further steps from that point.

Mercedes Villalba (North East Scotland) (Lab): The Scottish Government adopted a national marine plan in 2015 to develop a planning system for our seas, in which no-take zones play a part, but the recent Open Seas report, "Ease the Squeeze: Ocean Recovery in Busier Seas", highlights the Government's failure to comply with that plan. Therefore, will the Scottish Government commit to creating a cohesive spatial plan for our

seas, with community consultation, engagement and development at its core?

Mairi Gougeon: I thank the member for raising that point. She will be aware that we are in the process of updating and bringing forward a new national marine plan, which I am sure that she will engage with. I am happy to write to her to provide further information and any indicative timelines for that.

Greyhound Racing (Animal Welfare)

6. **Clare Haughey (Rutherglen) (SNP):** To ask the Scottish Government what its assessment is of the welfare of animals used in greyhound racing in Scotland. (S6O-02201)

The Cabinet Secretary for Rural Affairs, Land Reform and Islands (Mairi Gougeon): The Scottish Animal Welfare Commission published its report on the welfare of greyhounds used for racing in Scotland on 9 March. The Government welcomes the publication of that report and we are currently considering the recommendations.

Further to that, we will shortly be launching a consultation on extending the animal licensing framework that was introduced in 2021; that will include greyhound racing and other animal care services. The responses to the consultation, along with the views of the Rural Affairs and Islands Committee, which is currently considering greyhound racing, and the Scottish Animal Welfare Commission's report will inform our next steps regarding greyhound racing in Scotland.

Clare Haughey: The cabinet secretary will be aware that Shawfield stadium in my constituency is the only licensed greyhound racing track in Scotland, and no racing has taken place there since the start of the Covid pandemic. Given my concern about the welfare of greyhounds that have been raced at Shawfield previously, I hope that there is no return to racing.

Can the cabinet secretary confirm exactly when the consultation on extending the licensing legislation to animal care services will be launched and whether, as part of the consultation, the Government will consider a phase-out ban on greyhound racing?

Mairi Gougeon: I thank the member for asking the question and highlighting that important subject. Màiri McAllan, who was the Minister for Environment, Biodiversity and Land Reform at the time, confirmed in a debate in October last year that the licensing of racing would be considered as part of the animal care services consultation. On the timescale, we hope to bring forward the consultation shortly.

The committee is currently considering greyhound racing in Scotland, and it is important that we consider the evidence that it has taken. I believe that it has had a number of evidence sessions so far on the topic. Of course, the Scottish Government will carefully consider any recommendations that the committee makes before we set out our next steps. On the consultation, we welcome responses from everyone with an interest, and we will consider the next steps once we have completed that exercise and received the committee's report.

Rural Crime Strategy

7. **Emma Harper (South Scotland) (SNP):** To ask the Scottish Government what discussions the rural affairs secretary has had with ministerial colleagues regarding the delivery of the rural crime strategy. (S6O-02202)

The Cabinet Secretary for Rural Affairs, Land Reform and Islands (Mairi Gougeon): The Scottish Government takes all crime, including that committed in rural areas, extremely seriously.

Although delivery of the "Rural Crime Strategy 2022-2025" is a matter for Police Scotland and its partners within the Scottish Partnership Against Rural Crime, or SPARC as it is known, the Scottish Government is fully engaged with the work of SPARC and receives regular updates on its activity.

The member will be aware that the overriding aim of the strategy is to protect rural communities through strong partnerships, and ministers are looking forward to hearing more about that work as it progresses.

Emma Harper: SPARC has seen positive results in reductions in rural crime and associated financial costs in the past year alone. Between April 2022 and March 2023, there were 284 fewer rural crimes reported than there were in the previous year, as well as an overall reduction in the financial harm to Scotland's rural communities of more than £2 million, which equates to a drop of almost 36 per cent. SPARC's approach is working, so will the cabinet secretary meet me and SPARC to discuss what action can be taken to build further on the reduction in crime for our communities across Scotland?

Mairi Gougeon: I thank the member for highlighting those important statistics, which demonstrate how important and necessary SPARC's work is. The member will be aware that the ministerial responsibility for rural crime sits with the Cabinet Secretary for Justice and Home Affairs. However, the fight against rural crime requires, and benefits from, the support and input of all our ministerial colleagues.

As Emma Harper highlighted, the reduction in rural crime is testament to that partnership approach and the vital work of Police Scotland and

the other partners that are involved in SPARC. Ministers would be delighted to join Emma Harper in meeting SPARC to discuss those issues further.

Alexander Burnett (Aberdeenshire West) (Con): The SPARC report highlighted that the cost of rural theft of machinery was almost £350,000 in March alone. The north-east was identified as one of the most targeted areas and we are now heading into May and June, which are the worst months for theft. Bold steps need to be taken to tackle the issue, particularly when such crime makes it impossible for farmers to work. Does the cabinet secretary agree with the Scottish Conservatives' plan to introduce immobilisers and regulate the sale of agricultural vehicles to reduce rural crime?

Mairi Gougeon: I am happy to discuss the matter further with Alexander Burnett to see what more can be done in that area.

Willie Rennie (North East Fife) (LD): Despite the passing of Emma Harper's law, there is still an enormous task ahead of us to stop dog attacks on lambs. The minister will have heard about the recent terrible attack near Kelty. There has also been a further attack at West Lomond where more sheep were lost. Both those farmers are incandescent with rage. Why have too many dog owners still not got the message?

Mairi Gougeon: It has been absolutely terrible to see some of the incidents that have taken place recently, especially at a time when we have been trying to increase awareness and do what we can to ensure that every dog owner is aware of their responsibilities, which are very clearly set out. We know that the penalties for that crime have increased due to the member's bill that was taken forward by Emma Harper. Important work was done there, but I am more than happy to consider what more we can do to raise that awareness and ensure that we are doing everything we possibly can to get the message out there that all dogs should be on leads so that we are saved from truly horrendous scenes of the kind that we have seen in recent weeks.

Good Food Nation (Scotland) Act 2022

8. **Kaukab Stewart (Glasgow Kelvin) (SNP):** To ask the Scottish Government what discussions the rural affairs secretary has had with ministerial colleagues regarding the role of the Good Food Nation (Scotland) Act 2022 in promoting a healthier diet. (S6O-02203)

The Cabinet Secretary for Rural Affairs, Land Reform and Islands (Mairi Gougeon): The ministerial working group on food provides a forum for me and my ministerial colleagues to come together and work across portfolios on relevant aspects of food policy as we work towards our ambition of Scotland becoming a good food nation. At our last meeting, on 12 January, the group covered issues relating to the promotion of a healthier diet. I look forward to continuing to discuss the next steps in relation to the Good Food Nation (Scotland) Act 2022 with my colleagues.

Kaukab Stewart: Partick farmers market, in my constituency of Glasgow Kelvin, brings into the heart of Glasgow's west end fresh food produce straight from the producers. Does the minister agree that such good models play an important role in educating people about the food that they eat, promoting healthier lifestyles and supporting farmers and food producers?

Mairi Gougeon: I could not agree more. Farmers markets play an important role in supporting our farmers and producers and our local communities and economies. They also do so much more, because if we support such initiatives, we also shorten supply chains, connecting people to our food and where it comes from, as well as helping to promote healthier diets. Through our local food strategy, we recognise the importance of connecting people with their food and where it comes from as well as better connecting Scottish producers with their buyers. All of that plays a vital role in our vision of Scotland being a good food nation.

The Deputy Presiding Officer: A brief supplementary, please, Mr Whittle.

Brian Whittle (South Scotland) (Con): The cabinet secretary will be aware that, for all the time that I have been here, I have been pushing the role of public procurement in schools and hospitals. Does the cabinet secretary now agree with the Conservative position that we should be pushing public procurement as much as possible to buy local food to increase the health of the nation?

Mairi Gougeon: I do not think that we have ever really disagreed with that point. I know that Brian Whittle has raised the issue with me on a number of occasions. It is important that we look to address that through the good food nation plans that will be developed, as there will be a critical role for them.

I would also point to some of the other work that we are looking at. The Food for Life programme has been working with our local authorities to increase the supply of local produce to our schools, in particular. We can see the benefits for health and for our local communities and economies of taking such an approach. That is why we decided to extend the pilot to look at other areas of the public sector in which we could make that approach work, with a particular focus on

Glasgow. Ideally, we would like that approach to be expanded across Scotland.

I look forward to working with the member on that, and I am more than happy to have a conversation about how such work can feature in our future good food nation plans.

NHS Recovery, Health and Social Care

General Practices (National Health Service Boards)

1. **Liam Kerr (North East Scotland) (Con):** To ask the Scottish Government whether it tracks how many GP practices are currently being run directly by NHS boards. (S6O-02204)

The Cabinet Secretary for NHS Recovery, Health and Social Care (Michael Matheson): Public Health Scotland regularly publishes data in relation to GP practices, including their contractual status. As of 1 April 2023, 57 out of 905 GP practices in Scotland were classed as 2C practices, with 2C status usually being understood to mean that those practices are run directly by an NHS board.

Liam Kerr: The decisions by Inverurie and Oldmeldrum practices to end their contracts with NHS Grampian due to a lack of GPs mean that 34,000 patients within a 5-mile radius in Aberdeenshire face challenges in accessing a local doctor. Dr Innes, a partner at the Inverurie practice, said:

"We have explored every avenue to recruit ... but there ... are not enough ... GPs out there."

It is clear that GPs are beyond the end of their tether at the lack of support from the Scottish Government.

What specific measures were put in place by the cabinet secretary's predecessor to address the lack of GPs? When will the north-east have sufficient numbers?

Michael Matheson: A range of actions have already been taken to support GP numbers. For example, we are going through a programme of recruiting another 800 GPs into the system by 2027. We have also put in place additional measures. For example, since 2017, there has been an increase of 291 GPs, and we now have a record 5,209 GPs working in practices in Scotland.

Alongside that, we have put in place initiatives to support GPs in rural areas such as Aberdeenshire, in relation to which Liam Kerr made representations, including the golden hello programme. We are also taking a range of actions to encourage graduate entry medical students to go into rural settings through the Scottish graduate entry medicine—ScotGEM—programme.

A range of work is under way to increase further recruitment to general practice in Scotland, as well as a range of measures to encourage people to work in our rural areas. As I mentioned, a record 5,209 GPs are operating in Scotland at the moment.

However, I recognise the concerns that Liam Kerr has raised on behalf of his constituents. I know that the health and social care partnership and the health board are looking at the specific issues that exist in relation to the Inverurie practice and whether it would be possible for others to come in to operate the practice or whether it will require to be operated directly by the local health board in the future. It is important that people are reassured that they will continue to be able to access general practice services, whether those are delivered through the NHS or through another practice.

John Swinney (Perthshire North) (SNP): What encouragement can the cabinet secretary give to NHS Tayside to consider directly providing GP services in the village of Invergowrie, in my constituency, where there is some uncertainty over the future of GP provision, to ensure that my elderly and vulnerable constituents can have convenient access to GP services, given the transport challenges that they may face in accessing services in other parts of the county or in the city of Dundee?

Michael Matheson: It is important that any practice that is looking to change access to GP services in a local health board area goes through a process of engaging with the health board to ensure that patients at the practice will continue to have access to a GP as and when that is necessary.

I encourage the practice in question to engage with the health board, and I encourage the health board, in engaging with the practice, to take proactive action to ensure that the concerns that John Swinney has raised regarding his constituents' access to GP services, particularly in the light of the transport issues that they face, are addressed and that appropriate measures are maintained in place so that his constituents can access a GP.

Brian Whittle (South Scotland) (Con): Jeane Freeman brought in the policy to recruit another 800 doctors within 10 years. Audit Scotland suggested that that number was arbitrary, given that Scotland was about 860 doctors short at that time, and that, at the end of the 10 years, because of wastage, we would still be 660 GPs short. Can the cabinet secretary enlighten us as to why the number 800 was arrived at?

Michael Matheson: As the member has just acknowledged, the figure predates me, but it was

chosen in recognition of the need for an increase in the number of GPs in the country. The good thing—I am sure that the member will be pleased about this—is that we are making progress on the recruitment programme at an appropriate rate, so that we can deliver on the 800 figure by 2027.

At the same time, we are doing all that we can to encourage more people into general practice as we go forward.

Mercedes Villalba (North East Scotland) (Lab): A representative of the British Medical Association has said that the closure of Inverurie medical practice in Aberdeenshire means that "no practice is safe" and that the crisis in GP care could lead to the collapse of NHS Scotland. What is the Scottish Government doing to support affected communities until such measures to increase GP numbers take place?

Michael Matheson: Key to supporting primary care services that are delivered by general practices are not only GPs but the wider support teams that assist them in delivering the services that patients require. The provision of advanced nurse practitioners, the deployment of musculoskeletal physiotherapists and the basing of pharmacists in GP practices can all help to provide a range of primary care services directly to patients.

That workforce has increased markedly over recent years. We have recruited more than 3,000 additional staff to work alongside GP practices to support them in the delivery of the services that they offer to patients. We certainly need to do more to expand and develop that workforce further, because primary care is absolutely critical to delivering a sustainable healthcare system. That wider multidisciplinary primary care team that can support GPs is going to be critical in making sure that we can deliver that.

Alongside that, we also need to ensure that patients get access to the right services directly at the time when they require them. Much of those can be provided by primary care, with the right support team in place, rather than people always having to go to a secondary care setting, which is what happens for most patients at the moment.

Beatrice Wishart (Shetland Islands) (LD): The GP position at the Hillswick surgery, in my constituency, is still vacant after six months of advertising. Hillswick offers an established training practice for medical students. How is the Scottish Government supporting GP practices in island areas to recruit and retain GPs?

Michael Matheson: As I said, we are taking forward a number of initiatives to help to attract GPs to rural areas, including our golden hello programme, which helps to support GPs to take up harder-to-fill posts in rural environments such as the one that the member highlighted.

We have also established the ScotGEM programme to encourage graduates to enter general practice in rural areas. That will encourage more people to go into rural areas such as the one that the member has highlighted.

Musculoskeletal Pathway (Implementation)

2. **Pam Duncan-Glancy (Glasgow) (Lab):** To ask the Scottish Government whether it will set out its proposed timetable for implementing the new musculoskeletal pathway, including how it will ensure that the views of third sector organisations are reflected in the process. (S6O-02205)

The Minister for Public Health and Women's Health (Jenni Minto): The Scottish Government is continuing work with NHS 24 and stakeholders to review the musculoskeletal—or MSK—pathway. Any timetable would be contingent on the outcome of that on-going review work. We expect individual health boards to continue to improve their own MSK pathways for patients with third sector partners at a local level.

Pam Duncan-Glancy: Having an up-to-date and fit-for-purpose MSK pathway is vital to ensuring that patients can access the care that they need when they need it, and third sector organisations are a key part of that. Will the minister agree to meet relevant charities and MSK groups as a matter of priority?

Jenni Minto: I thank Pam Duncan-Glancy for inviting me to the cross-party group on arthritis and musculoskeletal conditions, where I learned a lot about the various conditions. I appreciate that very much.

As I said in my speech at that meeting, third sector organisations are incredibly helpful—I referenced a couple in my constituency of Argyll and Bute. I would be very happy to meet with the groups that the member has suggested.

Palliative Care Sector (Support)

3. **Jeremy Balfour (Lothian) (Con):** To ask the Scottish Government what plans it has put in place to support the palliative care sector, in light of reports that the number of people needing these services is estimated to rise by an additional 10,000 by 2040. (S6O-02206)

The Minister for Public Health and Women's Health (Jenni Minto): We are aware of Scottish research that shows a rise in the number of people with a palliative care need, and the Scottish Government is developing a new palliative and end-of-life care strategy to ensure that everyone who needs it can access seamless, timely and high-quality palliative care. We are considering the

issues that Scottish hospices raised at their meeting in March with the then Cabinet Secretary for Health and Social Care and the then Minister for Public Health, Women's Health and Sport, which included funding and the long-term sustainability of the hospice sector.

Jeremy Balfour: Hospices will start closing if help cannot be sourced to match the national health service pay offer. Scottish charitable hospices need to find £15.5 million over the two years to 2024. The time for meetings and discussions is over. What can the Scottish Government do urgently to address the crisis in the palliative care sector?

Jenni Minto: I recognise the importance of palliative care and the importance more widely of the need for us to speak about the end-of-life stages that we go through. Last week, I was at "The Cost of Dying" photography exhibition in Glasgow, which I found incredibly important and thought provoking.

As Jeremy Balfour will know, the 2023-24 Scottish Government budget underlines our on-going commitment to prioritising investment in health and social care, in providing additional funding of £1 billion. However, I recognise that there are issues in the hospice sector, and I am working with officials to discuss them.

Marie McNair (Clydebank and Milngavie) (SNP): A major provider of palliative care in Scotland is our hospice network. St Margaret of Scotland Hospice, in my constituency, has contacted me regarding funding pressures. Will the minister meet me and representatives of the hospice to discuss those pressures and how we can assist hospices as we move forward?

Jenni Minto: I would be very happy to meet representatives of St Margaret of Scotland Hospice.

