OFFICIAL REPORT
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DRAFT

Health, Social Care and Sport Committee

Tuesday 3 February 2026

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 3 February 2026

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
5th Meeting 2026, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Tom Arthur (Minister for Social Care and Mental Wellbeing)
Sandra Auld (Perth and Kinross Integration Joint Board)
Matt Crilly (Convention of Scottish Local Authorities)
Rob Gowans (Health and Social Care Alliance Scotland)
Councillor Paul Kelly (Convention of Scottish Local Authorities)
Imogen Lambert (Scottish Government)
John Paul Liddle (Scottish Government)
Natalie Masterson (Third Sector Interface Scotland Network)
Jenni Minto (Minister for Public Health and Women's Health)
Stephen Smellie (Unison)
Karen Titchener (Patient Safety Commissioner for Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 3 February 2026

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the fifth meeting in 2026 of the Health, Social Care and Sport Committee. I have received no apologies for today's meeting.

The first item on our agenda is a decision on taking business in private. Do members agree to take items 6 and 7 in private?

Members *indicated agreement.*

Patient Safety Commissioner for Scotland

09:15

The Convener: The second item on our agenda is an oral evidence-taking session with the Patient Safety Commissioner for Scotland. The committee had lead responsibility for scrutinising the primary legislation that created the role of the Patient Safety Commissioner earlier this session, and this morning, members will have an opportunity to ask Scotland's first Patient Safety Commissioner about her experience of the role and initial priorities since her appointment began last September. I welcome to the committee Karen Titchener, the Patient Safety Commissioner for Scotland. We will move straight to questions.

Emma Harper (South Scotland) (SNP): Good morning. During the whole process of establishing the Patient Safety Commissioner, it was stressed that public confidence in Scotland's healthcare system was a core reason for establishing a commissioner who was independent. Therefore, I would be interested to hear how you can demonstrate independence from Government in order to pursue your Patient Safety Commissioner role.

Karen Titchener (Patient Safety Commissioner for Scotland): Thank you for that question, and thank you for allowing me to be here today.

At every meeting and at every point, the first thing that I say is that I am independent of the national health service, and of Government. I try to emphasise that to anybody I meet. In order for this role to be successful, I have to collaborate with people, because I cannot do this work in silo, and the question, for me, is how I measure that collaboration while remaining fiercely independent. I have to ensure that when I meet Government, or an NHS board, I still have that independent voice.

Indeed, I am about the only independent on the latest maternity and neonatal task force. The Royal College for Nursing is represented on it, but most of the task force is made up of board members, representatives from Healthcare Improvement Scotland and so on. I said at a meeting of the group, "Just so you know, I am always going to bring it back to the fact that I'm independent and that we need to have independent voices at all of these meetings." Independence is fiercely in my DNA with regard to this role, and I hope that I am able to be independent.

Emma Harper: Do you think that the current statutory provisions give you enough independence, or are there any limitations?

Karen Titchener: I have it in my head that there might be, but I have been in position for only five months. I do not have my team in place yet, so I have not opened the floodgates to major investigations and inquiries.

I hope that there is enough in the Patient Safety Commissioner legislation that, if I find something very serious, I can act. Again, though, I have been discussing escalations in that respect. In the same way that Healthcare Improvement Scotland can escalate to Government, I am hoping that I can have that kind of tiered approach when I am concerned about something.

Emma Harper: I think that we are almost at the two-year anniversary of the publication of a report by the Patient Safety Commissioner in England, and it was the fact that people such as mesh survivors felt that they were never listened to that led to the establishment of the Patient Safety Commissioner in England. We have also taken evidence on sodium valproate and Primodos and how they have affected people. How do you support and give confidence to people who have been failed previously and who feel they have not been listened to? How do we take that forward?

Karen Titchener: The legislation specifically says that I should not look at the past, but I have been very involved with sodium valproate in Scotland as well as with the mesh group. In fact, when I was down at the House of Commons last Thursday, I was invited to a patient safety forum, and the mesh advocate down there and Henrietta Hughes, the English Patient Safety Commissioner, were there. Indeed, Henrietta has brought out the Hughes report in order to get Westminster to move forward with redress.

In Scotland, the main concern for patients is twofold. There is the issue of redress, but people also need to understand the syndrome that is attached to the medication. When those affected go to social care and try to get help, people think, “What is sodium valproate syndrome?” I have been speaking to the health minister and asking whether there is anything that we can do while we are marking time and waiting for the Westminster decision, because patients’ lives are being affected now and today by the on-going situation. I did not really get anywhere with that, but I am still seeing whether we can we push Westminster on this; after all, we have a large patient group that is affected by this. Only yesterday, I heard that Henrietta Hughes is meeting Westminster to say, “This has been dragging on long enough. How are we doing this?”

I am very involved with the issue in both England and Scotland, because some of this involves Government decisions on issues that have not been devolved. I am trying to think how we can drive things forward to ensure that patients still feel heard and listened to, and that we do something about this.

Emma Harper: Finally, has there been any movement on redress, or is it just not going anywhere? Is there a reluctance to address the issue of redress for sodium valproate?

Karen Titchener: There is reluctance, because of the amount of money that it is going to cost. I meet the Medicines and Healthcare products Regulatory Agency every month, and when I have asked about this issue, it has talked about the huge cost of redress. It has still not decided whether it is even going to provide redress, let alone how much it is going to provide.

That is why I have been saying that we have to do something about this. After all, the Cumberlege report came out five years ago, I think, so the question is: where are we with that? We have to keep pressing Westminster, so I am still talking to Henrietta Hughes about it and asking, “What can I do to help you move this forward?”

Emma Harper: Thank you.

David Torrance (Kirkcaldy) (SNP): Good morning, commissioner. What mechanisms and processes will you establish to ensure that meaningful participation of individuals with lived experience shapes the work of your office?

Karen Titchener: We are doing two things—well, we are doing many things, but, first of all, I would highlight the advisory group that I am establishing, which will meet in March for the first time. I have not quite narrowed that down to a date yet, because I am waiting for my team to come, but the group has to have 50 per cent patient representation and 50 per cent clinical representation, so it will have the voice of the patients on it. I can probably get more voices in there as it grows; at the minute, there are only six people on it, but it has to have a 50:50 balance.

The reason why I am on, say, the maternity and neonatal task force is absolutely to represent the lived experience of all families, not just the mums who have serious concerns about maternity care in Scotland. Wherever I go and whatever I am invited to, lived experience is the biggest thing that I bring. For example, I have been out to Stranraer to meet people who have been affected by the reduction of maternity services there. I am talking to people in Wick and up that way, and they want me to go up and meet them. I have been out to patients’ homes. Members of the Scottish Parliament have said that they feel that the voice of the patient still needs to be heard, even though their operation was in 2007. If they have not felt heard almost 20 years later, we are doing something wrong.

I say to people that I do not come with a magic wand or a pot of money, but I come with a listening ear and I ask them what it is that they are asking for to find their peace, if you like, 20 years on. If they are still anxious and concerned about what happened, we have to look at how we address that.

Some of the Stranraer families still have post-traumatic stress disorder from the things that happened, so I am asking NHS Dumfries and Galloway: what is it doing about serving patients who feel that its care damaged them emotionally? I tell the health board that it should be supporting those patients through that. I am pushing back and challenging the status quo, because that is my role.

David Torrance: How do you ensure that disabled patients, ethnic minority groups and rural communities are captured meaningfully in what you are doing?

Karen Titchener: I have met many disabled people on Teams and said to them that, when I can balance the representation on the advisory group, they will come on to that. Someone whose care ended up making him disabled will bring a meaningful discussion to the table.

I have not got my website set up yet. I am in the process of doing so, but everything takes a long time. When I have it set up, I want it to be open access so that people can have a discussion with my office. I am also willing to travel out, because, for example, when the people in Wick were talking to me about maternity care, they said that they cannot travel to me, so I said, “That’s fine—I will come to meet you.” I want to meet the patients where they are at, but the act says that I cannot interfere or repeat processes. If it is an individual complaint, they have to go to the Scottish Public Services Ombudsman and do other things before that.

I try not to interfere with due process but, at the end of the day, I still want to support patients who feel that they are not being supported while they are going through something. I do not turn people away, but I do signpost them. The whole point is all about hearing the patients, and even now, I am hearing stories about how the patient’s voice is still being ignored. We have to do better in Scotland to amplify that voice and change healthcare practice because of it.

That is the big picture. The small picture is about how I do that on a daily basis. In whatever I do and the conversations that I have, I always bring a patient’s story to that to say that, although we might think that there is nothing to see here, the lived experience is saying something different.

David Torrance: I have no further questions, convener.

Sandesh Gulhane (Glasgow) (Con): I make a declaration of interest as I am a practising NHS general practitioner.

I turn to the Queen Elizabeth university hospital scandal. Several families were lied to by NHS Greater Glasgow and Clyde over many years and the Scottish Government ignored their concern. On top of that, whistleblowers were sidelined, called troublemakers and put in danger of losing their jobs. What are you doing to ensure that the Government and health boards listen to the voices of patients like them and the whistleblowers?

Karen Titchener: That is still going on. Only yesterday, I had a conversation with a nurse who is afraid for her job, so she will not whistleblow, but she is talking to me. It is hard to not expose people who are living in fear while trying to implement change.

I agree with you and families are still being lied to and staff shut down rather than whistleblowing. When that comes to my attention and I hear about it, it is very important to me. At the minute, I am getting lots of candid reports. If I do not have a name and I do not hear about the issue directly, it is very hard to go with that. Yesterday, when I heard about that situation, I said that I would have to talk to the person, rather than it being a third-hand experience.

09:30

The role of Patient Safety Commissioner will grow, but it is still in its infancy—we have not even got our website up and running. In relation to the inquiry that you mentioned, rather than having lots of inquiries, we have to make sure that patients and staff are listened to on day 1 when they have concerns. If the processes that we have in place are not working, the issues will fall at my door. Rest assured that I am no wallflower and, if I hear from a patient about something that is endangering life, I will be going straight to the top—to the Cabinet Secretary for Health and Social Care. I have already promised him that, if I hear something, he will be the first person to hear it next.

If we are going to work collaboratively, we cannot have a shotgun approach. It has to be done so that the Government knows about it. At the same time, if I tell the health secretary something and nothing gets done, I will still make sure that that voice is heard, whether that means going to the press or to the health boards. We have to make sure that we are not bolting the door when the horse has already gone.

What I want for Scottish health is proactive, pre-emptive measures, rather than drama when something has happened. It is about looking for the little signs that are telling a story. I have already spoken to the ombudsman and said that, if they are seeing themes in a hospital and think, “Hang on a minute, this is the third time this has happened,” they must speak up and say, “Karen, I am a bit worried about this, because this is now the third patient who is reporting that.”

The problem is that we have no national reporting that brings all the facts together. Therefore, we are working in a very siloed area, where there are little reports—Datix reports and adverse events reports—and there is the ombudsman and Healthcare Improvement Scotland. I feel that we need to bring all the evidence together and, at the early stages, when we detect that something is going wrong, we need to do something about it there and then, rather than waiting for the 10th patient to tell their story.