Edington Hospital

4. **Martin Whitfield (South Scotland) (Lab):** To ask the Scottish Government what discussions it has had with NHS Lothian, and local groups, since March 2023 regarding the reopening of the Edington hospital in North Berwick. (S6O-02207)

The Cabinet Secretary for NHS Recovery, Health and Social Care (Michael Matheson): My officials engage regularly with NHS Lothian and with East Lothian health and social care partnership on a range of issues, and they last discussed Edington hospital in March 2023. The health and social care partnership has recently provided the Scottish Government with an update on its on-going review of community provision, which includes Edington hospital, and we have been informed that a 12-week public consultation on proposed changes is due to take place.

Martin Whitfield: As the cabinet secretary will be aware, the story around Edington hospital's closure goes back to 2021 but, as the First Minister has confirmed, the responsibility for continued Covid recovery now passes to all elements of Government rather than being centred in one place.

Can the cabinet secretary confirm that he will be able to attend the meeting on 22 May—which has been arranged by Paul McLennan, as the constituency MSP—with local groups, including North Berwick community council and Friends of the Edington Hospital?

Michael Matheson: I am aware that the health and social care partnership board is taking forward a consultation exercise to look at the existing provision that it has in place. I am not aware at this stage of the particular meeting to which Martin Whitfield referred, but it is clearly important that a consultation exercise is being taken forward in order to consult with the local community, hear what its views are, and take those views into account in determining the final outcome of any process. That is what I would expect to happen in this case.

Craig Hoy (South Scotland) (Con): By the sound of it, there will be no meeting. That is consistent, because ministers have repeatedly failed to meet local stakeholders following the closure of residential care beds at the Edington and the withdrawal of minor injuries services.

With access to community treatment and care services restricted in some surgeries, vulnerable older people and young families face long and impractical bus journeys to East Lothian community hospital in Haddington, or all the way into Edinburgh, in order to access simple national health service services, such as having their wounds dressed. Does that not prove that the Scottish National Party has all but failed and has given up on community-based health services in East Lothian and across the south of Scotland?

Michael Matheson: That is wrong, especially considering the facility that we have built at East Lothian community hospital, which provides a range of services to the local community.

That aside, Craig Hoy is well aware that the health and social care partnership and the health board are responsible for designing and developing services to reflect the needs of the local community. They have set out their intention to take forward a consultation exercise that will involve the opportunity for people, including elected members such as Craig Hoy, to participate in that process and submit their views to the health and social care partnership and the health board. That will then determine the future approach to delivery of those services locally. The best way to

deliver services is through local processes and local consultation, to allow the local community to have its views on what should be provided locally.

National Health Service Dentistry

5. **Jamie Greene (West Scotland) (Con):** To ask the Scottish Government what its response is to recent research from the British Dental Association that shows that 83 per cent of dentists in Scotland expect to reduce the amount of NHS work they do in the year ahead. (S6O-02208)

The Minister for Public Health and Women's Health (Jenni Minto): The Scottish Government is aware of the survey and understands the concerns expressed, which is why it wrote to all national health service dental teams on 7 February to confirm the continuation of the bridging payment to 31 October 2023 while we prepare for the implementation of payment reform. Payment reform will comprise a new, modernised system that will provide greater clinical discretion for NHS dental teams and greater transparency for NHS patients. It is our intention that payment reform will maintain the confidence of NHS dental teams by ensuring the future viability of NHS dentistry in Scotland.

Jamie Greene: That sounds like a temporary filling to what is a long-term cavity in their funding—no pun intended.

I will be frank with the minister: NHS dentistry in Scotland is at crisis point, and everybody knows it. A person would need to be living in a cave not to. If members have not seen their inboxes, they are filled with constituents' problems in accessing NHS dentists and with emails from dentists who face massive funding issues.

In my region, not only can people not register for an NHS dentist, but the waiting lists have been closed altogether. Put simply, some people have no access to an NHS dentist. My question on behalf of those constituents is a very simple one. If the only way to get immediate dentistry treatment in Scotland right now is to pay for it, what do people do if they cannot pay for it?

Jenni Minto: I compliment Jamie Greene on his puns, but I disagree with him. I do not believe that NHS dentistry is in crisis. However, there are—[*Interruption*.]

The Deputy Presiding Officer: Members, we need to hear the minister's answer, please.

Jenni Minto: I accept that there are a number of difficulties, but we have come far in a reasonably short time and, as I said, payment reform is how we will change the system.

The Scottish Government has clearly linked ambitions to sustained and improved NHS dental services, and we intend to work collaboratively with health boards to find local solutions. We have expanded funding to local dental services to support that. In addition, we are working with the other nations of the United Kingdom to improve the pipeline of dentists coming to Scotland from Europe, which was so negatively impacted by Brexit.

Colin Smyth (South Scotland) (Lab): Last week, dental practices in Langholm and Annan announced that they were deregistering 2,000 adult NHS patients. That adds to the more than 10,000 NHS patients who have been deregistered with other practices in recent weeks in Dumfries and Galloway. People cannot register with an NHS dentist, and that is a crisis. Why does the minister think that the Government's actions, including promises of future funding arrangements, are so badly failing to stem the collapse of NHS dentistry in Dumfries and Galloway?

Jenni Minto: I appreciate the issues in dentistry in Scotland, and I am working very hard with my colleagues to ensure that we find solutions with dentists. I outlined in my response to Jamie Greene's question what those are.

Liam McArthur (Orkney Islands) (LD): A single practice in Orkney provides NHS dentistry. That shows the particular fragility in the islands in the context of the BDA figures that Jamie Greene referred to. With payment reform now pushed back to November, does the minister accept that it is vital that dentists have sight of the detail of what is proposed well ahead of the November deadline? What assurances has she had from the chief dental officer that there will not be any further delay in the reform process?

Jenni Minto: I agree that it is important to involve the dentistry profession in the discussions that we are having. That has happened to date, and that is continuing apace as I stand here.

Bill Kidd (Glasgow Anniesland) (SNP): In 2022, the Nuffield Trust found that the number of European Union and European Free Trade Association-trained dentists registering to practice in the United Kingdom was halved after the EU referendum and that that is yet to recover. It is undeniable that Brexit, along with the pandemic, has been a factor in the current challenging situation that dentistry faces. Despite that difficult context, can the minister provide an update on the progress that is being made in providing extra support in areas in which there is the greatest patient need?

Jenni Minto: It is true that some areas are particularly affected by the present situation, which is made worse, as I have highlighted before, by the labour market effects of Brexit. That is why we have expanded Scottish dental access initiative grants. Those grants—[*Interruption.*]

The Deputy Presiding Officer: Please. We need to hear the minister. I will not have all this harping away from a sedentary position. The minister has the floor, and we need to listen to her response.

Jenni Minto: We have extended Scottish dental access initiative grants to wider parts of Scotland, and we have also made available an enhanced recruitment and retention allowance.

I am also fully aware of the need to increase workforce pipelines from overseas. As I have said previously, I am working with and writing to Department of Health and Social Care ministers to ensure that the changes are made on a four-country basis to improve the registration process for overseas dentists.

General Practitioner Workforce

6. **Ruth Maguire (Cunninghame South) (SNP):** To ask the Scottish Government what action it is taking to increase the general practitioner workforce. (S6O-02209)

The Cabinet Secretary for NHS Recovery, Health and Social Care (Michael Matheson): We are making good progress to increase the GP workforce. Since 2017, GP head count has increased by 291 and a record 5,209 GPs are now working in Scotland.

We have increased medical undergraduate intake by 448 places since 2015-16, and we will also be increasing the number of general practice specialty training posts by 35 in 2023, with further uplifts being considered for 2024 and beyond. Fill rates for specialty training are at a record high, with a 99 per cent fill rate for 2022.

Last year, Humza Yousaf launched our GP recruitment marketing campaign, and we are providing significant investment in initiatives that ensure that being a GP remains an attractive career for those in the medical profession.

Ruth Maguire: I spoke with staff at one of my local GP practices, and they told me that their unsuitable premises are making recruitment and retention difficult. They are currently operating in a building that is too small. What capital funding is available for building, developing or improving primary care facilities in Ayrshire and Arran?

Michael Matheson: I recognise the member's point, because I have GP practices in my constituency that are experiencing similar challenges.

Part of the difficulty that we have at present is that the cut to our capital budget has resulted in the Scottish Government having less capital available to it. That is restricting the level of investment that we can make across the whole of the public sector. Alongside that, projects that are presently in delivery or due to be delivered are experiencing very significant inflation as a result of construction inflation being markedly higher during the past year and a half.

All that is having a negative impact on the expansion of capital investment projects, including in primary care, but I assure the member that, once we have more flexibility in our capital budgets, we will always look at the opportunity to make more funding available to invest in areas such as primary care to support GP practices across the country.

Sandesh Gulhane (Glasgow) (Con): Being a GP is a team effort. There is a disparity between agenda for change uplifts for national health service admin staff in hospitals and Review Body on Doctors' and Dentists' Remuneration uplifts for GPs, which is leaving primary care staff feeling devalued. We hear that staff are leaving general practice for comparable hospital posts. A concerned practice manager wrote to Douglas Ross and me to express concern, as the disparity means that they are losing staff. That is putting pressure on practices to close and is leaving patients frustrated because they cannot contact their practice.

I am concerned that the cabinet secretary cares more about hospitals than primary care, which is where 90 per cent of all patient contact occurs. Will the cabinet secretary ensure parity between hospital and GP admin staff uplifts in pay so that primary care providers can recruit and retain the staff they desperately need?

Michael Matheson: I recognise the issue that the member raises, because it is one that I have discussed with GPs in my own constituency. We have passed on the uplift for general practice that was recommended by the DDRB. I recognise the challenges that some of our GP practices face because of the agenda for change agreement for the rest of the NHS, but the reality is that the finances are not available to enable us to pass that on to primary care in the same way. The member will be well aware why that is the case; it is because of the financial circumstances that we face as a result of the appalling management of the United Kingdom economy—[*Interruption.*]—by his colleagues at Westminster.

The Deputy Presiding Officer: Members, I keep having to say this. The point of having questions and answers is that we ask the questions and then we listen to the answers. Cabinet secretary, please continue.

Michael Matheson: I suspect that the Conservative members are interrupting because they do not like the answer. The reality is that the Conservatives' mismanagement of the UK economy has resulted in significant cuts to public

expenditure, which is having a direct impact on our expenditure here in Scotland.

I hear what the member is saying—I recognise the challenges that that creates for general practice. However, I think that the member should also recognise the consequences of his own party's actions at Westminster, which are having a direct impact on public expenditure here in Scotland.

Child and Adolescent Mental Health Services (Waiting Times)

7. **Murdo Fraser (Mid Scotland and Fife) (Con):** To ask the Scottish Government what it is doing to reduce waiting times for NHS Scotland's child and adolescent mental health services. (S6O-02210)

The Minister for Social Care, Mental Wellbeing and Sport (Maree Todd): We have set the conditions needed for long-term, sustainable improvement to CAMHS. That includes significant additional funding for CAMHS services and new community-based mental health and wellbeing support for children and young people. As a result, we are seeing sustained, positive changes in waiting lists, with a significant drop in the number of waits over 18 weeks. I absolutely recognise that we must see further sustainable improvement and reduced variation. We are continuing to provide tailored support to the boards that are facing the greatest challenges and ensuring that robust improvement plans are in place. Progress is being monitored closely.

Murdo Fraser: I have a teenage constituent who has been waiting the best part of three years for a diagnosis from CAMHS. She could well be an adult by the time it comes through. We learned this week that a Scottish Government pledge to recruit an additional 1,000 mental health specialists has not been delivered. Families such as the family of my constituent are now facing a crisis situation, so when is the minister going to make things better?

Maree Todd: At the moment, we are seeing the most sustained positive changes in CAMHS waiting lists that we have seen for over half a decade. I know that that is not much comfort to the member's constituent who has been waiting for over three years. If the member wants to write to me about that particular case, I am more than happy to look into it.

However, the last four quarters have seen the highest figures on record for the number of children starting CAMHS treatment. The number of children starting treatment in the latest published quarter is comfortably the highest figure on record—5,548. That is up by 11.1 per cent.

The overall CAMHS waiting list has decreased by 9.3 per cent since the last quarter—a reduction of 777. The number of children waiting over 18 weeks has decreased by 31.9 per cent since the last quarter, which is a reduction of over 1,000 children. The number of children waiting over 52 weeks has decreased by 41.9 per cent since the last quarter, which is a reduction of 523 children.

That has been made possible by the hard work of the CAMHS workforce, which has more than doubled under this Government.

Paul Sweeney (Glasgow) (Lab): Addressing the CAMHS backlog is only one part of improving the mental health of our young people. Research by the Mental Health Foundation last year found that 54 per cent of college students presenting to student mental health teams had moderate to severe symptoms of depression. Therefore, will the minister provide an update on when the Government expects to conclude the development of the student mental health action plan and when it expects the plan to be published?

Maree Todd: I had a meeting recently with my ministerial colleague Graeme Dey, and that was the topic of our discussion. We are working closely on ensuring that the commitments meet the needs of the student population and that there is sufficient financial backing for the commitments that will be made. We will be more than happy to update the member as soon as we can.

General Practice (Long-term Sustainability)

8. **Alex Rowley:** To ask the Scottish Government what action it is taking to ensure the long-term sustainability of general practice. (S6O-02211)

The Cabinet Secretary for NHS Recovery, Health and Social Care (Michael Matheson): We are absolutely committed to the long-term sustainability of general practice. We continue to make good progress on increasing the general practitioner workforce. Since 2017, GP head count has increased by 291 and a record 5,209 GPs are now working in Scotland. We remain committed to the GP contract and the delivery of extended multidisciplinary teams, making it easier for patients to see the right person, at the right time, in GP practices and the community. We have recruited more than 3,220 healthcare professionals since 2018 to support GP practices through our £170 million primary care improvement fund.

Alex Rowley: In Fife, the Rosyth practice has become the latest to fall under the direct management of NHS Fife. The medical director of NHS Fife has said:

"The GP Partners at Park Road medical practice are independent contractors of the Health Board. They have

confirmed, following the retirement of one of their GP Partners, that they are now no longer able to continue to manage the practice."

That follows the news that the total number of full-time, whole-time equivalent GPs in Scotland fell by 119 between 2019 and 2022, despite a rise in patient numbers.

I have tried to ask NHS Fife to establish how many GPs are due to retire in the next few years, but it is very difficult to get that information. Does the Government hold that information? What plans are you putting in place to address that? As it stands, the information that I am getting is that more and more GPs are ready to retire; the crisis will get worse. What will you do to deal with that?

The Deputy Presiding Officer: I remind members to speak through the chair, please.

Michael Matheson: I hear the point that the member is making about the information that he has not been able to get from NHS Fife. I will undertake to see whether we can get that information for him.

As I have already outlined, we are taking forward a range of different measures, including recruiting more GPs, increasing the number of training places that are available for GPs and expanding the workforce that supports GPs through primary care services. All those measures are collective actions that we are taking to address the issues that the member has highlighted. It is important that general practice is seen as being an attractive place for individuals to work.

I assure the member of my determination to make sure that we do everything that we can to support general practice, expand the primary care services, make general practices attractive locations for GPs and wider multidisciplinary teams to work in and make sure that patients get the appropriate care in the right place within their local communities. I hope that I can assure the member that the actions that we are taking will address the issues that he has highlighted.

Emma Harper (South Scotland) (SNP): The cabinet secretary has commented on ScotGEM a couple of times. Does he recognise the positive feedback that I have had from NHS Dumfries and Galloway regarding the programme, which is unique to Scotland?

Michael Matheson: The member is right that ScotGEM is proving to be an effective programme that provides graduate entry medical degrees with a focus on rural practice. It is an important part of a wider range of programmes that we have in place to encourage individuals into general practice in rural areas. I want to make sure that we build on that programme. We are also committed to developing our remote and rural workforce recruitment strategy, which will be published by the end of next year. We are committed to supporting employers to ensure that health and social care staff in our remote and rural areas are able to meet the needs of their local communities in the years ahead.

The Deputy Presiding Officer: That concludes portfolio questions on NHS recovery, health and social care. There will be a short pause before we move on to the next item of business.

Patient Safety Commissioner for Scotland Bill: Stage 1

The Deputy Presiding Officer (Liam McArthur): The next item of business is a debate on motion S6M-08869, in the name of Jenni Minto, on the Patient Safety Commissioner for Scotland Bill at stage 1. I invite members who wish to participate in the debate to press their request-to-speak buttons now or as soon as possible.

15:00

The Minister for Public Health and Women's Health (Jenni Minto): I am pleased to open the debate on the general principles of the Patient Safety Commissioner for Scotland Bill, which will establish an independent public advocate focused on ensuring that patients' voices are heard.

We know from the testimony of countless patients, gathered by Baroness Cumberlege in the independent medicines and medical devices safety review, that, too often, patients, their families and members of the public do not feel listened to when they raise concerns about the safety of healthcare. As a result, they doubt that their feedback will lead to change and their relationship with healthcare providers may break down, causing them to lose trust in the healthcare system. At worst, as the cases highlighted by Baroness Cumberlege starkly demonstrate, that can lead to patients suffering serious avoidable harm.