Sandesh Gulhane: I am glad to hear you speaking like this because—let us be frank and honest—this culture within health boards of secrecy, shutting down staff and gaslighting families is not new to the Queen Elizabeth university hospital scandal. This has been going on and on. I have been in the NHS for almost two decades, and that culture has been there the entire time that I have been there. That is because our management are working with complete impunity. Nothing affects them. At the end of the day, when scandals break, something happens, and we move on, but nothing happens to the management. What can you do to hold management to account?

Karen Titchener: I agree. I think that accountability is the biggest failing, because people hide behind the institution. Absolutely, accountability is one of my first things that I will be looking at. That is not about blame, but we cannot get change if there is no accountability and people are not speaking up and saying, “Yeah, we got that wrong.” That is what most of the patients want to hear. They just want somebody to say, “Karen, that care was terrible, and I’m really sorry. The next time, we’re going to do something else.” I have that lived experience with my mum, who died a horrible death in the hospital that I trained in as a nurse. When I made a complaint, all I wanted was that nobody else would die like she died. I said, “You wouldn’t allow a dog to die like that, but you allowed my mum to die like that.” All I wanted them to do was to say, “Karen, we’re going to bring in training for our staff on end-of-life care.” We know that that is something that hospitals are bad at in Scotland.

Obviously Pandora’s box is very big, and there are lots of areas where care could be better, but, for me, it is about holding people’s feet to the fire and saying that I will not let it go until accountability has been recognised and voiced, and change has happened. If we brush things under the carpet, nothing will change, and care will not be better. Scotland does a lot of things well, so let us make sure that our patient safety is recognised at a global level. I want Scotland to be the safest place in the world to have surgery and to go to accident and emergency. We must do that together. My office is very small, but it will be very influential and it will be a mighty division of the army of healthcare in Scotland.

Sandesh Gulhane: I am glad to hear that. The big concern for me—you will know this, as a former nurse—is that nurses are really vulnerable when it comes to whistleblowing. Doctors have a bit more protection, especially at the more senior levels, but it is still very difficult, and nurses are very vulnerable.

I will ask my final question. After concerns were raised by the Women’s Rights Network, you called for health boards to consistently record or categorise all incidents of sexual assault and rape, which was not being done. The Cabinet Secretary for Health and Social Care says that it is now happening. Is it actually happening?

Karen Titchener: I had that conversation with the health secretary at our last meeting and was reassured, as you were, that that is happening. I am speaking with the Women’s Rights Network to see what it is hearing about that.

At the meeting about that issue that I went to, many points were raised, such as chaperone policies. This is about basic human rights and human needs. Even last week, I was hearing of staff who, because of their concern about losing their job, would not whistleblow about male patients identifying as female patients on acute mental health wards and female patients having to lock themselves in their rooms because they were concerned about that. We have not even got that right. Everybody has a right to care. I am not getting into the gender realignment discussion, but I am hearing too many times about concerns for patients. My remit is safety, and if patients are not feeling safe and are locking themselves in their rooms, who is looking after their mental health?

I hear stories of nurses having to share changing rooms—not just the case that is in the press. Whether it is in relation to healthcare or prisons, we have to decide what we are going to do about listening to that voice and keeping patients safe, because everybody has a right to care. This is not about a male who wants to identify as a female, because that is their right; we have a duty not just to give them the care that they need, but to protect the other patients. Why are we not doing single-sex wards—particularly for mental health patients? I am very concerned about that, because they are a very vulnerable group, as are older people in care. I really want to make sure that that recording is happening, and, over the next month or so, we will look at what has actually taken place after that report was given.

Emma Harper: Going back to Stranraer, I remind everybody that I am still a nurse. I trained in NHS Dumfries and Galloway and worked in NHS Dumfries and Galloway, and Stranraer is the town that I was born in, so I have a particular interest in the maternity services there. I have been working with the Galloway community hospital action group, as have other colleagues at this table. We have been campaigning with that group and helping them to look at options for a long time now, since 2017, when babies stopped being born at the Galloway community hospital. I am interested to hear your current position on that. Is there a way forward? Some action has been taken in that there are overnight stays when early labour is presented, instead of women being sent back to Newton Stewart or Glenluce, but I would be interested in an update on the current situation.

Karen Titchener: I was going to have a meeting with NHS Dumfries and Galloway and the action group. We did not get the information that we asked for, so I had to cancel that meeting. Last Friday, I met with people from NHS Dumfries and Galloway—the director of nursing, the director of midwifery and the medical director—and they will get me the information that they did not give me for that meeting.

I understand the need to centralise things in order to get the expertise, but what I was trying to say to the board is that it has not demonstrated its risk mitigation. It has closed down the services but it has not reassured me about what it has done to ensure that somebody who is in labour in Stranraer is safe, or what it has done about response times for ambulances or about local responders. For example, is there somebody who has Entonox? I heard about a lady having to travel from Wick to Inverness in an ambulance that did not have gas and air, and I thought, “What ambulance doesn’t have gas and air? I don’t understand.”

We need to look at rural communities and, actually, we should not be doing that as a whole, because every rural community is distinct. Stranraer is distinct from the communities in the north. I want to see what Dumfries and Galloway can do. It is trying to reassure me, and it says that patient safety is paramount in what it is trying to do. I said to the board, “You’re failing to impart your risk mitigation to the locals, because they still feel that they’re not served well and are vulnerable and at risk when they are giving birth.”

We are in discussions on that. I am going to meet the head midwife, who will take me round Dumfries hospital, and I am also going to meet the midwives in Stranraer. I have to get both sides of the story and hear how everyone feels, but, as with the BBC story on the Edinburgh hospital, those midwives have to feel free and able to tell me their concerns. However, I agree that the issue has been going on for too long. That is why I have tried to force it by saying, “You need to tell me what mitigating actions you’re taking after you have retracted a service that was serving the local community.”

Emma Harper: Do you mean mitigation measures such as making sure that accident and emergency teams have some SCOTTIE-ED—Scottish core obstetric teaching and training in emergencies for emergency departments—training for pregnancy emergencies, or something like that?

Karen Titchener: Exactly. That is what happens in the north. People are allowed to go to the emergency room. That is not the ideal place to have a baby, but at least it is a safe environment. However, the community in Stranraer are told that they cannot go to A and E.

I am also going to speak to the Scottish Ambulance Service. I am thinking, “Hang on—if I have a heart attack, you’ll medevac me to A and E, but, if I’m in labour with twins, as has happened in the north, you’ll put me in an ambulance, I’ll have a baby in one place and then move on and have a baby in another.” Why are we not thinking about maternity when we are looking at these issues?

We have to look to places such as Australia, which has communities that are more rural than the ones that we have, and think about what they do and therefore what we are doing. For me, it is about how we are going to do this. Part of the mitigation is about thinking differently. This is not just about brushing it under the carpet and saying, “We feel that everything is in place and these patients are safe.” I do not feel they are, which is why I am pushing back and saying, “What are you doing to mitigate the risk?” That is, for me, about more local intervention for those people.

09:45

I agree with you—quite why they were sending somebody back home when they were in labour, I do not know. Again, I asked for the figures of how many people they were offering accommodation to, and they said, “We don’t do that, because we can put them somewhere.” I said, “That’s not what I heard. I heard that you had no room at the inn and that you sent people all the way back home, even though they were 5cm dilated.” There is a gap between the lived experience and the perception of the lived experience.

Carol Mochan (South Scotland) (Lab): Your discussion with Emma Harper was very helpful. I have spoken to people in that area and, right through pregnancy, there is some of that batting back and forth. As you say, it is about trying to help people to understand each other's side and come to a conclusion. It is helpful to hear that you will be doing that work.

That leads on to the questions that I was going to ask you. You mentioned that there is such a big remit and that it is a Pandora's box. I am interested to know how you are going to select your strategic priorities. Have you had a think about that? The committee's report highlighted that it would be important to have a strategic plan. Is that starting to get put into place?

Karen Titchener: Again, I am waiting for my team to come on board, so that it is not my strategic plan. I am also waiting for the principles of the office and the charter of the office, because those have to be agreed by the advisory board and the Scottish Parliamentary Corporate Body.

In relation to a strategic plan, what is the thing that I need to focus on now? This is an eight-year tenure—clearly, Scotland realised that magic was not going to happen overnight and that it was going to take time. I really want to think about what we can impact within the first year and what we can impact moving forward and the long-term plan.

Obviously, maternity is a big focus and I am now on the task force for that. On women's rights and how safe our hospitals are, I really want to make sure that we have dotted all the i's and crossed all the t's. Since that report, patients should be feeling safer, but they are not, because things have not been implemented, so I want to follow that through.

I have come from England, which has the Care Quality Commission, but you have HIS, which is not a regulator but an inspector that also does improvement. That is not critical, but it does blur the edges. How can you be a good cop and a bad cop? Some of the improvement that HIS does comes without a pot of money, which is restrictive. If you see bad practice and you are telling boards that they need to change but you do not have any authority to help them to make that change, it is quite difficult.

I am still trying to get my head around the regulatory field in Scotland, because it is about accountability and making sure that we are doing the right thing for the patient. Is that my first goal? No, but I am a little wary of the powers that other organisations have and whether those are enough to make sure that we are moving at speed.

I worry about inquiries and task groups, because, for me, maternity needs sorted now, not in five years, so, if it went to an inquiry, that would be a bad thing for maternity and for patients. The service needs to be redesigned. It needs people in a room with a whiteboard saying, "What we're doing is not working for patients, so how can we move it forward?"

Having many years of big operational experience, I know that that is not my job, so I have to pull back and say, "I can't sort everything." However, let us consider not inquiries but service redesign and change.

Carol Mochan: As part of your plan, do you see yourself saying that people are telling us about issues now and that we need action to address them now?

Karen Titchener: Yes.

Carol Mochan: That is very helpful.

Karen Titchener: That is what I am trying to do at Stranraer. I am saying, "Look, guys—patients aren't hearing what you're telling them is going on. It's not working." Parents still feel vulnerable. Pregnant mums still feel vulnerable. We have to do something about that now; we cannot leave it for another five years.

Carol Mochan: My final question was going to be whether your plan will be dynamic enough to deal with issues as they emerge, but it definitely sounds as though, as well as doing what you are doing, you will aim to deal with issues that emerge if they can be dealt with quickly.

Karen Titchener: Yes.

Carol Mochan: Lovely. Thank you.

Joe FitzPatrick (Dundee City West) (SNP): I was not going to come in here, but you have said a couple of times something that will concern some of the most vulnerable patients in Scotland: trans patients. A couple of times, you have almost implied that women need to be protected from trans patients, so I just want to give you the opportunity to make it clear that, as well as protecting women's rights, we should be protecting trans people's rights.

Karen Titchener: Exactly. I was saying that everybody has a right to care. There could be the perception of danger, but that does not mean that there is actual danger. However, what we are not doing is protecting both groups. Female patients might be feeling vulnerable, and there might be male nurses working. The situation with a trans patient should not be any different from a safety point of view. If there are two vulnerable people who both need exactly the same care, it is really important that they both perceive that they are getting the right care for them. We need to look at that issue, because I do not think that we are being very clear.