We need to address that. Good healthcare is a fundamental right for everyone. It is essential that patients have confidence that, every time they access part of the healthcare system, not only will they receive the best available treatment without fear of harm but any concerns that they raise will be listened to. A culture of openness and learning enables everyone to feel able to share not only what has gone well but what has gone wrong or could have gone better. We must ensure that learning and improvement happen when things go wrong, so that we continue to make healthcare better.

In her report, Baroness Cumberlege recommended:

> "The appointment of a Patient Safety Commissioner who would be an independent public leader with a statutory responsibility. The Commissioner would champion the value of listening to patients and promoting users' perspectives in seeking improvements to patient safety around the use of medicines and medical devices."

The bill will create a patient safety commissioner who will be directly accessible to patients, their families and members of the public to hear their concerns and will bring their stories together with quantitative safety data from across the healthcare system to spot trends and make healthcare safer for us all. The commissioner will be independent of the Scottish Government and NHS Scotland, which will allow them to challenge the healthcare system, and they will be free to consider any issue pertaining to the safety of patients in healthcare settings throughout Scotland. The bill demonstrates that we have taken Baroness Cumberlege's work and the views of patients seriously.

The commissioner's remit will be wider than Baroness Cumberlege recommended: it will not be restricted to consideration of medicines and medical devices but will be able to look at patient safety more widely. That is because patients have told us that there is the potential for harm in many other areas of healthcare and we want the commissioner to be able to look at the things that patients tell them are important.

I am grateful to the Health, Social Care and Sport Committee for its support for the general principles of the bill and to committee members for their detailed and careful consideration of the issues. I thank my predecessor, the Minister for Public Health, Women's Health and Sport, Maree Todd, for her leadership of the bill. Most importantly, I also thank the various people and organisations who have participated by giving evidence on the bill since it was introduced, including the patients and family members who showed great courage in telling their stories once again and in advocating tenaciously for the creation of the post. It was powerful evidence.

I am pleased that the committee has agreed to the general principles of the bill, although I recognise that it has requested further clarity and changes in some areas. The Government recognises the importance of listening to a wide variety of views to ensure that the patient safety commissioner role, once created, is as effective as possible in being able to freely and independently advocate for the views and interests of patients to improve the safety of care.

It is particularly encouraging that the committee has backed the general principles of the bill unanimously and that it reported strong support for the patient safety commissioner's role from the patients and patient representatives from whom it heard. The committee emphasised the importance of ensuring that the role is clearly defined and that the commissioner helps to foster a culture of openness, learning and collaboration.

I am also pleased that the committee recognises how vital it is that the patient safety commissioner role is underpinned by robust powers that allow the commissioner to find out what has gone on, make meaningful recommendations to improve patient safety and then work with other organisations to achieve positive change.

The committee has asked for further clarity on how the commissioner's formal investigations will work and, in particular, on the collaborative approach that we expect the patient safety commissioner to take when engaging with other organisations. That element of collaboration in the commissioner's ways of working will be crucial, given the complexity of the patient safety landscape. Baroness Cumberlege also emphasised that point in her findings, and I agree that it is important that we get it right.

There will be instances in which it is important that the commissioner is able to share confidential information that is obtained in the course of their investigations with certain other bodies, to enable them to exercise their statutory functions. The bill seeks to strike a balance between enabling that, while also encouraging a broad approach of collaboration, openness and learning, instead of taking a punitive approach.

I agree with the committee on the importance of the commissioner being able to hear the views of staff when that supports the overall purpose of amplifying the patient voice. It is important that the commissioner functions as a listening ear in the whole healthcare system. I have asked my officials to explore how that can be clarified at stage 2.

The committee has also emphasised how important it is that the commissioner carries out thorough and meaningful consultation during the development of their principles and strategic plan, particularly with those whom they seek to represent—the patients. I agree that that will be key.

Parliament will also have a crucial role. Patients and the public have made it very clear that they want someone other than the Government to scrutinise what is going on in the healthcare system. The patient safety commissioner's freedom to determine their own priorities, informed at all times by the views of patients, as well as the office's distinctness from other parts of the safety system—in that it will report directly to Parliament and, therefore, to the people of Scotland—will help to maintain trust in the role.

It is clear from the stage 1 report that the committee's view is that the patient safety commissioner for Scotland will make the views of patients heard, ensure learning and improvement when things go wrong, and help to make healthcare in Scotland safer for us all.

In reaching this milestone in the development of the bill, I thank the patients and families who have helped us to shape the draft legislation. They have taken time to tell us their stories and share their experiences. We have listened and, I hope, have reflected their concerns in the draft bill that we are debating today.

I also thank the many other people and organisations who, along with patients, worked with us on the consultation and bill advisory groups, sharing their expertise and collaborating in just the way that we hope that they will with the patient safety commissioner, to foster a culture of learning and improvement.

I look forward to listening closely to members' views and having the opportunity to engage with them on the bill. I again thank the committee for its work during stage 1 and in the weeks to come.

I move,

That the Parliament agrees to the general principles of the Patient Safety Commissioner for Scotland Bill.

The Deputy Presiding Officer: I call Clare Haughey to speak on behalf of the Health, Social Care and Sport Committee.

15:08

Clare Haughey (Rutherglen) (SNP): I refer members to my entry in the register of members' interests. I am a registered mental health nurse, with current Nursing and Midwifery Council registration.

In September 2020, the Parliament debated the independent medicines and medical devices safety review—the Cumberlege review—and the then Cabinet Secretary for Health and Sport, Jeane Freeman, set out how its recommendations would be implemented in Scotland. Those recommendations included establishing a patient safety commissioner.

As the convener of the Health, Social Care and Sport Committee, I am pleased to speak to our stage 1 report on the Patient Safety Commissioner for Scotland Bill. The committee unanimously supports the bill and believes that the role has the potential to improve patient safety across healthcare services.

I was not the committee's convener when it took evidence on the bill, so I thank Gillian Martin for her leadership during the bill's scrutiny. I also record our thanks to the committee clerks, the Scottish Parliament information centre researchers and everyone else who has supported the committee's work on the bill so far.

Before commenting on the committee's recommendations, I will take a moment to reflect on the evidence that those who engaged with the committee provided. I thank everyone who assisted the committee with its scrutiny—those who responded to our call for views and those who gave evidence in person or online.

I particularly thank Charlie Bethune, Marie Lyon, Fraser Morton and Bill Wright, who spoke about their experiences of serious patient safety issues.

They told us that their voices were repeatedly ignored by a system that was meant to provide care and support for them and their families, and by those who were meant to regulate that system. They told us that their fights were not over and that their issues were still not resolved—some are still not resolved after more than 70 years. They told us about investigations that are still needed and support that is still required. In some cases, there has been no resolution; grief has been compounded by the way in which people have been treated, and families have had no closure.

We are grateful for those people's testimony. We know how difficult it must be to keep recounting their experiences. I commend their passionate campaigns on behalf of others in similar situations who do not have that opportunity or voice. Their experiences emphasise the vital role that a patient safety commissioner can play. A patient safety commissioner cannot change what they have been through, but the role could make a difference to how cases like theirs are managed in the future, by providing a voice for patients and their families and championing their causes.

The commissioner could use their powers to make sure that no one else has the same experiences. Crucially, they could ensure that lessons are learned and that other such incidents are prevented from happening. They could identify patient safety issues that require investigation but which the system is not yet aware of.

Our report concentrates on areas where the bill might need to be clarified to make sure that it can achieve the intended outcomes. The committee supports widening the remit of the role beyond medicines and medical devices to include patient safety more broadly. Although the committee recognises the complex systems for patient safety, governance and regulation that are already in place, we believe that the voice of patients is missing from those systems. The commissioner can fill that gap by amplifying patients' voices and advocating for systemic improvements that draw on patient experiences.

The committee welcomes the independence of the role as set out in the bill. It endorses the proposal that the commissioner should have the freedom to define and establish the principles that will underpin their work and the remit and scope of that work.

We believe that patients should be given an opportunity to provide input into the process of establishing the office of commissioner and informing its strategic direction. That will ensure that patients' concerns are addressed and that their voices are heard as the commissioner embarks on their important work.

During its scrutiny, the committee heard a range of views about the scope of the commissioner's role—some argued that it was too wide and others argued that it did not go far enough. Issues were raised about how safety concerns in social care would be dealt with, especially given that, as one witness noted,

"People do not experience primary care, secondary care, social care or nursing care; they experience care."—[*Official Report*, *Health, Social Care and Sport Committee*, 21 February 2023; c 18.]

Some people suggested that the commissioner should have an additional role in taking on individual cases. On the whole, the committee believes that the bill strikes the right balance by defining a remit that is broad but manageable. However, we would like the Scottish Government to confirm that the commissioner will be empowered to investigate, to make recommendations and to act as the voice of patients on issues that intersect with or transcend health and social care.

The committee does not want to interfere with the commissioner's independence, but it calls for a commitment that the principles that underpin the commissioner's work will include an explicit commitment to listen to and support underrepresented voices. The committee believes that that is important particularly because of the specific patient safety issues that gave rise to the Cumberlege review and the circumstances of those affected by them—notably women.

The committee considers that it is vital for the commissioner to have the necessary capabilities to compel evidence from all organisations that are involved in providing healthcare, including private companies that supply medicines and medical devices. The commissioner should also have the power to follow up on the implementation of any recommendations.

Public confidence in the role of the commissioner is of paramount importance. Given the patient experiences that the Cumberlege review highlighted—many people felt that they were not listened to and felt frustrated by the time that it took for their problems to be acknowledged—work will need to be done to raise public awareness of the new role but, equally, to manage expectations. Crucially, the role will need to be sufficiently resourced to fulfil its functions.

The committee recommends robust monitoring and evaluation to ensure that patients' voices are effectively amplified through the commissioner's work and that there is on-going public confidence in the role and in the wider system for reviewing and addressing patient safety issues.

In conclusion, the committee is content to support the general principles of the bill and

considers that it will be a crucial addition to the patient safety landscape in Scotland that should help to ensure that patients' voices are consistently heard and acted on. I am grateful to the minister for having provided such a quick response to the committee's stage 1 report. We look forward to seeing further improvements to the bill at stage 2, as set out in that response, to reflect our key recommendations.

15:16

Tess White (North East Scotland) (Con): I am pleased to open on behalf of the Scottish Conservatives in this stage 1 debate on the Patient Safety Commissioner for Scotland Bill. I pay tribute to the Health, Social Care and Sport Committee clerks, to our present and former conveners, and especially to the witnesses, campaigners and experts who contributed their insights and lived experience.

As a starting point, we must recognise why a patient safety commissioner is needed. In the report of the United Kingdom-wide independent medicines and medical devices safety review, Baroness Cumberlege pointed to the avoidable harm that patients—mostly women—have experienced as a result of the hormone pregnancy test Primodos, the use of sodium valproate in pregnancy and pelvic mesh implants. She described the truly

"heart wrenching stories of acute suffering, families fractured, children harmed and much else".

The adverse effects of hormone pregnancy tests included congenital anomalies and, tragically, miscarriage, stillbirth and baby deaths. If taken by mothers during pregnancy, sodium valproate can cause physical and neurodevelopmental effects in children. Many of the MSPs who are in the chamber this afternoon have been contacted by mesh-injured women about the life-changing and distressing symptoms that the surgery has caused. It is alarming that Baroness Cumberlege found that the patient voice was dismissed, that patients blamed themselves for the harm to their children that was caused by medicines that they took in good faith, and that patients struggled to navigate a complex healthcare landscape in order to advocate for themselves.

It was against that background that Baroness Cumberlege's report called for a

"public spokesperson with the necessary authority and standing to talk about and report on, to influence and cajole where necessary without fear or favour on matters related to patient safety",

which brings us to the bill that we are debating. The debate is consensual and the bill has cross-party support. The Scottish Conservatives are pleased to support its general principles at stage 1. However, support does not mean the absence of scrutiny.

The patient safety commissioner must be an effective champion for patients, so it is vital to get the approach and the role's powers right. As the Royal College of Nursing emphasises, the views of staff on patient safety must be heard and the commissioner must have the power to follow up on the implementation of recommendations.

In her evidence to the committee, Baroness Cumberlege said that she was "satisfied" with the bill. She said that she agreed "with all of it" and that it is "extremely well put together." She described the patient safety commissioner as the "golden thread" running through a complex patient safety and clinical governance landscape and helping to tie it all together.

The patient safety landscape is, indeed, saturated. Alongside regional health boards, we have the Scottish Public Services Ombudsman, Healthcare Improvement Scotland, the Scottish patient safety programme, the national health service incident reporting and investigation centre, a patient advice and support service that is provided by Citizens Advice Scotland, professional regulatory bodies such as the General Medical Council, and legislation including the Patient Rights (Scotland) Act 2011. That list is not exhaustive.

The patient safety commissioner can help to unify those organisations and create more coherence in a cluttered landscape, but there is also a risk of duplication. What works well on paper does not always work in practice, and there will need to be relationship building on both sides to effectively support and advocate for patients.

When the former health secretary first announced the creation of a patient safety commissioner, she indicated that the role would focus on improvements to patient safety in relation to the use of medicines and medical devices. However, the Scottish Government's approach has since changed considerably, and the bill widens the patient safety commissioner's remit to cover patient safety more generally.

A wider remit has implications for resourcing. The committee explored that issue in some depth after the Finance and Public Administration Committee raised a red flag about commissioners being an

"expensive extension of our public sector",

which is a cause for concern.

In his evidence to the Health, Social Care and Sport Committee, Dr Gary Duncan, chief of staff to the Patient Safety Commissioner for England—who has a much narrower remit—emphasised that

"We would need expanded resources if we wanted to take on further work."—[*Official Report, Health, Social Care and Sport Committee,* 21 February 2023; c 38.]

That suggests that more resources for the role in Scotland will need to be available sooner rather than later.

In her evidence, the then Minister for Public Health, Women's Health and Sport responded to resourcing concerns by pointing to the collaborative approach that the commissioner is expected to adopt by working with existing patient safety bodies, organisations and regulators. She indicated that that way of working would reduce the burden of work on the PSC. However, there is still insufficient clarity on that dynamic in the bill, and that needs to be addressed at stage 2.

It is important to get the resourcing right, because there are already high expectations about what the role will achieve for patients whose voices have too often been ignored. It is also important because public funds are being used, and the process should involve transparency and accountability from the outset. To that end, after the bill completes its parliamentary passage, the Health, Social Care and Sport Committee should be involved in the oversight and monitoring of the patient safety commissioner's performance.

Notwithstanding those comments, it is clear that there is significant support for the bill. My colleagues and I look forward to strengthening it at stage 2.

15:23

Paul Sweeney (Glasgow) (Lab): Labour will support the bill at stage 1, as we are supportive of its general principles, although we have some reservations about the detail and we will look to engage with the Government on amendments before stage 2.

As has been outlined, the bill seeks to establish the office of patient safety commissioner for Scotland, as described in section 1. The patient safety commissioner will have two primary functions:

"to advocate for systemic improvement in the safety of health care, and ... to promote the importance of the views of patients and other members of the public in relation to the safety of health care."

Both provisions are warmly welcome.

As deputy convener of the Health, Social Care and Sport Committee, I echo the comments of the convener, the member for Rutherglen, about the committee's excellent stage 1 report, which was published at the end of April. I would also like to take a moment to thank the clerks and officials for their work on the report. It is a great summary, and I recommend that all members take some time to digest it.

The bill is supported by a wide array of stakeholders, including Valproate Scotland, Haemophilia Scotland and the Association for Children Damaged by Hormone Pregnancy Tests, all of which gave evidence to the committee, and I am incredibly grateful for that.

The establishment of a patient safety commissioner for Scotland is long overdue. At present, the voice of patients and NHS service users is all too often forgotten, which frequently leads to situations where we do not learn from systemic mistakes that have been made and failures that have occurred in the past, and run the risk of repeating them.

The committee highlighted that issue in our report. It is safe to say that there was a large body of concern among stakeholders that the proposed commissioner will not have a remit to investigate individual complaints and that there will be no locus for the commissioner in matters that pertain to systemic issues in social care.

Given the inherently intertwined nature of health, the NHS and social care—something that the Government seemingly recognises, given the National Care Service (Scotland) Bill—it would be helpful for some thought to be given to how we expand, whether immediately or in the future, the commissioner's role to include social care.

My colleague Paul O'Kane, a member for West Scotland, raised that point in committee. I know that the minister disagrees with the idea of extending the remit to include social care; however, we know how complex the policy and regulatory landscape currently is and I would hate for us to be back here again in just a few years doing something similar for social care when we could deal with it here and now, in this bill.

As the Scottish Public Services Ombudsman said in its evidence to the lead committee,

"Given the potentially seismic changes in the health and social care landscape in Scotland, it is evident to the SPSO that a legislative separation between health and social care, which is embedded in this bill (which focuses solely on healthcare), may be becoming outpaced by other developments."

We, in the Scottish Labour Party, have some concerns, too, around the resourcing of the commissioner's office. Currently, we are looking at a budget of around £644,000 per annum. Although I appreciate that that is a significant sum of money, we are talking about a role that is tasked with investigating extremely complex, deep-rooted issues, and I worry that it risks becoming a public relations exercise instead of a substantive mechanism for delivering justice and positive outcomes for patients.

I would like to clarify, too, that it is not only Labour that has that concern. The Royal College of General Practitioners Scottish patient forum has raised it, too, and it emphasised the disappointment that it would feel should future budgetary decisions cause the commissioner's office to fold. It suggested that funding levels should be confirmed by parliamentary procedure. I would like to see the Government consider whether the budget is adequate; I would welcome further engagement and dialogue on that particular point as we progress through the legislative process.

On a positive note, we agree with the Government that a patient champion is required, although we might have slightly different views on exactly what that looks like in practice. We are also grateful to the Government for its commitment to the committee that the commissioner should be able to hear from staff about patient safety concerns as flagged by the Royal College of Nursing Scotland.

On a more general point—I am conscious of the time—I want to assure the Government that Labour will work with it to ensure that we end up in a place where we are all in agreement and can wave the bill through unanimously.

There are plenty of policy areas where we have disagreements, but I genuinely do not think that this has to be one of them. We are all looking for the same outcome here: to improve the voices of patients and to ensure that the systemic issues that many have experienced and have been adversely affected by do not come to pass ever again.

I commit to working constructively with the Government. I know that I speak for my Labour colleagues when I say that they also want to work positively with it, and we have heard from a wide variety of stakeholders that they want to do so, too.

I will conclude on that note. I look forward to the bill's progression through its subsequent stages.

The Deputy Presiding Officer: I advise the chamber that we have a bit of time in hand, so, if anybody wants to make an intervention, members can take one, safe in the knowledge that they will get their time back.

15:28

Alex Cole-Hamilton (Edinburgh Western) (LD): Before I start, I express my apologies to the chamber for having to leave the debate early this afternoon for an unavoidable reason.

I rise to offer my support and that of the Scottish Liberal Democrats for the general principles of the bill and I thank the committee for its work up to this point.

The NHS, as we often rehearse, is one of the finest and best-loved national treasures that these isles have ever produced. It emerged as a Liberal brainchild, which was delivered by the Labour Party as a universal system designed to give remedy to patients in need and to support the hard-working staff administering it.

That system is now in crisis. We have said that many times in the chamber, but it bears repeating. The Government is routinely failing patients and staff alike.

The NHS's most basic principle is that people can access healthcare at their time of need. For too many Scottish people, that principle is no longer being fulfilled. Figures from last month revealed that cancer waiting times are the worst on record for the fifth quarter in a row. Meanwhile, one in 10 people had to wait longer than eight hours to be seen in our accident and emergency departments. Our healthcare staff go above and beyond the call of duty every single day, but instability and a lack of resource are having a deleterious effect on patient safety.

For the past decade healthcare has been mired in scandal, and we have heard much about that in the exchanges in the chamber. Tens of thousands of women have been afflicted with an excruciating and debilitating life-changing pain because of mesh implants that went wrong. There have been multiple deaths, including of two children, linked to sanitation problems at the flagship Queen Elizabeth university hospital. Those are only two of the multiple scandals that Scottish healthcare has faced in recent times.

It is clear that structural change is required, including safeguards that ensure patient safety, and there is an urgent need for a powerful independent figure—a canary in the mine, if you like—who champions the rights of patients and secures improvements in treatments.

The establishment of a patient safety commissioner in Scotland could aid the course of such a change. Although the Scottish Liberal Democrats have been calling for the creation of that position for more than three years, there are several elements of concern with regard to the road to its delivery. Scotland was the first nation to start talking about a patient safety commissioner in all these islands. However, as a result of the dithering and delay that has become characteristic of this SNP-Green Government, we are still only in the early stages of its inception.

Meanwhile, not only has England appointed a patient safety commissioner, but it filled the post more than eight months ago. The delay is causing real harm, as was evidenced by an excellent

article written by Marion Scott of the *Sunday Post*. She spoke to Victoria from Ayrshire, a woman whose three-year-old tragically died at the Queen Elizabeth university hospital. Victoria said:

"One of the promises I held on to ... was that the government would be appointing a commissioner to do everything possible to prevent health scandals ... But here we are. Nobody has been appointed ... and I feel betrayed all over again."

I am sure that there are many people across Scotland like Victoria who feel similarly let down.

Furthermore, the patient safety commissioner is designed to listen to patients' invaluable insights into our NHS and, thus, to be a platform for their voices. Therefore, as others have said, it is somewhat confusing that the commissioner is expected to amplify patients' concerns if they are not given the ability to listen directly to individual patients. It is worth noting the concern among stakeholders that, under the bill as proposed, the patient safety commissioner would not be able to listen to individual complaints.

Elaine Holmes, the founder of Scottish Mesh Survivors, expressed concern that that barrier to patient access

"flies in the face of everything a Patient Safety Commissioner should be."

It is vital that lived experience is at the heart of the patient safety commissioner's job and their mission, and patients' having clear access to the commissioner is fundamental. I remind the chamber that there is precedent for that, because we empowered the Children and Young People's Commissioner Scotland to listen directly to individual voices and take up individual cases through their investigative powers.

We must also remember the key role that our NHS staff play in ensuring patient welfare. With their expertise and experience, our staff are often best placed to identify problems in patient care. Despite that, in its latest report, the RCN noted that members do not always feel listened to when they raise concerns regarding the wellbeing of their patients.

Gillian Mackay (Central Scotland) (Green): I thank the member for taking an intervention. Does he also acknowledge that the work of the patient safety commissioner should be seen not only as a stick but as a learning opportunity for staff and health boards more widely in order to change policy and go forward in a positive manner?

Alex Cole-Hamilton: I absolutely agree with Gillian Mackay's intervention. Yes, of course, there should be investigative powers, but there should also be an opportunity for the commissioner to disseminate best practice and bring it to the fore and to celebrate success in our health service. Staff, too, should have the ability to properly voice these concerns. I look forward to further clarification from the minister about how these avenues will be put in place.

Staff safety and patient safety are inextricably linked. Right now, NHS staff are having to endure mammoth workloads to the detriment of their own wellbeing. In advocating and pushing for patient safety, we must not forget the importance of staff safety. As I indicated at the beginning of my speech, the NHS is an integral and lifesaving institution. Its value to our country cannot be overstated, and it is incumbent on us as policy makers to fight tooth and nail to preserve it. In order to do so, we must introduce real structural change. That starts with this commissioner. The introduction of that office could play a significant role in the reform that we need to see, but only if it is introduced properly. That means everyone and anyone with concerns or experience of patient safety having access to it.

The Deputy Presiding Officer: We move to the open debate, with speeches of around six minutes.

15:35

Evelyn Tweed (Stirling) (SNP): I am very happy to speak in the stage 1 debate on the Patient Safety Commissioner for Scotland Bill. I thank those who engaged with the committee and gave evidence—it is very much appreciated. I think that a patient safety commissioner is much needed, and I will outline why.

Hundreds of thousands of people have been fitted with transvaginal mesh, which was once considered the gold standard and billed as a simple procedure. Although many people are symptom free, for thousands the negative side effects have been profoundly life altering. Yet, despite the widespread negative impacts, Elaine Holmes and Olive McIlroy, founders of Scottish Mesh Survivors, were both told that they were unique—that the extreme and constant pain that they were living with had not been seen in anyone else. They believed that until they met each other. Their symptoms were not unique.

As we have heard, the patient safety commissioner was recommended by the independent medicines and medical devices safety review. Speaking of that review, Baroness Cumberlege said:

"we have never encountered anything like this, the intensity of suffering, the fact that it has lasted for decades. And the sheer scale. This is not a story of a few isolated incidents. No one knows the exact numbers affected ... but it is in the thousands. Tens of thousands."

Despite the variety of issues covered, the review found several common themes. Those patients were not listened to. When the healthcare system

would not support them, they—like Elaine and Olive—turned to each other. Despite the fact that they raised their concerns again and again, the problems that they faced were not acknowledged, sometimes for years. For those years, many patients lived in pain and uncertainty. We cannot let that happen again.

Transvaginal mesh, sodium valproate in pregnancy and Primodos all have something in common: their adverse effects impact women, a group who have historically been, and continue to be, dismissed and patronised in medical settings. I know and can relate to that experience, and I am sure that many others in the chamber can, too. It is of the utmost importance that those barriers are acknowledged and are at the heart of the legislation.

We clearly have some way to go. Recently, the Young Women's Movement found that young women in Scotland are not taken seriously in healthcare settings. They are often dismissed and their experiences are minimised. They are often left with no further offer of support or follow-up. Age, gender, living in rural areas, being part of an ethnic minority, being disabled, being trans, and body type and weight compounded those issues. That is why, as a committee, we recommended that the commissioner be given powers to undertake follow-ups in order to ensure that patients have been listened to and that safety issues have been addressed. In addition, the committee has called for the principles underpinning the work of the patient safety commissioner to include an explicit commitment to listening to and supporting underrepresented voices.

Several witnesses described an existing cluttered landscape for patient safety. It is not only cluttered but siloed, allowing patient safety issues to be missed and to slip through the cracks. With the bill, we have an opportunity to connect those silos, with the role of the PSC acting as a golden thread, as Tess White alluded. The commissioner will have a clear responsibility for patient safety and will be in a position to join the dots and identify systemic problems.

As a committee, we are dedicated to ensuring that patients are listened to. The commissioner will be required to establish an advisory group, 50 per cent of the members of which will have to be drawn from patients and their representatives. It is vital that barriers to participation on the advisory group are minimised as far as possible. We have recommended that all representatives on the advisory group be entitled to reimbursement, regardless of their employment status. That is especially important given the links between long-term sickness and unemployment. In addition, travel expense calculations should take into account the higher costs that people who have to travel from rural or less well-connected areas may face.

The English PSC is already in post and making a difference, and we can learn from her appointment. I am pleased that the Scottish Government has agreed with the vast majority of our recommendations. Above all, the patient safety commissioner must be a voice for patients, and people must finally be listened to and have back-up when things go wrong. We have an opportunity here, which experts have said could

"fundamentally alter the landscape of patient safety for the better."—[*Official Report, Health, Social Care and Sport Committee*, 21 February 2023; c 3.]

Let us get on with making that happen.

15:41

Brian Whittle (South Scotland) (Con): I am pleased to have the opportunity to speak in the stage 1 debate on the Patient Safety Commissioner for Scotland Bill. I, too, add my thanks to the Health, Social Care and Sport Committee, and especially to the witnesses, campaigners and experts who contributed to its report.

As my colleague Tess White said, we recognise the need for a patient safety commissioner for Scotland. What has been said in the speeches so far really resonates with what I want to say about the experience of a constituent. I will use my time to illustrate the need for a commissioner by highlighting a rather harrowing case that I was involved with early on in my political career, which ended up dragging on for several years and has still to reach a resolution.

I was contacted by a couple—Fraser Morton, whom Clare Haughey mentioned, and his partner June—who tragically lost their son Lucas in childbirth. The official report stated that he was stillborn, but the couple struggled to accept that, as the process was rushed through and any questions that they had were shut down and went nowhere. Fraser and June were sure that Lucas had been alive right up until the point of birth, and they requested a significant adverse event review. That was denied because it was insisted that Lucas was stillborn and that, therefore, an SAER was not needed.

By the time the couple approached me, they had already established an anomaly in baby deaths at Crosshouse hospital, with statistics showing that there was an unusually high level of such losses at the hospital over a number of years. I attended various meetings with Fraser and June, at which they met hospital officials, board members, Healthcare Improvement Scotland and even the then cabinet secretary. It was obvious

from those early meetings that they were being fobbed off in the hope that they would eventually give up.

However, the participants in those meetings did not realise how persistent Fraser and June were. They went about reading many case reviews from across the UK, as a result of which they built up a knowledge that it would be very difficult to argue against. They joined with other families who had similar concerns, who, coincidentally, had been labelled as "troublemakers" by some who were under scrutiny. An attempt was even made to blame some members of staff for the tragedy. Everything was done bar accepting the need to review the case and to learn.

Eventually, HIS agreed to instigate an investigation. At the same time, a BBC investigative journalist began her own scrutiny. The upshot of those investigations was that serious flaws were highlighted, not least that the neonatal unit at Crosshouse was 24 staff short and that staff there were under far too much pressure as a result. I would say that Fraser and June are directly responsible for the neonatal unit in Crosshouse being fully staffed. They continue to support other couples around the UK in similar circumstances and they even raise money for cuddle cots, to help parents to deal with their grief.

I tell that story because, if we were able to wind the clock back and put a patient safety commissioner in place prior to that all transpiring, perhaps that loss and other losses could have been avoided. That is not least because statistics indicating a problem such as an increased number of baby deaths would, I hope, have been noticed, investigated and corrected way before it got to that stage. Having identified a problem, the safety commissioner would have been able to monitor the hospital to ensure continuous improvement—I think that Evelyn Tweed made that point.

What that case highlighted to me is that there seems to be no accountability—no place for patients to go where there is no self-interest in the outcome. It has highlighted to me that it is nearly always the system that is at fault, not the healthcare professionals—who, incidentally, seem to carry the can far too often. Serious adverse event reviews are measured, and health boards do not want them against their records, and they vary widely from health board to health board. We need to look at the criteria for investigating a serious adverse event review.

We often talk about what must be learned and changes that must be made to prevent similar things from happening again, as Gillian Mackay highlighted in her intervention on Alex Cole-Hamilton. How can lessons be learned if the issues that caused the incident are not properly investigated and discussed without prejudice or blame? That is why I, along with many of my colleagues in the Scottish Conservatives, will be supporting the bill.

A patient safety commissioner should be able to have an overview and oversight of health boards, be able to spot potential warning signs, and carry out and make impartial investigations and recommendations. The position's remit has to be very clearly defined. We need to look at cases such as the one that I have highlighted and ask the question: what would the commissioner have to be able to do to improve such a situation? Real life—that is where the difference must be felt.

I know that the concern is that the commissioner's remit could become too wide and that the real impact that they could make could become diluted. I would appreciate it if, in her summing up, the minister could assure the chamber about what considerations are being given to making the commissioner's remit as tight as is needed to make them as effective as they can possibly be. After all, the position is about supporting our NHS and making our patients' journey as safe as it can possibly be.

15:47

Emma Harper (South Scotland) (SNP): As a member of the Health, Social Care and Sport Committee, I am pleased to speak in this debate on stage 1 of the Patient Safety Commissioner for Scotland Bill, and I remind Parliament that I am a registered nurse with a current Nursing and Midwifery Council registration.

As colleagues have said, the bill was introduced in response to the recommendations of the Cumberlege review. It is a direct response to patient-led campaigns on use of the hormonal pregnancy test Primodos, sodium valproate in pregnancy and transvaginal surgical mesh. Each of those products is associated with significant patient harms and injury, and one of the main findings of the Cumberlege review was that patients were not being listened to.

We took direct evidence at committee from Charlie Bethune, whom I subsequently met, as he is a constituent of mine. He and his wife Lesley have championed the cause of children who have been impacted on by the anti-epilepsy medication sodium valproate, because of the impact that it had on their adopted daughter. Many others have been affected—the number across the UK is estimated to be 20,000.

As colleagues have said, a patient safety commissioner should be created to listen to and amplify the voices of patients, in order to drive systemic improvements in care, with a focus on medicines and medical devices. The patient safety commissioner, or PSC, will be an independent

champion for everyone who receives healthcare, and will work alongside healthcare bodies such as NHS Education for Scotland and Healthcare Improvement Scotland. The Scottish Government places high importance on the patient voice and the patient experience.

During the committee's stage 1 scrutiny, many of the questions were on the remit of the PSC, because the proposed remit is wider than that of the Patient Safety Commissioner for England. The remit of the commissioner will include bringing together patient feedback and safety data that is shared by NHS boards and Healthcare Improvement Scotland, in order to identify concerns and recommend actions.

The commissioner will also, where necessary, lead formal investigations into potential systemic safety issues, with powers to require that information be shared in order to ensure that every investigation is fully informed.

I believe that the remit of the PSC is directly relevant to issues in Dumfries and Galloway, in my South Scotland region, that I have been raising as a result of my work with constituents. I believe that the PSC could play a part in specific aspects, including a focus on cancer treatment and cancer pathways, and travel reimbursement.

Geographically, Dumfries and Galloway is in the south-west of Scotland, but it is aligned with the south-east Scotland cancer network. Nowhere in D and G are people closer to services in Edinburgh than they are to services in Glasgow. In many cases—particularly for people in Stranraer and Wigtownshire—a trip to Edinburgh can mean a 260-mile round trip for treatment. Constituents have been campaigning about unnecessary travel for more than 20 years now, and I know from my engagement with constituents that the trip can often exacerbate already poor health and cause more anxiety and unnecessary stress. Perhaps a patient safety commissioner will help to amplify the voices of my constituents in order to address that.