Joe FitzPatrick: You said that you are speaking to the Women's Rights Network, which takes a particular view in relation to excluding trans people. Are you also speaking to LGBTQ organisations, to ensure that you hear the lived experience of that very vulnerable group of people, particularly trans patients?

Karen Titchener: I have not spoken with them yet.

The Convener: But you will.

Karen Titchener: Yes.

Gillian Mackay (Central Scotland) (Green): As we know, the Patient Safety Commissioner has no remit to deal with individual complaints from patients. How do you plan to communicate that clearly to the public and manage patient expectations about your role and the level of support that you can provide?

Karen Titchener: That work has started. Once my website is up and running—in, I hope, a month or a couple of months—I will put what we do and what we do not do on the front page, so that it is clear. I explain my role in my presentations to health boards and so on. If patients come to me, I say to them that I do not deal with individual complaints and direct them to the ombudsman, but I say that I am still here, because I do not want them to feel as though I am passing them off and their voice is not being heard. I say, "Please come back to me if you're not satisfied with how you get on."

Some individual patient complaints show that there is a systemic problem. There is a balance to be struck when considering whether it is a case of an individual patient having received bad or unsafe care or whether there is a system-wide problem. I always listen to the person's story when considering whether the case is a one-off or whether a review is needed. However, we cannot blur the lines between what the ombudsman does, which involves dealing with individual complaints, and what my office should be doing.

Gillian Mackay: That is great. To overcome perceptions of a cluttered landscape of scrutiny, do you plan to develop any protocols or memoranda of understanding with other scrutiny bodies?

Karen Titchener: Yes. In fact, I just got some through yesterday. I am trying to do that so that we can share information and so that our defined roles are very clear and we do not tread on each other's toes. Even though we have HIS, the Nursing and Midwifery Council and the General Medical Council, some patients write to me thinking that I can get a doctor struck off a register and things like that, so it is very important not only that I understand but that patients understand that that is not my role. I am definitely starting to develop memoranda of understanding with other bodies, to make sure that we can work collaboratively, because that is really important, and that we do not overstep our reach in relation to what each of us is doing.

Gillian Mackay: That is great. Thanks, convener.

Brian Whittle (South Scotland) (Con): Good morning, Karen. A couple of things have arisen out of the conversations so far. In response to Sandesh Gulhane, the issue around trans people was raised and my colleague Joe FitzPatrick quite rightly highlighted vulnerabilities and how we deliver healthcare across that. In terms of vulnerable patients generally, are we seeking informed consent? The issue with informed consent keeps rearing its head, so where are we with that?

Karen Titchener: I am concerned about that. It is not something that I have dived into yet but I am hearing about vulnerable patients getting care but not being chaperoned or not having given informed consent. It is definitely something that is happening, but I do not know how widespread it is, so I will be looking into it. Again, everybody is reassuring us that they have chaperone policies, but do they actually use them? GPs do it all the time—if they are going to do any sort of physical exam on a patient, they will bring somebody else into the room. Why are we not doing that in hospitals? There is a bit of a blasé approach to the issue. I am speaking to the board chairs at the end of the month and I will ask them how they can prove to me that informed consent is happening, and that chaperoning is happening with patients.

Brian Whittle: My concern is that there is potentially a breach of the law here, and we do not need any more of that within the health service.

Karen Titchener: I agree.

Brian Whittle: That leads me on to my next point, which is on whistleblowers. Again, the issue has been raised before and every board will tell you that it has a whistleblower champion—that it has somebody that people can go to. The reality is very different. How do you change that whole culture of trying to shut down whistleblowers? It is not peculiar to one area; it exists across the whole of Scotland at the moment.

Karen Titchener: Clearly, what we are doing is not working, so we need to look at it. People are saying, "I wouldn't go to the whistleblower champion because I would have no confidence in doing that—I'd be concerned about my job," so we have to look at how we are dealing with whistleblowing. Once or twice a week, I hear about people who are afraid to whistleblow. They are afraid of losing their jobs; they are being bullied and shut down. What we are doing is not working.

HIS has a whistleblowing route, but I could not persuade the people that I have been talking to to go down that route. If people are scared about whistleblowing, it means that what we are doing is not working and it is not keeping our patients safe.

Brian Whittle: Moving on from that, you have stipulated that part of your job is about “never again” events such as the Eljamel case—never again can that happen. However, somebody said that they are not convinced that some of the actions that should have been taken in the Eljamel case would be taken if there was a rogue surgeon right now in our health boards. Do you think that that is right? If it is not right, how do we change that confidence factor?

10:00

Karen Titchener: From what I am hearing, I am not confident that such a case could not happen again, because of the issue of people closing ranks and shutting things down.

Brian Whittle: Wow.

Karen Titchener: Obviously, there is an on-going inquiry in that regard, and I do not want to muddy the waters, but I would say that, even within the board where that happened, there are still concerns.

We have to start trying to open doors that have been closed and trying to prevent boards from closing ranks and stopping things, because there is nothing safe about that. Also, I could not work in an environment where I was continually shut down.

Brian Whittle: I am not quite sure what to say about that. I suppose that the question is, from your perspective, and given your role, what has to happen to make sure that such a case can never happen again?

Karen Titchener: We have to change what we do in relation to people speaking up. If a nurse or a patient is concerned about something and feels that it should not have happened in the way that it did, we should perhaps take that out of the internal processes. I think that there needs to be an independent voice. I am not saying that that person should be me, but the point is that what we are doing now is not working for staff or patients, and it is not keeping Scottish hospitals safe. If staff are worried about a trend that they see and they do not feel that they can express that, what can we do about that? We are in healthcare, and we should not be allowing nurses and doctors to feel like that.

I will put on my website a statement that says that, if someone is concerned about anything that is going on in their workplace, they should talk to me. Of course, that could open the floodgates, which might be a problem, as I have only four staff, but that is why I am saying that we have to stop the issues arising earlier: we have to stop something at the first whisper that it feels like another Eljamel case. I hope that there is not another case of that sort, of course; I am just saying that we have to try to stop such cases earlier, and I am not sure we are in a place where we can do that yet.

Brian Whittle: You mentioned that there is no real national reporting. One of my hobby horses is the issue of data analysis and intelligence gathering. I am not sure that we do not have enough evidence, data and so on; my concern is that we are just not properly exploring what we have. Where are we with that? Is there a need to have a real think about how data is delivered and how we engage in data gathering?

Karen Titchener: Obviously, data gathering takes very smart technology. When I asked for all the Datix information from Stranraer, I was told that someone would have to go into every individual Datix and read it before they could give me that data. We are not using a system that can be scanned. I told the person I was talking to—a senior midwife—that I did not want her to go into 100 patient notes just because I have asked for Datix information. Why is it not possible to simply generate a report? I should say that the NHS does not use Datix any more—I cannot remember what system is used now.

The Convener: It is InPhase.

Karen Titchener: Yes—InPhase. However, I do not know whether anyone is particularly satisfied with it.

I am just saying that the data that we are gathering does not contain the emotional intelligence that would proactively give us themes that would enable us to take pre-emptive action. Nationally, we are getting information, but there is nothing that pulls all of that data together.

Am I going to address that in the first six months? Probably not. Is it something that I would like to target? Absolutely. The decision on that will be for Government—it is not a decision for a little Patient Safety Commissioner—but if we are going to make Scotland safe for patients, we have to look intelligently at the data that we are gathering. Currently, we are not doing anything with it, because we cannot merge it.

Brian Whittle: I urge you to keep talking about that.

Joe FitzPatrick: I want to follow up on what has been said about the Eljamel situation. Obviously, the overwhelming majority of our surgeons and staff in the NHS are amazing and do a fantastic job. I acknowledge that the inquiry is on-going but I would raise two particular aspects that should be mentioned. First is the issue of the closing of ranks, which you have talked about, and which we probably all accept that we need to get better at dealing with. We need to ensure that the duty of candour that is in law now and the whistleblowing legislation are used to benefit patient safety.

The other aspect concerns the fact that Eljamel was performing outwith his competences. You say that you are not confident that the Eljamel situation could not happen again. Do you think that there could be a situation in which someone who is not qualified ends up doing surgery that they are not qualified to do?

Karen Titchener: What I do not understand is how that issue was not challenged at the time by the senior medical officer. I do not know what is within the capabilities of a neurosurgeon, but somebody must, and he was clearly going outside his scope, probably every day that he practised. Am I confident that that will not happen again? I do not know, because I do not know who should be watching somebody like him.

We have to look at our centres of excellence and almost define the roles better by setting out the things that, for example, a neurosurgeon should be doing. As a nurse practitioner, I did not do maternity work, because it was not my sphere of expertise. Similarly, a clinician should not be doing things that they are not qualified to do.

Joe FitzPatrick: Eljamel started practising in Scotland in 1995, before this Parliament even existed, and a great many of the regulations around employment are still reserved. Once the Eljamel inquiry publishes its report, will you be liaising with your United Kingdom counterparts to ensure that those aspects are dealt with? We need to have confidence that the staff in Scotland and across the UK are competent to do the work that we put so much trust in them to do. Of course, we know that the overwhelming majority are competent, and that there is only a tiny number of cases in which they are not.

Karen Titchener: As I say, I need to wait for the output of the inquiry. However, I meet the GMC once a month, which means that I am meeting the right people to whom I can flag those issues. You are right to say that we do not want that situation happening again, so we need to think about what we are doing to ensure that people are keeping to what they should be doing.

The Convener: Sandesh Gulhane has a supplementary question.

Sandesh Gulhane: Thank you for allowing me to come back in on this important issue, convener.

When I was working in orthopaedics, I came across a surgeon who was not competent to be performing the operation that he was engaged in. That is a problem at consultant level: there is not really a competency that says that someone can or cannot do something, because a consultant is trained in the specialty that they are in.

One of my big concerns is that, in general practice, we have physician associates who are actively saying that they can do everything a GP can, so a lot of undifferentiated patients in general practice are being seen by people who are not GPs. To me, that is a patient safety issue, because I do not think that those people have the necessary qualifications to be dealing with those patients in that way. What are your thoughts on that?

Karen Titchener: As a nurse practitioner, I worked at a GP surgery and did all house calls. I know that you are not talking about nurse practitioners but about physician associates, and there is a big gap between those two professions, as a nurse practitioner has to have been a registered nurse before they can be a nurse practitioner, whereas physician associates can just come straight in from being a car mechanic to suddenly looking after people. I understand that, and they should definitely never tell people they can do everything a doctor can do. We should be making sure that, in terms of their competency and the framework that they are working under, they are always under the guidance of a GP. They should not be working independently of a GP.

When I worked in a GP surgery, if I was concerned about something, I would just knock on the door and say, “Hey, I am thinking this, but it might be this. Can you come and have a look?” We need to be careful with physician associates that, on top of their licence, their working practice keeps the patient safe. The problem is that registration is UK-wide, not Scotland only.

I have not looked into the issue so I do not know how many physician associates are working in GP surgeries, but I would be interested to know how GP groups are guiding the care that such people are giving.