In addition, patients in D and G are means tested for reimbursement for journeys of more than 30 miles for medical appointments, despite the fact that people who live in other similarly rural parts of Scotland are not. Other travel reimbursement schemes exist in the Highlands and Islands, for instance.

I know that those issues are not overtly safety related, but, considering the specific issues and the evidence that has been presented that care and compassion should also be taken into account, they are worth noting. I therefore seek assurances from the minister that a future commissioner will consider the issues that I have just highlighted, in order to pursue real change.

I welcome the minister's response to the committee report that was issued this morning. In particular, I welcome the minister's agreement with our committee's recommendation

"that the wording in Section 16(4)(c) ... should be amended to specify that"

members of the proposed advisory group who represent patients

"must actively demonstrate a commitment to representing the voice of patients, rather than simply appearing to the Patient Safety Commissioner to be representative of patients."

That is an important recommendation, because it ensures that those who are receiving care are being represented by someone who has an acute understanding of the impact of their circumstances and who is committed to improving processes in the future. I therefore welcome that appointments to the advisory group will be the subject of oversight by the Scottish Parliamentary Corporate Body, which will function as an external check on their appropriateness.

It is clear that the bill will make sure that the voices of people who are using health services are heard and that their concerns are acted on, with the creation of a champion who is independent of the NHS and of Government and who will focus on the safety of people who are receiving healthcare in Scotland. It is vitally important that patients have a voice and a place to turn to if they have safety concerns, and the bill will help to ensure that that happens.

I look forward to continued scrutiny of the bill as we move forward to stage 2. Brian Whittle's retelling of the experience of Fraser and June at University hospital Crosshouse was a powerful statement of the need for a patient safety commissioner, so I welcome his comments today.

In closing, I welcome the minister's comment that the PSC "will work collaboratively with" healthcare bodies, and I thank all those, including the many people who have demonstrated great courage, who have helped us to get to this point today. I, too, support the general principles of the bill.

15:53

Carol Mochan (South Scotland) (Lab): I start by apologising to fellow members, as I will not be able to remain in the chamber for the entire debate. I have been granted permission by you, Presiding Officer, to leave before its conclusion, so I thank you for that.

I thank my colleagues on the Health, Social Care and Sport Committee for their work on the bill. I was not on the committee at that time, but I

know how hard they worked. I also thank the committee clerks for their guidance.

As my colleague Paul Sweeney mentioned, Labour will support the bill at stage 1. We agree with the general principles and, as such, we support the establishment of a patient safety commissioner to ensure that patients have a champion and a voice to protect their interests.

For too long, patient safety has not been prioritised by the Government. We have heard some clear examples from members today of the tragedy that has been experienced by families who, for too long, were made to suffer in silence. If the minister truly wishes the establishment of a commissioner to lead to real and meaningful change, she must listen to committee recommendations on ensuring that lived experience is heard and considered at every stage of the appointment process.

Moreover, the Scottish Government must agree to Labour's calls for the commissioner, when appointed, to be well resourced with funding, as colleagues have mentioned, and to have the power to stand up for patients' rights and to advocate for the safe treatment and care that they should receive. We want the bill to be successful, but we also want it to be meaningful. The appointment of a commissioner is the first step, but there will be a long way to go afterwards to deliver for patients across the country.

In her response to the committee's recommendations addressing calls to define "patient safety", the minister noted that she believed that

"the meaning of 'safety' is well understood by patients and the public."

That may well be true, but we do not know whether it is well understood by the Scottish Government. Despite safe staffing legislation having been passed years ago, health and social care staff are still waiting for implementation of the legislation to improve conditions.

We know from trade unions such as Unison that low staffing levels is one of the many issues that staff face, which is dangerous to staff and patients. Given that it took the Government four years to confirm when it would implement legislation that has a particular focus on improving staff and patient safety, how can people have confidence that things will be any different in this case? Patient safety cannot be improved without significant improvements to staff safety—they go hand in hand. Indeed, on that point, the minister might wish to consider whether the bill should provide clarity on the commissioner's role in taking forward the concerns of staff who raise patient safety issues.

Therefore, we need a commitment that the bill will be meaningful and will positively impact patients. Scottish Labour will continue to call for existing challenges in staffing safety to be addressed in order to ensure that the bill does not fail to achieve the aims that have been set out.

Furthermore, as has been mentioned, we know that the commissioner's initial remit will not include social care, and the committee supports that position. However, I note from the minister's letter to the committee that she acknowledges that that requires flexibility. Although I stress the importance of considering the committee's recommendation regarding giving the commissioner the ability to have a role in issues that intersect and transcend health and social care, the minister raises an important point.

The new patient safety commissioner will have their work cut out for them if they are to address issues linked to patient safety with the gravity that they deserve, but concerns around funding levels are real and must not be ignored. I hope that the minister will work constructively at future stages—as, I am sure, she will—to ensure that the bill is as strong as possible. From what we are hearing from members across the chamber, that is where we want to be.

However, we cannot suggest for a moment that a patient safety commissioner alone will produce significant improvements to patient safety. As we have seen in recent times, confidence has eroded due to scandals that have been linked to patient safety. They have often, as we have heard, been linked to women's health, including the use of mesh and, more recently, the provision of endometriosis care.

Although the bill is welcomed, the Scottish National Party has overseen long-term decline in the running of public services, and, although clinicians and staff go above and beyond for patients, confidence is not where we want it to be and people are demanding real and tangible change.

In conclusion, the bill has our support at stage 1. The bill is well intentioned and is similar to the Health and Care (Staffing) (Scotland) Act 2019. If it is implemented effectively and with purpose, and if it is supported by financial resources and the freedom of the commissioner to stand up for patients' rights and to advocate for safe treatment and care, it can be successful. It is important that we reverse the trend and work towards delivering positive patient experiences and improved patient safety. I thank members for the debate.

15:59

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I am pleased to speak in the debate as a member of the Health, Social Care and Sport Committee. I, too, thank all those who generously gave their time to provide evidence to the committee, and I thank committee clerks and my colleagues for their hard work and commitment. A special thanks goes to Brian Whittle for speaking with such passion and compassion about his constituent's experience.

The health and wellbeing of Scotland's people lies at the heart of the Scottish Government's responsibilities, and the Patient Safety Commissioner for Scotland Bill is an important step that helps to ensure that good-quality, accessible and patient-centric healthcare services are available to all of us.

The independent medicines and medical devices safety review—known as the Cumberlege review—drew attention to significant changes that were needed for health-related quality and safety and highlighted major disparities in how different groups of patients and service users experience healthcare services, which is an imbalance that must be addressed.

We heard that a patient commissioner would act as an advocate for patients by directly representing their interests in healthcare and drawing on their feedback and experiences to enhance the safety and quality of care. The bill's primary purpose is to give patients a voice—especially the patients who are least likely to be heard in our healthcare system.

Despite the Scottish Government's good progress on patient safety in recent years, some patients have been let down, and the consequences of not listening have been extensive and damaging. For example, we heard about vaginal mesh, which is still an issue many years on.

The Cumberlege review and the evidence to the committee highlight that women still experience a lack of understanding of their symptoms. I am sure that we can agree that it is wrong and harmful for women who are experiencing excruciating chronic pain not to be taken seriously. Too many women are told that these are just women's issues. I thank Carol—I cannot remember her surname—

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): It is an afternoon for that.

Stephanie Callaghan: Absolutely.

I thank Carol for also bringing up endometriosis.

The situation is a clear impediment to securing a correct diagnosis and the right support for people. Irene Oldfather from the Health and Social Care Alliance Scotland spoke for many women when she said:

> "To say that they felt that they were not being listened to is an understatement—they were banging their heads against brick walls."—[*Official Report*, *Health, Social Care and Sport Committee*, 7 February 2023; c 8]

I welcome the minister's recent response to the committee, which recognised our call for the patient safety commissioner's work to include an explicit commitment to listening to and supporting underrepresented voices and agreed about the need for follow-up and for work with organisations to ensure that recommendations really do bring positive change. Patient trust must be strengthened and early intervention is critical. That is exactly what the commissioner will ensure.

Further to that, the bill recognises the key role that data analytics will play in effectively supporting the patient safety commissioner to amplify the voices of patients. We have heard today that sodium valproate can be an essential medicine for those with epilepsy or bipolar disorder, but we are now aware of the imposed physical and neurodevelopmental risk to babies if it is prescribed during pregnancy and also of the trauma and guilt that Tess White described so well. Substantial evidence reaffirming those risks has emerged since the early 2000s, yet Valproate Scotland has noted that there is still no exact figure for how many people in Scotland have been impacted—there is only an estimate of about 2,000. If prevalence is not understood, those who are affected will suffer in silence and go unsupported. Thanks to fierce campaigning by Valproate Scotland, that data is now being collected.

However, we should not be reliant on campaigners to bring such issues to the forefront. We must be proactive—not reactive—in data collection, to identify trends early and minimise harms. It is good to have the minister's reassurance that the commissioner will have access to the data analytics that they require to implement robust and evidence-based systematic improvements. We simply cannot afford to allow another surgical vaginal mesh or sodium valproate event to unfold.

Today, we have heard much about patient experiences that highlight the need for the bill and about the importance of creating a patient safety commissioner role that is independent of the Government to champion patients' rights. We have heard that the patient safety commissioner needs the authority to investigate and report on patient safety matters and the power to make recommendations to healthcare providers, professional regulatory bodies and the Government.

The bill should matter to every Scottish citizen, because any one of us might unexpectedly face a situation that goes beyond an individual complaint and appreciate having a patient commissioner who is on our side. I stand by the bill's aims, and I hope and trust that members will support its general principles.

16:04

Gillian Mackay (Central Scotland) (Green): I, too, welcome the bill's introduction, and I thank all those who gave evidence to the Health, Social Care and Sport Committee, the committee clerks and the organisations that provided briefings for today's debate.

This is one of the rare occasions when we do not disagree on an issue and can have a genuine discussion about how to get the best out of the bill for patients. The committee heard a wide range of views from those who gave evidence. We heard varying opinions on how the commissioner should respond to individual cases. When I asked her about that in committee, Baroness Cumberlege said that the commissioner will need to take an overall system-wide view in order to identify trends and that other organisations can support individuals.

We heard from Haemophilia Scotland that people do not always know where to go when they have complaints and that a culture of defensiveness in the NHS may prevent their complaints from being addressed. Haemophilia Scotland made the powerful point that the infected blood inquiry has resulted in the issuing of the apologies that some people have been waiting 20 years for and that there would be value in the commissioner being the first point of contact rather than the last. However, there was largely a consensus among those who gave evidence that the commissioner should not take on and solve individual cases, although they should certainly listen to individual concerns and identify where they form a pattern.

The commissioner's role in relation to individual cases must be clearly defined as the bill progresses through Parliament so that it can be clearly communicated to the public. As the committee report states, given the on-going issues around

"patients feeling they were not listened to and the length of time taken for their problems to be acknowledged ... raising public awareness, as well as managing expectations, in relation to the role of Patient Safety Commissioner"

will be essential, and the Government must plan for that accordingly.

Alongside excellent communication about the role and responsibilities of the commissioner, there must be an early focus on the building of relationships. It was stressed to the committee that patients will need to see the commissioner as someone who is on their side when they may have struggled to be heard for some time.

The commissioner must take a person-centred approach to complaints that recognises the individual who is behind the complaint. Those with lived and living experience of patient safety issues should also have a meaningful role in the recruitment process. That will be essential in establishing patient trust and confidence in the commissioner. Consulting people with lived experience and other stakeholders should be an on-going process and not a one-off event.

The committee's report calls for the commissioner to consult stakeholders on the principles that will underpin the role and says that these should

"include an explicit commitment to listening to and supporting under-represented voices".

The commissioner needs to be keenly aware that not all complaints are treated equally and that existing inequalities will impact the experiences of patients when things go wrong. The Cumberlege review examined themes that specifically affected women and found a culture of silence about women's pain and discomfort, which are often dismissed or ignored by the very system that is meant to keep patients healthy and well.

The commissioner must take an intersectional approach. The MBRRACE-UK report in 2022 revealed that, in the UK, black women were 3.7 times more likely to die from complications from pregnancy than white women were, Asian women were 1.8 times more likely to die than white women were and mixed ethnicity women were 1.3 times more likely to die than white women were.

The General Medical Council has suggested that the commissioner should adopt an explicit focus on addressing and mitigating healthcare inequalities that have the potential to impact on patient safety. I fully support that call.

On the relationship between NHS staff and the commissioner, I appreciate the comments from the then Minister for Public Health, Women's Health and Sport during her evidence session. She was clear that there should be communication between NHS staff and the commissioner and that that could be clarified in the bill.

The Royal College of Nursing has welcomed that commitment and has highlighted that, although policies and procedures are in place for staff to raise concerns, staff do not always feel that those concerns are heard. Given the pressure that staff are under at the moment, it will be essential to build positive relationships from the beginning, so that staff are not reluctant to raise issues

because of fears about punishment. Staff and the commissioner will share a commitment to patient safety, so we need to create an environment where they can work towards that common goal.

The commissioner will need to work co-operatively and not just be seen to be wielding a big stick. As the committee report notes, the complex governance structures that are in place, with responsibility for the safety of patient care shared among several organisations, not only create the risk of overlap and duplication of effort but can make things confusing for patients and lead to them having to tell their stories over and over to different agencies.

That is one example of how raising complaints can be traumatic for patients. More detail is needed on how the commissioner will work with other agencies in a way that will ensure that there is no meaningful duplication or overlap. I look forward to that clarification being added to the bill.

Although the establishment of a commissioner will, I hope, help to alleviate some of the aforementioned trauma that has been experienced by patients who are raising complaints, the need for emotional and practical support is still clear. As we have seen from the infected blood inquiry, seeking resolution for complaints can be an extremely lengthy, drawn-out process that can reinforce trauma for patients. The support that is available to patients and how they can access it while their complaints are being investigated need to be made clear.

The appointment of a patient safety commissioner is a vital step towards improving patient safety and will reassure people that, when things go wrong, their voices will be listened to and lessons will be learned. The Scottish Greens will support the bill at stage 1.

16:10

David Torrance (Kirkcaldy) (SNP): It is well established that health is a fundamental human right, and it should be treated as such. Although our healthcare system has faced unprecedented challenges in recent years, my view is that it is essential to use this time as an opportunity to learn and do better for the safety of patients and the foundation of our healthcare system.

We are faced with unique circumstances in this period of post-pandemic rebuilding in implementing the changes needed to put patient safety at the heart of our healthcare. I therefore very much welcome the Patient Safety Commissioner for Scotland Bill, which intends to establish a patient safety commissioner in order to ensure that patients' voices are heard, amplified and carefully considered.

The bill proposes that the patient safety commissioner would have two key functions:

> "to advocate for systemic improvement in the safety of health care, and ... to promote the importance of the views of patients and other members of the public in relation to the safety of health care."

As a member of the Health, Social Care and Sport Committee, I have had the privilege of taking verbal and written evidence from a range of stakeholders and experts across the sector. Their views have been invaluable in informing the committee. In addition, we have heard from a range of patients and patient representatives, many of whom strongly supported the establishment of a patient safety commissioner for Scotland and told us about the difference that such a role could have made in their cases.

I am incredibly pleased that the committee has unanimously backed the bill. It was introduced in response to the recommendations of the UK Government-commissioned Cumberlege review. The committee was pleased to welcome Baroness Cumberlege to our first evidence session on the bill, earlier this year. The review was established to examine how the health system responds to reports from patients about patient safety concerns that are related to medicines and medical devices.

Our committee has heard on numerous occasions that the Patient Safety Commissioner for Scotland Bill goes further than the corresponding legislation in England. Under the bill as currently drafted, the patient safety commissioner for Scotland would have the power to make it publicly known if an organisation had failed to co-operate. However, it goes further than that. The commissioner would have the power to compel the organisation to act.

It is reassuring to hear that the Patient Safety Commissioner for England has already made remarkable progress. If the bill is passed, I look forward to seeing even better results in Scotland.

I thank the individuals and members of the public who volunteered their time to speak to the committee at an evidence session. Many of them spoke about their personal experiences, and I know that all members who were present were incredibly moved by their stories.

Patients need to feel safe in the hands of our medical professionals. I cannot fathom the unimaginable pain and mental distress that patients across the country and their families have faced. The harm that has been caused to patients and their families is often avoidable, and I appreciate and recognise that many continue to fight for answers.

Safety lies at the heart of delivering our health services, and it will be essential for the

commissioner to instil trust and confidence in our communities and to be a clear and strong voice for patients.

We are debating the bill thanks to the tireless work of campaigners and individuals who have been massively affected by the issue. I am absolutely certain that future generations will benefit from safer healthcare thanks to their incredible efforts.

We cannot talk about healthcare without discussing the universal and entrenched inequalities that patients face. During the committee's evidence sessions, we heard time and again about how marginalised groups bear the brunt of patient safety issues and about how the establishment of a patient safety commissioner could ensure that marginalised patients' voices are heard and that their concerns are picked up and acted upon.

Patient safety is incredibly gendered. Experts told the committee that women and children are overwhelmingly the groups that have been affected by medicines and medical devices that are thought to have jeopardised patient safety. Women across Scotland have been let down by ingrained prejudice within the medical system. Research has shown that the healthcare system seems to be poor at listening to women and taking seriously their concerns about their health and wellbeing and the outcomes of the procedures that they have had.

Based on the evidence that we have heard, it is clear that there is a requirement for the system to act more coherently for the public interest. The establishment of a patient safety commissioner is an effective mechanism to ensure that.

In response to the consultation, the Health and Social Care Alliance Scotland—the ALLIANCE—set out a number of considerations, many of which I welcome. They included the importance of a fully transparent appointment process for the commissioner and of clearly explaining the role and remit to the general public through accessible and inclusive messaging. With that in mind, and as the bill progresses to its later stages, a clear focus should be given to the following points.

First, the patient safety commissioner's remit and scope need to be clarified to ensure a clear definition of roles across the medical system. The medical system is a complex landscape, and it is essential that the commissioner's role is clearly defined so that there is no overlap with current governance systems and so that patients know who they can contact for support.

Secondly, the commissioner needs to be independent of the Government and the NHS and to have the resources to carry out their role properly. That will help to restore public confidence in our healthcare system and encourage patients to come forward to report any cases of medical wrongdoing.

Thirdly, a person-centred approach is necessary and critical. Patient voices, particularly those from marginalised or underrepresented groups, need to be at the heart of the work. A diversity of voices is paramount for patient safety, and people with lived experiences should play a meaningful role in the process of establishing a patient safety commissioner for Scotland.

I am confident that, throughout the process, the Scottish Government will continue to work with the relevant organisations to ensure an outcome that is robust and comprehensive.

I once again thank those who gave evidence to the committee in the run-up to the debate, and I look forward to the bill progressing through its upcoming stages.

16:16

Colin Smyth (South Scotland) (Lab): I add my thanks to the members and clerks of the Health, Social Care and Sport Committee for the work that they did on the stage 1 report and to everyone who took the time to give evidence to the committee to shape that report.

It is clear from reading the evidence to the committee that there is widespread support for the establishment of a patient safety commissioner. Crucially, the commissioner should be independent of Government, to provide a strong voice for patients and champion their interests.

Patient safety must be a non-negotiable aspect of our health and social care service but, too often, patients in Scotland feel that they have been failed. From the chemotherapy dosing scandal for breast cancer patients in Tayside and the pelvic mesh surgery scandal to the infected blood scandal and the tragic death of Milly Main at the Queen Elizabeth university hospital in Glasgow due to contaminated water, it is clear that Scotland needs an independent body with the power and resources to shed light on such mistakes and, crucially, ensure that lessons are learned for the future.

Too often, patients feel that they are not being heard and that they do not have the information to make the right decision about their care. Too often, they do not trust the answers that they are given and do not believe that the system prioritises their health and that of their families.

Take the example from Parkinson's UK. It highlighted in its evidence to the committee the time-critical nature of the administration of Parkinson's medicine. If people with Parkinson's

do not get their medication on time, even a delay of 30 minutes can seriously impact their health.

Through its get it on time campaign, Parkinson's UK and the wider Parkinson's community have been raising significant concerns about missed and late medicines in hospitals since 2006. That is almost two decades. However, Parkinson's UK estimates that there are still around 100,000 incidents a year in Scotland in which Parkinson's medication is administered more than half an hour late—in breach of clinical guidelines—or, on occasions, missed altogether, often with tragic consequences. As we have heard in relation to sodium valproate damage, the Parkinson's community feels that calls from patients too often fall on deaf ears at a systemic level.

In evidence to the committee, some people argued that there were already established organisations—such as Healthcare Improvement Scotland, the Scottish Public Services Ombudsman and the Health and Safety Executive—to do the job, as well as initiatives such as the NHS Scotland patient safety programme, and they expressed concerns about overlapping responsibilities. Of course, as the committee has highlighted, we need to avoid duplication, but it is clear that the scandals that we have heard about were not properly addressed by the current organisations and the systems that we have in place. That is devastating for patients, but it is also devastating for clinicians and other staff, the overwhelming majority of whom go above and beyond every single day.

Concerns were also raised by the Finance and Public Administration Committee about the increasing number of commissioners and the resource challenges that that brings to the Scottish Parliamentary Corporate Body. However, that is not an argument against having new commissioners; it is an argument that the Health, Social Care and Sports Committee rightly makes to properly resource the Parliament's corporate body to support the work of the patient safety commissioner and any other commissioners that might be proposed, and to properly resource the commissioners themselves. There are strong arguments for the role that commissioners can play in independently scrutinising Government and providing a voice to people with lived experience, not least in health.

There is currently a petition before Parliament from Dr Gordon Baird, who is a retired general practitioner in my region. It urges the Government to establish independent advocacy in health, specifically for rural areas, to ensure that health service provision is fair and reasonable. Dr Baird has cited the successful model of Australia's rural health commissioner.

Dr Baird took up the cause after his former music teacher—a woman in her 80s with terminal cancer—had to spend nearly nine hours travelling back from Edinburgh to her home in Sandhead each time she received palliative therapy, for no other reason than the historical convenience of consultants, which led to Dumfries and Galloway being made part of the South East Scotland Cancer Network instead of the West of Scotland Cancer Network. That means that patients from the region have to travel primarily to Edinburgh—

Emma Harper: Does the member agree that Dr Gordon Baird has been working on that issue for 20 years?

Colin Smyth: Absolutely. He has been working on that and many other issues in our rural communities.

Concerns that patients have raised about the lack of services in areas have just not been tackled. In this case, that means that patients from the region have to travel to Edinburgh for specialist cancer care and not Glasgow, which is far closer for residents in the west. As Emma Harper highlighted, the health board has promised action to realign those services to the west of Scotland since 2006, but there has been no progress from the board or from Government to deliver that.

Since 2018, we have also seen the maternity unit at Galloway community hospital in Stranraer closed—temporarily, we were told—because of a shortage of midwives. That means that mums-to-be in Wigtownshire have to travel up to 90 miles to Dumfries to give birth.

One of my constituents—Claire Fleming—lives in Glenluce, which is 15 miles from Stranraer. Her first pregnancy was with Abbey, who was, sadly, stillborn. Despite the tragic end to that pregnancy, Claire had to drive herself to the hospital in Dumfries to deliver Abbey. That was 60 miles away. Since then, she has had three children—Molly, Andrew and James—which is wonderful. However, along with her husband, Richard, she has had to clock up more than 7,500 miles between her home and Dumfries for maternity appointments because, even before the maternity unit in Stranraer closed, services had been scaled back.

Claire suffered from hyperemesis during pregnancy, which meant that she had to stop on the journey to Dumfries every 15 minutes to be sick. She told me that she was aware of women in Wigtownshire who had decided not to get pregnant because they were "so scared" of having to make that journey in a rush if they went into labour. They feared that they would have to give birth in a lay-by at the side of the road. Claire has chosen to be sterilised because she says that she

could not face that journey again. That is not putting patient safety first.

I have no doubt that, had we had a rural health commissioner shining a light on those scandals and independently holding Government to account, we would have seen progress on ending them before now. I also have no doubt that a patient safety commissioner who is properly resourced, has the proper powers and, crucially, is backed by safe staffing levels in our hospitals could play an important role in standing up for patients' rights and advocating for the safe treatment and care that we should all be receiving.

The Presiding Officer (Alison Johnstone): James Dornan will be the final speaker in the open debate.

16:23

James Dornan (Glasgow Cathcart) (SNP): My apologies for the short delay, Presiding Officer. I was kicked out and had to log myself in again.

Across the chamber, there is not a member who puts themselves forward to stand for election without believing that their work can improve and protect the lives and wellbeing of the constituents they represent. The health and safety of each and every one of us, and of every one of the people in our constituencies, our cities and across Scotland are, above all else, at the heart of all the work that we do as MSPs.

As we often reflect on, the NHS is one of the finest institutions in the world. The care and dedication of the staff and practitioners are second to none, and I am always in awe at the levels of diligence that they show when carrying out such complex and challenging care.

However, it would be remiss of me not to admit that one of the more difficult parts of our job as members is dealing with complaints and concerns about the NHS. In my experience, our office has usually found NHS Greater Glasgow and Clyde to be extremely helpful when it comes to difficult issues. However, there have been and will be times when issues fall outwith its remit and we are left with patients frustrated and issues unresolved.

I have recently been in discussion with constituents who are mesh survivors and members of groups supporting patients who were treated with transvaginal mesh, and I was flabbergasted and horrified by their shocking stories of discomfort and pain and the wider impact that it has had on their lives. The Parliament has had many debates on the subject, and we, as members, have learned so much from the various testimonies that have been proffered to us by the brave women who have campaigned so hard for patients to have correctional treatment where possible, and for steps to be taken to support those involved. With the launch of the Cumberlege review, I was delighted to see that transvaginal mesh was one of the cases that highlighted the need for the introduction of the patient safety commissioner.

Healthcare and innovation have worked hand in hand for ever. However, as we move into an ever-changing world of artificial intelligence and tech-led healthcare, human beings must always be at the centre of all our care provision. I was recently speaking to a type 1 diabetic patient who, within a few years, has gone from monitoring their sugar levels with a manual prick of the finger and using difficult mathematical calculations and insulin pens to deliver insulin, to using a monitor that can be scanned with a smartphone, and having insulin delivered through a micropump that is attached to the patient's body. That not only ensures that the patient has more accurate and cohesive regulation of insulin in the body but could mean a massive improvement to their life and a reduction in the other difficult side effects that come with poor diabetic management.

However, it was very interesting to hear that the technology, although transformative, is not without flaws. For example, if the Bluetooth signal from the smartphone to the pump fails, insulin will cease to be delivered, resulting in a spike in blood glucose levels. That very specific example shows that, even when medical technology is transformative, it is not without its difficulties. The patient safety commissioner's office would be the perfect place for somebody who wishes to raise an issue that could affect people besides themselves but who does not want to seem as if they are complaining about a particularly good service. Hopefully, the patient safety commissioner would be able to take that on and see whether anything could be done about it. That is a very good step in the bill.

One of the key areas that I am really pleased about is that the commissioner role is designed to improve communications with patients and members of the public. During the Cumberlege review, I saw the evidence that recommended that a patient's lived experience should no longer be considered as anecdotal and should not be downgraded, as it presently is, when weighted against scientific and evidence-based medicine.

The Scottish Government has recognised public calls for patients to have a new voice, and continued engagement with the people of Scotland has confirmed that it should be a priority to fulfil the recommendations of the Cumberlege review, which the bill clearly seeks to do. When it comes to public safety and health, the best outcome for patients will be achieved only if there is strong partnership working.

NHS procurement, run by National Services Scotland, is a prime example of partnership working. Clinicians and management work together to ensure that the needs of the organisation and, ultimately, the service users are met in the most efficient, safe and cost-effective way. Therefore, it is great that although the commissioner will be independent, they will work closely with professionals such as clinicians, lawyers and advocates to ensure that a wholly rounded service is delivered to the people of Scotland.

I am confident that patient complaints are dealt with to the best of each individual health board's ability, but organisations such as Healthcare Improvement Scotland and others are doing all that they can to ensure the safety of people using healthcare facilities, both public and private, across Scotland. However, the Scottish Government is right to take on the recommendation of the committee report to follow the guidance of the Cumberlege review and the evidence that will ensure that the voices of service users are not lost among the many others.

Although the commissioner will not be advocating in individual cases of patients, it is good that there will be advocacy for safety and health across Scotland and that the voices of patients and service users are central to that. Patients will benefit greatly from streamlined advocacy and guidance when it comes to their safety and care in the healthcare system. The overwhelming public support during the consultation period for the bill is proof that it is absolutely the right implementation to make.

I am therefore delighted to support the Patient Safety Commissioner for Scotland Bill at stage 1.

The Presiding Officer: We move to closing speeches.

16:29

Paul O'Kane (West Scotland) (Lab): I am pleased to have the opportunity to close the debate on behalf of Scottish Labour. I begin by welcoming Jenni Minto to her place as minister. This is the first occasion on which I have been across from her in the chamber in this context and, quite possibly, it is the last as, obviously, I am speaking as the former deputy convener of the Health, Social Care and Sport Committee—of course, I was referring to my change of shadow roles and not to the minister.

However, I am pleased to be speaking, to look back at my time on the Health, Social Care and Sport Committee and to follow on from colleagues on that committee in speaking about the bill.

The committee scrutinised the proposals carefully and thoughtfully. It was clear from all the evidence sessions that there is a consensus that a patient safety commissioner can play an important role in improving public confidence in the healthcare system and serving as a powerful advocate for patients. As my colleagues have articulated—most notably Paul Sweeney in his opening remarks—Scottish Labour supports the establishment of a patient safety commissioner to champion the rights of patients and defend their interests. However, as we have said, we want the bill to be as robust as possible and to go as far as possible to ensure that those interests are defended robustly.

It is, of course, a positive step that the Government is implementing a key recommendation of the Cumberlege review. As we have heard from members from across the chamber, in recent years we have witnessed too many scandals, often with fatal consequences, affecting too many families. The stark reality is that we cannot afford the cost—either the economic cost or, critically, the human cost—of unsafe care. It is estimated that, globally, unsafe care in health settings significantly contributes to more than 3 million deaths per year, which is clearly a sobering and significant figure. It is estimated that the financial cost of unsafe care here in Scotland is around £2 billion. In that respect, the importance of legislation is self-evident.

As I said, the crucial aspect is that the bill is well crafted and well implemented. As we have heard, pieces of well-intentioned legislation have often failed to have an impact on improving patient safety or patient care. We heard from my colleague Carol Mochan about the passing of the Health and Care (Staffing) (Scotland) Act 2019, which was hailed as a landmark piece of legislation that would improve patient safety, as well as the safety of the workforce, by ensuring safe staffing levels on wards. However, four years on since that legislation was supported by members across the Parliament, there has been a failure to properly implement it and to meet the standards. I think that everyone is keen to raise that issue once more and to see progress in that space.

Alex Cole-Hamilton and Colin Smyth rightly raised the scandals that have impacted patients across the country, most notably at the Queen Elizabeth university hospital. Those harrowing stories are part of the reason why we need to ensure that the bill goes as far as possible. Scottish Labour has advocated for many years for better and more robust systems to be in place to ensure that the voices of the victims of poor care are at the heart of any inquiries into tragedies. Of course, most notable among those stories is that of Milly Main and the advocacy for Milly's law to

put families at the heart of such inquiries. We need the patient safety commissioner to take a strong role in that regard.

Evelyn Tweed spoke powerfully about the importance of the barriers that are experienced in healthcare, particularly by women, and she acknowledged that those barriers have to be broken down. I am sure that we all want the barriers to be broken down, which is why the recommendations of the committee that Evelyn Tweed referenced about following up with patients, giving them holistic support and representing the underrepresented in this space are vital.

Brian Whittle and Emma Harper brought to the Parliament's attention the personal cost of the experiences that people have had across Scotland. People have experienced unthinkable pain, both physical and mental, and have had to live with that for many years before progressing towards an outcome. Those members' contributions were particularly important in helping us to focus on what we want the patient safety commissioner to do. The system, at its heart, needs to be about transparency, accountability and, crucially, safety. I think that we all want those values to underpin the proposal.

As the bill moves to stage 2, it is critical that the Government works with members from across the chamber to iron out some of the issues that the committee raised at stage 1. I welcome what the minister said in her opening speech about the Government being in listening mode, which is really important.

The issues in the committee's report that stood out to me have already been covered. We need to explore how healthcare staff can raise patient safety concerns freely, without fear of repercussions, with the commissioner. I appreciate what the minister said about working with officials to see what can be done in that regard.

We should provide greater clarity on the powers of the commissioner in relation to compelling private companies that provide devices and medicines to submit evidence during investigations. We should ensure that the commissioner has the teeth to push companies to do that.

Paul Sweeney mentioned investigations into individual cases. That is an important point that merits consideration. It is also important, as he said, to clarify the commissioner's remit in relation to social care and how that remit will interact with the proposals for a national care service, because the significant safety issues relating to social care that came to light during the pandemic and throughout the period since then need to be addressed. There is an opportunity to do that through the bill.

I join others in thanking my former colleagues on the committee for all their work, and I thank the clerks and those who gave evidence. As I said, Scottish Labour will support the bill because it is evident that there is consensus on the need for a patient safety commissioner. All parties in the Parliament recognise that need. As the bill moves to its subsequent stages, it is critical that the Government gets it right and delivers, because patients have already waited too long and need a champion.

16:36

Sandesh Gulhane (Glasgow) (Con): I start by stating for the record that the vast majority of health interactions are safe, and I thank all NHS and social care staff for their hard work.

The Scottish Conservatives support the bill's principles in introducing a patient safety commissioner for Scotland who will highlight patients' concerns and advocate for systemic improvements in healthcare. The Scottish Conservatives want an NHS that is modern, efficient and local and that takes a fresh approach to trying to fix the issues in healthcare.