Paul Sweeney (Glasgow) (Lab): I thank the commissioner for coming to give evidence today. I have a quick supplementary on prevention. We know that many in the NHS worry that cuts to facilities maintenance, for example, can create a culture of scarcity that is unhelpful for embedding a true focus on health and safety for staff. In the past few days, we have had a report about a lift at the Glasgow royal infirmary that has been broken for more than six months, leading to a significant number of lost appointments. There have been reports of sanitation issues in hospital wards, showers that have been broken for long periods of time and so on. That general pattern of poor facilities management can undermine confidence that the NHS is a prevention-focused organisation. How do we rebuild confidence? Do we use a combination of inquiry and lessons learned?

Karen Titchener: I agree that it is not a great picture if you walk into a hospital and see that the lift has been out of action for six months. No board has a bottomless pit of money, but functional facilities should be high on the list. If the showers or the lifts are not working, that is a patient care issue and it shows that what is happening with the patients is not being prioritised. We should be looking at enforcement and making sure that the building is safe, fully functional and operational. We should not be putting patients into buildings that are not fit for purpose. We need to be looking at that, for sure.

Paul Sweeney: I assume that the nearby Marriott would not have the same problem, so why does the hospital have that problem? Perhaps there are benchmarking opportunities there.

Karen Titchener: Yes, that is worth thinking about.

Paul Sweeney: I also want to look at your role in implementing recommendations. As a parliamentary office-holder, do you see any role for yourself in reviewing the implementation of public inquiries and reviews that are relevant to patient safety and making sure that their recommendations are being delivered?

Karen Titchener: Absolutely. That is very important. There is no point in spending public money on an inquiry, that inquiry making recommendations and those recommendations not being followed up. I do not know what HIS's role is in that, so I would need to work with it. I would definitely be involved with anything that HIS needs to implement that I feel is to do with patient safety.

I think that boards should be given timelines. Rather than the soft approach and the hand holding that we sometimes see happening with boards, it should just be a case of, "No—these are the recommendations. You've got six months, and then we'll come back in." The UK Care Quality Commission gives boards six months and says, "We're coming back in six months. If that's not sorted, we'll downgrade you." If we really want to focus on patient safety, we need to get our big hobnail boots on, call people out and say, "You've got to do it in this timeframe," although if it is something massive that a board has to do, it must be given a timeframe that is reasonable.

Again, I come back to accountability. The biggest safety gap that we have is the lack of accountability and the lack of people speaking up and saying, "We put our hands up—it's our fault and we're going to sort it."

10:15

Paul Sweeney: We have covered benchmarking opportunities and time-bound accountability for implementation. Are there any other metrics or processes that you envisage using to assess whether interventions are being properly implemented and are actively promoting patient safety?

Karen Titchener: I have not yet thought about that, but it is definitely something that we need to do, because there is no point in implementing change if we are not looking for improvement. That might involve saying, "A year ago, there were 800 deaths in our A and E departments that were avoidable. Next year, let's get that down to 200." We must look at what can be implemented to improve patient safety. I will look to ensure that, when our office recommends change, that change happens. I will provide timescales for that.

Paul Sweeney: You mentioned the Care Quality Commission as a sort of template. Have you looked at anything similar to that?

Karen Titchener: Not really. Healthcare Improvement Scotland does the investigations and then helps with the improvement. That is a positive in relation to the CQC, which wades in, tells boards off and raps them on the knuckles, but it does not help them to implement the change. Therefore, HIS has an advantage over the CQC in that respect, but I am not sure that it has the same authority. It is a question of balance.

There are good things that are happening, and we must not let the bad muddy the good. We need to amplify the good and sort out the bad.

Paul Sweeney: Thank you.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning, commissioner. We have touched quite a lot on the issue of the cultural change that is required. It lies at the heart of why we are in the situation that we are in.

The committee's stage 1 report on the Patient Safety Commissioner for Scotland Bill, which created the office of Patient Safety Commissioner, highlighted that, rather than being a result of gaps in policy, the systemic failures that we have seen have arisen because of deep-seated cultural and behavioural patterns in the healthcare system. You have already mentioned some of those, such as not listening to what patients say, the lack of accountability and the closing of ranks. Is the very hierarchical structure of our health boards a factor when it comes to tackling cultural barriers to change?

Karen Titchener: As someone who was new to Scotland and its health system, when I first came here I thought, “Oh my gosh—14 boards is a lot in a small country.” The fact that there are so many boards sets us up for finding it difficult to implement national change. I know that the boards are working to share learning and experiences. I certainly feel that the issue of having so many boards is something that I will have no say in, but I do think that the fragmentation makes it quite difficult to implement something at a national level.

How boards are set up creates silos and that sense of closing ranks, but I hope that I can build trust with them and that we can try to change the culture to ensure that it is not about blame, but about shared learning and our being all in this together for patients. At the minute, it does not really feel like that.

Boards are under immense pressure; their budgets are very tight; and their wards are imploding. I do understand the operational stretches and strains on the system, but that is no reason for not creating forums and environments where boards do not feel that they have to close ranks and shut things down. They should feel empowered—well, “empowered” is not the right word, because you do not empower people; they empower themselves—but we also need to ensure that our system helps people to implement change, to be open and honest and to have integrity and accountability the whole way along, from the smallest decision that they make to the biggest ones about, for example, shutting a unit or a ward. There must be openness, honesty and integrity, and it does not always feel as though we have those things.

Elena Whitham: Individual healthcare settings still have that very structured hierarchical system in place.

Karen Titchener: I agree.