It is interesting to consider the background to the bill. Tess White reminded us that, back in 2018, Baroness Cumberlege led a review into the harmful side effects of medicines and medical devices in England. The review made nine recommendations, including the appointment of a patient safety commissioner in England. In September 2020, the then health secretary, Jeane Freeman, announced the Scottish Government's intention to establish a patient safety commissioner for Scotland. She said:

"not everyone gets the outcome"

that they are looking for, and

"not everyone feels they have been properly listened to".

However, based on the evidence that the committee took, the patient safety commissioner will not take on individual cases.

In February 2021, the Patient Safety Commissioner for England was introduced in law via an amendment to the Medicines and Medical Devices Bill. We have heard from numerous members that the proposed Scottish PSC will be different from the English one. The proposed Scottish PSC will be nominated and sponsored by, and therefore accountable to, the Scottish Parliament, whereas the English PSC is sponsored by the Department of Health and Social Care. Furthermore, while the English PSC covers only medication and medical devices, the Scottish equivalent will cover all aspects of patient safety.

Patient safety is paramount, and we need to be very careful in how we frame the duties and responsibilities of Scotland's patient safety commissioner. Although the PSC will be accountable to the Parliament, the Parliament should not micromanage the commissioner. Based on the evidence that we heard, the PSC will, indeed, be independent.

We should be mindful that we are dealing with the public's money—about £650,000 per year. Tess White was correct to raise that issue. The spend must be justified and we need to demonstrate value for money.

There are also concerns about possible duplication of efforts and about where the PSC will sit among existing organisations. There is already a complex landscape in relation to the regulation, scrutiny and oversight of the NHS in Scotland, and the creation of another scrutiny body comes with risks of overlap, especially when functions and remits are not clearly articulated in the context of the wider landscape.

Minister Minto explained that the PSC will look at trends through the healthcare system. That golden thread is vital to safety as it stops the same issues from continuing to harm patients.

As a member of the Health, Social Care and Sport Committee, I say that it is vital that we discover the interaction between the commissioner, other commissioners and key stakeholders. As Minister Minto stated, that is because the commissioner will not be undertaking investigations but, instead, will try to use expertise from outside. I agree with Minister Minto that we need to foster a safe, open and learning culture within healthcare.

As the convener of the health committee stated, we are all grateful to the patients who gave such powerful evidence, which Brian Whittle so eloquently repeated. They are using their painful experiences to help create a system that prevents other patients and families going through the same pain.

The commissioner requires public engagement and public confidence that they are there to protect patients and will actually listen to them. Tess White told us that patients felt dismissed and that Baroness Cumberlege recommended the creation of the post—the baroness was clear in her evidence to the committee that she agreed with the bill.

Alex Cole-Hamilton and Brian Whittle spoke of how slow we had been in creating the post. Although we heard in evidence that listening to individuals to find the golden thread would be great for individual cases, those individuals will in fact be signposted to the appropriate place.

I agree with the Royal College of Nursing and Mr Cole-Hamilton that staff safety is paramount for patient safety. How can a nurse deliver excellent care when we ask them to fill reams of paperwork, which is duplicated? How can they be asked to cope with too many patients and be constantly under severe pressure?

Carol Mochan was right to speak of the Health and Care (Staffing) (Scotland) Act 2019, because there is nothing more demoralising than constantly having rota gaps that you need to cover.

Paul Sweeney made excellent points about the social care aspect but, at the moment, it seems that the role of the commissioner is very large and that getting on top of that before any expansion is definitely required. Mr Sweeney also questioned the cost, which the Scottish Conservatives are concerned about, too; indeed, the Finance and Public Administration Committee has flagged the overall cost of commissioners. We must be mindful of achieving a balance and not diluting the post, as Brian Whittle said.

Evelyn Tweed told us that women seem to be constantly dismissed and are not taken seriously in healthcare settings. Fifty per cent of the population are not getting the help that they need; we must do better. I hope that the commissioner is a step in the right direction, but we need to see the Scottish Government doing more for women. As Gillian Mackay said, ethnic minorities suffer disproportionately, too.

Brian Whittle was spot on when he said that most incidents reflect systemic issues—it is described as the Swiss cheese model, because the holes line up, which allows the incident to occur. The commissioner must find those potential holes and close them.

The Scottish Conservatives want the bill to succeed, so we will support it at this stage. We are keen to see more detail on the relationship between a commissioner and Parliament, and on the appropriate scrutiny criteria. We believe that the commissioner should set the work agenda for each year, along with the criteria against which they feel that they should be judged, and present that agenda to the Health, Social Care and Sport Committee, along with the previous year's work, for scrutiny. We then want to see the health committee hold a debate each year on the work of the commissioner.

We have a great opportunity here to establish a force for good that is accountable to Parliament and delivers value for money. Let us move ahead, but let us carefully consider the detail, too.

I refer members to my entry in the register of members' interests as a practising NHS doctor.

16:44

The Minister for Public Health and Women's Health (Jenni Minto): I am grateful to all members for their extremely thoughtful contributions to what has been a constructive and helpful debate. It is welcome that the chamber recognises that there is more to do to ensure that patients are listened to when they have concerns about the safety of healthcare and agrees that the creation of an independent patient safety commissioner is an important step that will promote the patient voice and make healthcare in Scotland safer for us all.

I will, of course, carefully consider all the points that have been raised today before stage 2. The range of suggestions that have been put forward to ensure that the patient safety commissioner is as effective as possible are very welcome and are doubtless testament to the commitment of the members of this Parliament to the safety of their constituents and all who need to access the healthcare system in Scotland, irrespective of whether that healthcare is provided by the NHS or through another route.

Clearly, some of the issues that we have debated today will need to be considered further, but I am pleased that there appears to be support across the chamber for the general principles of the bill. I will turn to some of the contributions that were made.

I thank Paul O'Kane for his kind words. I have really reflected on what he said about the thoughtful consideration of the committee under Gillian Martin's convenership. The evidence sessions that I watched were very powerful—especially those with people who had been impacted by previous circumstances. The member referred to the bill being well crafted, and I thank my bill team for that.

I echo the words of Sandesh Gulhane about thanking the healthcare staff who work in our NHS. He also noted that Jeane Freeman first introduced the idea of a patient safety commissioner to the Parliament as a result of Baroness Cumberlege's review. The member raised various other points that I will touch on if I have time.

I thank Clare Haughey, who raised points about evidence, social care and unrepresented voices, specifically the voices of women—a point that was also raised by Tess White. Tess White also emphasised the importance of collaboration, which is a word that I have used a lot.

Paul Sweeney talked about individual cases and the healthcare around those, and he offered to have further dialogue with me, which I would very much appreciate.

With regard to Alex Cole-Hamilton's comments, it is important to emphasise that the establishment of our commissioner will be done through stand-alone primary legislation, not, as Sandesh Gulhane mentioned, through an add-on to another bill. We are giving our commissioner statutory powers. We have also taken much time to listen to individuals, which is something that patients wanted.

Tess White: The RCN raised a really important point about safe staffing being integral to patient safety. In her new role, does the minister see that as a key principle, and will she be looking into it at stage 2?

Jenni Minto: I have taken the decision to review staffing and the contribution that staff can make to the work of the commissioner, but it will be the commissioner who decides their priorities. However, I certainly note Tess White's point.

Evelyn Tweed referenced the Young Women's Movement. I attended the launch of its research on women's experiences, and I would like to reflect on and agree with the points that Evelyn Tweed raised.

I thank Brian Whittle very much for bringing to the chamber the experience of Fraser and June Morton. I was particularly moved by Fraser Morton's evidence to the committee and his selfless actions. Mr Whittle pointed to what we need to review and learn from in order to move on positively on the basis of their terrible, traumatic experience.

Brian Whittle: Does the minister agree that one of the things that we have to do in creating the role of the commissioner is ensure that staff feel sufficiently empowered and safe to give evidence in such cases, so that they do not feel that there will be retribution or blame?

Jenni Minto: I reaffirm, as I said to Mr Whittle's colleague Tess White, that I have responded to that in my letter. It is important that we review that side of things, including the implications for staff.

Emma Harper talked about the importance of listening to and amplifying patients' voices and, along with Colin Smyth, talked about travel from rural communities, which is an issue that I recognise because I represent Argyle and Bute. Although I am happy to look at that, again, the patient safety commissioner will make decisions as to whether he or she reviews that.

Carol Mochan talked about lived experience, the power to stand up for patients' rights and this being a first step.

Stephanie Callaghan talked about how patient trust must be strengthened. To me, that is one of the core points of the bill—and that we are proactive, not reactive.

Gillian Mackay talked about building relationships and taking a person-centred approach.

David Torrance talked about trust and confidence in our communities.

James Dornan highlighted Baroness Cumberlege's point that lived experience is not anecdotal, and I believe that that is central to what we are doing.

I am sorry—how much time have I got?

The Presiding Officer: It was a scheduled eight minutes, minister, but do please continue. We have some time in hand.

Jenni Minto: Okay. I will touch on some of the other points that were raised.

I feel strongly that the safety commissioner's focus must be on the safety of healthcare, and I am pleased that the committee agrees with that. The commissioner's remit covers the safety of healthcare irrespective of where it is delivered, which I believe means that there will have to be requisite scope to examine issues at the intersection of health and social care, which the committee has looked at.

With regard to the issue of underrepresented voices, which a number of members raised, it will be for whoever is appointed as the patient safety commissioner to determine on that. However, I agree that a firm commitment to underrepresented voices must sit at the heart of the role.

Tess White talked about women, and I am very proud to be the women's health minister. This is a key priority of the Scottish Government, and the women's health plan sets out actions that are designed to achieve long-term success. I hope that, if it is appropriate, there will be collaboration and overlap between the two areas.

I also agree that we need to get resourcing right. It needs to be transparent and accountable.

We discussed individual cases, and I have already offered to have a separate conversation with Paul Sweeney.

I underline the fact that we will have an independent process to hold the patient safety commissioner correct through Parliament, regardless of whether we have that through the committee as well.

Carol Mochan talked about the definition of patient safety, and there are a number of definitions of patient safety, whether the World Health Organization's or NHS England's. I suggest that the commissioner may perhaps wish to look at that.

The bill will establish an independent public advocate for patients in Scotland regarding the safety of healthcare who is accountable to this Parliament and thereby to the people of Scotland. The patient voice will be at the heart of the patient safety commissioner role. The commissioner will be informed at all times by the views of patients when deciding what they focus on and which issues they wish to investigate. Crucially, they will be accessible to patients in order to hear their stories directly. People sharing their views and experiences will be key to making the role work and to improving the safety of healthcare for us all.

This will be a significant step forward for patient safety in Scotland and will build on the extensive suite of rights that already enable patients to give feedback. I believe that the bill is an important and positive step in making Scotland's healthcare system more responsive to the needs of patients and the wider public. Let us work together to take this step and show the people of Scotland that we are committed to ensuring that their healthcare system is as safe as possible. As Stephanie Callaghan said, it matters to every single one of us.

I call on Parliament to support the general principles of the bill.

The Presiding Officer: That concludes the debate on the Patient Safety Commissioner for Scotland Bill at stage 1.

Patient Safety Commissioner for Scotland Bill: Financial Resolution

16:54

The Presiding Officer (Alison Johnstone): The next item of business is consideration of motion S6M-06897, on a financial resolution for the Patient Safety Commissioner for Scotland Bill. I invite Michael Matheson to move the motion.

Motion moved,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Patient Safety Commissioner for Scotland Bill, agrees to any expenditure of a kind referred to in Rule 9.12.3A of the Parliament's Standing Orders arising in consequence of the Act.—[*Michael Matheson*]

The Presiding Officer: The question on the motion will be put at decision time.

Business Motion

16:54

The Presiding Officer (Alison Johnstone): The next item of business is consideration of business motion S6M-08894, in the name of George Adam, on behalf of the Parliamentary Bureau, setting out a business programme. I invite George Adam to move the motion.

Motion moved,

That the Parliament agrees—

(a) the following programme of business—

Tuesday 16 May 2023	
2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Topical Questions (if selected)
followed by	Scottish Government Debate: Celebrating the Success of the COVID-19 Vaccination Programme
followed by	Committee Announcements
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 17 May 2023	
2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions: Constitution, External Affairs and Culture; Justice and Home Affairs
followed by	Scottish Labour Party Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
followed by	Approval of SSIs (if required)
5.10 pm	Decision Time
followed by	Members' Business
Thursday 18 May 2023	
11.40 am	Parliamentary Bureau Motions
11.40 am	General Questions
12.00 pm	First Minister's Questions
followed by	Members' Business
2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions: Education and Skills
followed by	Ministerial Statement: Delivery of the Agreed Recommendations of the Barclay Review of Non-domestic Rates
followed by	Scottish Government Debate: Securing a Sustainable Food Supply for Scotland

followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
Tuesday 23 May 2023	
2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Topical Questions (if selected)
followed by	Scottish Government Business
followed by	Committee Announcements
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 24 May 2023	
2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions: Wellbeing Economy, Fair Work and Energy; Finance and Parliamentary Business
followed by	Scottish Conservative and Unionist Party Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
followed by	Approval of SSIs (if required)
5.10 pm	Decision Time
followed by	Members' Business
Thursday 25 May 2023	
11.40 am	Parliamentary Bureau Motions
11.40 am	General Questions
12.00 pm	First Minister's Questions
followed by	Members' Business
2.30 pm	Parliamentary Bureau Motions
2.30 pm	Portfolio Questions: Net Zero and Just Transition
followed by	Rural Affairs and Islands Committee Debate: Future Agriculture Policy in Scotland
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time

(b) that, for the purposes of Portfolio Questions in the week beginning 15 May 2023, in rule 13.7.3, after the word "except" the words "to the extent to which the Presiding Officer considers that the questions are on the same or similar subject matter or" are inserted.—[*George Adam*]

Motion agreed to.

The Presiding Officer (Alison Johnstone): I am minded to accept a motion without notice, under rule 11.2.4 of standing orders, that decision time be brought forward to now. I invite the Minister for Parliamentary Business to move such a motion.

Motion moved,

That, under Rule 11.2.4, Decision Time be brought forward to 4.55 pm.—[*George Adam*]

Motion agreed to.

Decision Time

16:55

The Presiding Officer (Alison Johnstone): There are two questions to be put as a result of today's business. The first question is, that motion S6M-08869, in the name of Jenni Minto, on the Patient Safety Commissioner for Scotland Bill, be agreed to.

Motion agreed to,

That the Parliament agrees to the general principles of the Patient Safety Commissioner for Scotland Bill.

The Presiding Officer: The final question is, that motion S6M-06897, in the name of John Swinney, on a financial resolution for the Patient Safety Commissioner for Scotland Bill, be agreed to.

Motion agreed to,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Patient Safety Commissioner for Scotland Bill, agrees to any expenditure of a kind referred to in Rule 9.12.3A of the Parliament's Standing Orders arising in consequence of the Act.

The Presiding Officer: That concludes decision time.

St Michael's Hospital

The Deputy Presiding Officer (Annabelle Ewing): The final item of business is a members' business debate on motion S6M-08317, in the name of Fiona Hyslop, on the future of St Michael's hospital in Linlithgow, West Lothian. The debate will be concluded without any question being put.

Motion debated,

That the Parliament understands that the land for the St Michael's Hospital facility in Linlithgow was originally gifted by St Michael's Church in the 19th century for the purpose of providing a hospital and garden for the community, and that, due to temporary demands to move staff elsewhere in the NHS due to illness absences, it is currently closed; recognises what it sees as the long history of St Michael's in providing hospital services to the people of West Lothian, the Friends of St Michael's Group's hard work and dedication in supporting families with loved ones cared for at St Michael's Hospital, and the invaluable local support and spirit of solidarity that the local community provides to all who use the hospital; notes the view that there will be an ongoing need for a health facility providing end-of-life and step-down intermediary care and, potentially, new support services to match increasing home-based care in the north of West Lothian; recognises what it sees as the strong community support for the retention of the hospital and the campaign to maintain hospital and health services there, including, it understands, the large number of people who attended the information evening on 7 February 2023 organised by the Friends of St Michael's Group and addressed by West Lothian Health and Care Partnership, which, it considers, saw a willingness from all to identify the best future needs for patients and families and the role that the hospital could play; understands that West Lothian has a growing population that is already well in excess of that of the City of Dundee, and also has one of the highest proportions of older populations; acknowledges what it considers the continuing challenges in securing and resourcing staffing for any expansion of care at home, and the ongoing pressure on caring families; notes the West Lothian Health and Social Care Partnership's consultation on the current closure of St Michael's Hospital and its community bed review, and further notes the calls on the partnership to take a strategic view in favour of using the physical, social and community assets of St Michael's for the benefit of the growing population in the north of the county.

16:58

Fiona Hyslop (Linlithgow) (SNP): I thank all those members, across parties, who signed my motion, allowing me to bring this important debate to the chamber. I also thank my constituents and the Friends of St Michael's Hospital, some of whom are in the public gallery this evening, for their work on the campaign.

St Michael's is a community hospital that provides end-of-life care, respite and step-down intermediary care, and it supports patients who are waiting for care packages or for placement in a care home. It is situated in Linlithgow, in the north

of the county, and it supports patients from all over West Lothian.

St Michael's hospital is the only national health service facility of its type in the north of West Lothian. The land for the hospital was owned by St Michael's church and gifted to the health authorities at no cost in 1854, on the stipulated condition that it would remain land for a hospital facility and a garden for the people.

I understand that the former Conservative Secretary of State for Scotland Michael Forsyth MP confirmed to David Steel—not our former Presiding Officer, but his father, who was minister of St Michael's at the time—that the land would revert, with the buildings on it, to the kirk session if it ceased to be used for the purpose for which it was given.

In August 2021, the West Lothian health and social care partnership integration joint board took the decision to close St Michael's temporarily, using emergency powers, under pressure from short-term staff shortages across the NHS. A decision was taken to move patients and staff to Tippethill community hospital in Armadale, which allowed staff to be reassigned to St John's hospital in Livingston. St Michael's hospital remains closed.

In June 2022, a report to the West Lothian integration joint board contained two recommendations: that either St Michael's should remain closed or a public consultation should be held with all relevant parties to review future bed-space requirements at the hospital. If the minister is told that there were few patients previously, that is because the IJB did not refer them.

In February this year, West Lothian health and social care partnership held a public information meeting, which was organised by the Friends of St Michael's Hospital, on the future of the hospital. Hundreds of people attended that standing-room-only public meeting in the kirk hall, and the health and care management were left in no doubt about the importance of St Michael's hospital to the community. Many of those who attended the public meeting had relatives who had been cared for there.

The IJB then launched a review of bed capacity with a consultation, citing moves for care at home. The review is due to report next month. However, the same IJB has since announced that it wants to outsource care at home and six care-of-the-elderly residences in the future. Taken together, that all points to an IJB that wants to own no community properties for elderly care and that exists simply to contract out home care services. That is not on. We need the public provision of quality care, and the certainty of a home for older people in our county and community hospital care when they need it.

I implore the Minister for Social Care, Mental Wellbeing and Sport to look carefully at what West Lothian IJB is doing in removing public facilities with stealth tactics over a number of years. We know that the IJB's finances mean that it has to make savings, but we also know that it holds significant reserves. With such drastic action planned, now is the time to allow the IJB to release reserves in order to support care for our elderly population.

When I raised the need for step-down care and facilities such as St Michael's—and specifically St Michael's—with the First Minister in October 2021, when he was Cabinet Secretary for Health and Social Care, during questions on his winter planning and social care statement, he agreed to "stress" the need for community-based elderly nursing care and respite in the north of the county as a priority "with local partners".

My constituency of Linlithgow is the largest in Scotland by population. West Lothian as a whole has a growing and an ageing population. It is forecast to have the fastest growth in pensionable-age population in Scotland over the next 25 years, with an increase of 44 per cent, which is twice the Scottish average. In addition, there are no hospices in West Lothian, which means that, without St Michael's, families in West Lothian who require end-of-life palliative care to support their loved one will have to travel for almost an hour, to St Columba's in Granton in the north of Edinburgh or to the Marie Curie hospice in south Edinburgh.

The IJB has previously used statistics that underreport the scale of population growth in neighbouring Winchburgh. Given the high price of property in Edinburgh and major population growth in Queensferry and Kirkliston, joint provision with the west of Edinburgh for elderly care at St Michael's would surely make sense. There is a clear moral and needs-based argument to keep the site for health purposes, but there is also possibly a legal argument, if the health board thinks that it will sell lucrative land for housing, that the land might revert to church ownership.

The Friends of St Michael's Hospital is a dedicated and committed group of volunteers, and I thank them for their work and their support and care over the years for patients and their families. They were a lifeline to the families of those who were staying at St Michael's, and they provided emotional support to many. They also provided financial aid to families who needed that extra help—they paid for taxis and other public transport to make sure that patients got to see their loved ones when they were at their most vulnerable. As the local MSP for Linlithgow, and on behalf of all patients and families who have benefited from

care at St Michael's in the past—as patients and families will, I hope, in the future—I thank them.

We know that there are continuing challenges in securing and resourcing staffing for any expansion of care at home, and we recognise that senior managers at West Lothian health and social care partnership have been clear that no decision has been taken about St Michael's and have made commitments to maintain the fabric of the hospital, pending their review. However, I reiterate my call to the partnership to take a strategic view in favour of using the physical, social and community assets of St Michael's for the benefit of the growing population in the north of the county.

It is clear that there will be an on-going need for a health facility that provides end-of-life and step-down intermediary care and, potentially, new support services to match the increase in home-based care for a rapidly growing elderly population in the north of West Lothian. The strong spirit and solidarity of local people who support the retention of the hospital exist because of the extraordinary nature of the way in which St Michael's hospital and the Friends of St Michael's Hospital have cared for their loved ones and their families. St Michael's hospital must be retained to benefit the communities and the families who depend on it.

17:05

Sue Webber (Lothian) (Con): I welcome the chance to speak about the future of St Michael's hospital, in Linlithgow, and I thank Fiona Hyslop for bringing the debate to the chamber. Like her, I believe that local health services are a vital part of our local communities and, as we know, St Michael's hospital has served the community for many years. However, the current situation demands that we take a hard look at the hospital's viability and its role in meeting the healthcare needs of the community.

St Michael's was first shut in August 2021, in response to acute staffing pressures that were created by Covid-19. That is a clear indication that the hospital was struggling to provide the level of care that was needed. It is important that it was a temporary closure, and it was done using emergency powers.

In West Lothian, we have a growing population that is well in excess of that of Dundee, and we have one of the highest proportions of older people. West Lothian needs a healthcare system that can meet the needs of the community now and in the future. As Ms Hyslop said, West Lothian has the fastest-growing population of pensionable age, with a projected increase of 44 per cent—twice the Scottish average. I, too, put on record my support with regard to the concerns about the data that is being used in relation to population growth across West Lothian.

The importance of the hospital to the local community cannot be overemphasised. I draw parallels with what is happening elsewhere within the NHS Lothian boundary, with the Edington hospital in East Lothian. That hospital remains closed as a result of very similar issues, so the situation with St Michael's is not simply an isolated incident in West Lothian.

Supporting, developing and protecting our workforce is vital and, in order to ensure that that happens, there will need to be active talent management and succession planning across NHS Lothian, in addition to recruitment and retention initiatives. That is key to keeping our local services in the communities open and thriving. Although I acknowledge the campaign to maintain the hospital and the health services at St Michael's, we must take a view that considers the future needs of patients and families in the area.

West Lothian health and social care partnership's consultation on the current closure of St Michael's hospital and its community bed review was an important step in understanding which direction needs to be taken. When I visited St Michael's last year, it was clear that the building was not in a good state of repair and that it would need significant investment to restore it to what would be expected in order to meet the standards that are required for modern healthcare. However, the Scottish National Party Government's funding decisions have resulted in the West Lothian IJB needing to save an eye-watering £17 million. Any decision to close St Michael's hospital must therefore be accompanied by a clear plan to ensure that the healthcare needs of the community are met in a way that is sustainable, effective and equitable.

Unfortunately, there is a funding shortfall in NHS Lothian relative to other health boards under the NHS Scotland resource allocation committee formula. In the 2022-23 financial year, that equates to approximately £14 million. That alone is a huge challenge, but, over the past decade, that equates to more than £100 million. If we are to continue services in the community across the Lothian region, that must be rectified, with reference to the changes in population in West Lothian specifically.

In conclusion, although the history of St Michael's hospital is important, we must prioritise the needs of the community and ensure that we have a healthcare system that can meet those needs in the future. I urge my fellow members to work together to find a sustainable and effective solution that meets the healthcare needs of the people of West Lothian.

17:09

Gordon MacDonald (Edinburgh Pentlands) (SNP): I thank my colleague Fiona Hyslop for securing this members' business debate. I point out that my wife is a district nurse in West Lothian.

As Fiona Hyslop outlined, St Michael's is the only hospital facility of its kind in that part of West Lothian. If it were to permanently close, patients and their families would be forced to use other sites, such as Tippethill House hospital in Armadale or one of the two respite and end-of-life centres in Edinburgh—St Columba's hospice in the north of the city and the Marie Curie hospice in my constituency of Edinburgh Pentlands. I have visited the Marie Curie hospice at Fairmilehead on many occasions and I recognise the dedication that the staff have to provide compassionate end-of-life care. However, the hospice has only 20 in-patient beds—a situation that is increasing pressure even without the proposed closure in West Lothian.

The Friends of St Michael's Hospital group has been unwavering in its support for the families of its patients, with regard to both emotional support and financial assistance. As Fiona Hyslop highlighted, the group has paid for many family members' taxis from different parts of West Lothian to the hospital—something that I am not certain that other hospitals would be in a position to offer, particularly if the journey were into Edinburgh, which is obviously more costly.

It is not just about the financial cost but about the time that is taken to travel and the ease of travelling, especially at peak times, given the congestion on the A71 into Edinburgh or, indeed, on the city bypass. It is especially difficult for people without a car who rely on public transport, given the recent cuts in bus services across West Lothian.

The closure of the St Michael's facility, which is forcing patients to other ones such as the Marie Curie hospice or St Columba's hospice, is already creating a huge stumbling block with regard to the patients' most basic need of spending time with their family and friends. How do those family members and friends—especially the elderly and vulnerable—get to the hospital to visit their loved ones, given the transport issues that I mentioned?

The proposed permanent closure is happening at a time when West Lothian has a growing older population, which means that the need for access to healthcare facilities will only increase. Hospital sites such as St Michael's will be in demand, from use as a step-down facility to relieve delayed discharge to provision of respite and end-of-life care. That is not to mention the fact that diverting patients elsewhere—indeed, out of West Lothian—reduces not only the availability of local healthcare but the number of jobs that are required to offer a fully functioning service.

On the suggestion that West Lothian patients could be moved to the city hospitals, I note that, in the 10 years to 2021, Edinburgh's population grew by 10 per cent to 526,000 and that it is expected to grow by another 26,000 by 2028. Edinburgh's 75-and-over population is projected to see a 25 per cent increase in the period to 2028.

I believe that the closure of St Michael's would be a retrograde step and that it should be paused until we understand the impact of the National Care Service (Scotland) Bill, which is proceeding through Parliament. I believe that stripping services at this point would be reckless.

Fiona Hyslop has raised the issue previously, and I know that she will continue to raise it in Parliament and with NHS Lothian and other stakeholders until a positive outcome for both the community hospital and the people who need to access its facilities now and in the future is secured.

17:14

Foysol Choudhury (Lothian) (Lab): I thank Fiona Hyslop for bringing the motion to the chamber so that we can discuss this important issue. In January, I wrote to the chief executive of NHS Lothian to express the concerns of my constituents, who were worried about the lack of end-of-life care at their nearest hospital—St John's hospital.

I also addressed the lack of GP surgeries in the area and the fact that the possible closure of St Michael's would be catastrophic if no alternative palliative and respite care services were made available. Constituents were also concerned that that might lead to nurses retiring earlier, adding to the overall pressures on the NHS.

The original purpose of St Michael's hospital was to provide a service for the local community, and that was thanks to the amazing dedication and commitment of the Friends of St Michael's Hospital group. For so many of my constituents, St Michael's hospital is not only vital for providing hospital and crucial end-of-life care but acts as a community hub, supporting families with loved ones who are being cared for at the hospital.

The SNP has been in power for the past 16 years, yet the state of the health and social care sector has deteriorated due to chronic underfunding and mismanagement. Local government and the integration joint board in West Lothian have been starved of resources and left between a rock and a hard place. St Michael's hospital is just one example of the current crisis in health and social care in West Lothian.

Many members might be aware of the public meeting last evening about the privatisation of care homes in West Lothian. More than 200 local residents turned up to express their concerns about the future of social care in West Lothian and the local residents who rely so heavily on it. I attended the meeting on behalf of my Lothian Scottish Labour colleagues, and there was clear frustration and anger about the insufficient resources and funding for health and social care. That is a result of cuts, made by the Scottish Government, which are putting councils under pressure.

It is important that all Lothian MSPs meet together now to discuss how we can get extra resources and funding allocated to health and social care in West Lothian and in Lothian generally and how we can move forward and tackle this crisis. A cross-party approach to that is essential.

Once again, I thank my colleague Fiona Hyslop for bringing attention to the issue, and I look forward to meeting with my Lothian colleagues soon, to deal with the crisis in health and social care in West Lothian.

17:17

The Minister for Social Care, Mental Wellbeing and Sport (Maree Todd): I thank Fiona Hyslop for bringing the debate to Parliament. I am grateful for her commitment to championing the role of St Michael's hospital. I am also grateful to the Friends of St Michael's Hospital, and similar groups across the country, that work hard to support those who benefit from community hospitals.

As others have said, St Michael's hospital was originally gifted by St Michael's church in the 19th century for the wider benefit of the community—a principle that endures today. Caring for individuals, whether they are our loved ones or members of our wider community, is a fundamental shared responsibility of us all, personally and as a wider society. I am committed to ensuring that we do that by providing those who need it with the utmost care, dignity and respect.

I pay tribute and place on record my thanks to all the individuals and teams who make that happen right across the country, from our unpaid carers to our social care staff, allied health professionals and clinicians. We are all indebted to the teams who provide care right across our health and social care system.

We all know that the best bed for us to be in is our own bed. When that is not possible, being close to home is extremely important for the individual and their family. Ensuring that people are cared for in the right place at the right time is absolutely at the heart of everything that we do, and community hospitals play a vital part in that. They provide care closer to people's homes that is personalised, holistic and patient centred.

Our community hospitals, including St Michael's, can provide a wide range of services, including non-acute in-patient services, rehabilitation services and palliative care. They form a crucial element in facilitating service integration locally, functioning as an integrator of services and as a locale for the development of a single point of access to services.

Palliative and end-of-life care spans a wide range of professionals and sectors, with clinical and social care being delivered in acute hospitals, community hospitals, hospices, care homes and people's own homes. The Scottish Government is committed to ensuring that everyone who needs it can access seamless, timely and high-quality palliative care.

We are developing a new strategy to achieve the highest standards of care up to the end of life. We will develop a strategy that reflects what matters to people who are experiencing serious illness, dying and bereavement. We are reviewing the information and evidence that we have about people's experiences of palliative and end-of-life care and bereavement to inform our strategy going forward. That will contribute to a holistic, integrated and multidisciplinary approach, which will ensure access to palliative and end-of-life care wherever and whenever it is needed, and which has the person and their families and carers at the centre.

As we seek to ensure that our services reflect the changing needs of patients and wider society, we must harness advancements in technology such as home health monitoring, community alarms and the Near Me service. We are constantly looking to develop clinical and care pathways to prevent people from being admitted to hospital.

For example, our hospital at home programme is an innovative approach to providing hospital-level care for patients in the comfort of their own home. We know that it assists with the recovery of patients as well as alleviating pressure on acute sites, emergency departments and the Scottish Ambulance Service. Hospital at home currently provides levels of virtual capacity matching that of St John's hospital in West Lothian. I am pleased that we are continuing to fund the expansion of the programme by providing Healthcare Improvement Scotland with a further £3.6 million in the current financial year to support more than 150 additional virtual beds.

Innovations linked to the advance of technology, such as the hospital at home programme, enable

health and social care partnerships to be more creative and pragmatic when designing future service provision. The design of those services must always put the patient at the centre by working with them and for them to provide the best level of care to suit their needs.

However, it is really important that decisions on how services are delivered are made at a local level in consultation with those who use services to ensure that local needs are met in the best way. I am aware that the consultation regarding St Michael's is on-going and I do not want to influence the outcome of that consultation in any way. My officials will continue to engage with West Lothian health and social care partnership as the consultation progresses, and they stand ready to provide support where appropriate. More generally, we will also continue to work with partners and people with lived experience to make sure that our social care services work for everyone.

On the point about population levels expanding, I am comfortable with my officials reaching in to the HSCP and making sure that it is using the most up to date and relevant data on population level as part of its strategic planning, if that would be helpful.

On funding, the door is always open to NHS boards to discuss funding with Scottish Government health officials. Sue Webber raised the NRAC formula, which is always contentious. On the point that Foysol Choudhury raised about local authority funding, the real-terms increase of £376 million, or 3 per cent, to local government applies. West Lothian is therefore getting £405 million to fund local services, which equates to £17.5 million to support day services.

Fiona Hyslop: I am not sure whether the minister is aware that West Lothian Council received an 8.9 per cent uplift in the current financial year, which is second only to what the city of Aberdeen received.

Maree Todd: I was not aware of that, but it is a good point to make at this juncture.

Funding is undoubtedly challenging, and I share the concerns of the IJBs and HSCPs. However, the Government has to balance finite resources and make tough decisions. The Scottish Government has an open-door policy when concerns need to be raised.

I will conclude where I began. The cornerstone of our health and social care system is the people who work tirelessly day in and day out to support individuals. I am grateful to them all. I am also grateful to communities such as the Friends of St Michael's Hospital for their dedication to providing care to individuals and their families.

Meeting closed at 17:25.

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