Elena Whitham: How can we shift the culture so that anyone in that setting feels empowered to call out problems as they see them and that they have protection? At the heart of the issue are employees and workers—and, indeed, patients—feeling that they cannot speak out or that, if they do, they are not listened to. How do you foresee our driving the cultural shift that needs to happen?

Karen Titchener: Something as mammoth as that has to be done one step and one day at a time. When I get involved in something in, say, a hospital, I bring the voice that says, “This is safe. You need to learn to be able to speak up.”

I want to be able to implement such change through the lived experience of staff and patients. When I sit down and talk to nurses who are stressed, because they do not feel that they are being heard or because they are concerned about something, we try to knock that on the head there and then and say, “Right, let’s go and talk to your managers now and see why that culture is inherent.” You are not going to break down a national and systemic culture of hiding things and not being able to speak up simply by waving a magic wand; you have to do it by living those people’s experiences, and by helping them to move things forward.

I hope that that is what my office will be able to do. In every instance in which we are involved, we will make sure that everybody feels safe enough to speak out. As a result, cultural change will start to move forward.

Elena Whitham: But how are you going to measure and monitor that cultural change? As we know, and as you have said this morning, the lack of data is a big difficulty. How will you and your office monitor that?

Karen Titchener: I hope that, when it comes to the lived experience of people who fear for their jobs not speaking out, the volume of speaking out will increase. It would mean that the culture was changing if clinicians and patients felt, “Do you know what? Now is the time that our voice is going to be heard and things are going to change.” That is the only way in which we can measure it.

If nothing had changed two or three years down the line and people still felt unheard and unable to speak out because of the threat of losing their jobs, the system would not be working. Therefore, I hope that we are able to move the work forward.

Elena Whitham: How will you ensure that lasting organisational change comes about, and not just localised pockets of improvement? Which other organisations will you work with? We need to think outside the silos, so how will you drive lasting change?

Karen Titchener: We have to consider what training is lacking. In particular, what leadership training is lacking, and do we need more education around it? As you said, we cannot just say that staff have to be heard; people must know how to respond to that. There needs to be some process change and more education, and job descriptions need to change so that people recognise, “Actually, do you know what? Part of my role is that I have to hear the lived experience of patients and do something about it,” or, “I have to hear the lived experience of my staff and do something about it.”

It is about more than just listening; it is about looking at what can change systemically and what other education needs to happen. Do we need to change leadership structures? Do we need to change how patient complaints are dealt with in hospitals? We have to look at the whole system and consider whether what we do now is actually working. Change for change's sake is not good; it has to lead to good outputs that result in better patient care and safety.

The Convener: I will ask a final question, but first I want to put it on record that I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

You have spoken quite a bit about maternity services this morning. Certainly, in the Parliament, we have heard some criticism about the delivery of neonatal services, and the best start report recommended moving to three neonatal intensive care sites for patient safety reasons. We have heard clear evidence from clinicians about why they feel that is necessary, and from the charity Bliss that it is the safest option for the sickest and most premature babies. You have spoken about the issue before. Can you set out your thoughts on the redesign of neonatal intensive care?

Karen Titchener: The care of neonates is not my forte, but I understand the need for centralisation and the importance of local expertise for those fragile perinatal children. I understand the decision that was made, but, as is the case with maternity services, you cannot just make decisions and then not back them up by not implementing other measures in the local area. For me, that is always the gap of change: people say, "This is a great idea, and we are going to do this," and then they leave devastation behind. Even in the light of that realisation, there has not really been a full redesign and families are still expected to travel. We still have to look at risk mitigation and what we do in local areas so that those families feel supported if they then have to travel to a centre of excellence.

In the task force, I want to look at how we listen to the voices of families and ask, "How does this feel for you? Where is the service gap between suddenly losing your local neonatal unit and having to travel? Where is the local support to help families through all that?" That is the issue with service redesign: the focus is on the end product, not the tsunami that it leaves behind. I want to explore that.

The Convener: There needs to be robust and honest communication and also probably less politicisation of some service redesigns, so that families get the correct information about what is changing and how it might or might not affect them, to alleviate some of the concern and worry. Is that fair to say?

Karen Titchener: I agree with that—it is one of the big gaps. To go back to an earlier example, people in Stranraer did not know what NHS Dumfries and Galloway had done to mitigate the risk of reducing services. It might have done some stuff, and the same applies in this context: families should consider holding a town hall meeting, so that services communicate what is being done in the local area.

My goal in this role is to go out into communities, hear people's concerns and align health authorities' decisions with the information that is provided to the local communities that they serve. There appears to be a gap in many such situations—there is either misinformation or a lack of information. It is very important, for the safety of everyone involved, that accurate information about service redesign is provided, rather than simply stating that changes are happening.

The Convener: Thank you for your attendance this morning. I now suspend the meeting to allow for a changeover of witnesses.

10:31

Meeting suspended.

10:38

On resuming—

Subordinate Legislation

Food Supplements (Magnesium L-threonate monohydrate) (Scotland) Regulations 2026 [Draft]

The Convener: Item 3 on our agenda is consideration of a draft statutory instrument, which requires approval by resolution of the Parliament before it can become law. The purpose of this Scottish statutory instrument is to allow the mineral substance magnesium L-threonate monohydrate, which is a novel food that is concurrently authorised in Scotland by the Scottish ministers under regulation EU 2015/2283, to be used in the manufacture of food supplements. The SSI also sets out the purity criteria for the mineral substance. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 20 January 2026 and made no recommendations in relation to it.

We will take evidence from the Minister for Public Health and Women's Health and supporting officials. Once we have had any questions answered, we will proceed to a formal debate on the motion. I welcome to the committee Jenni Minto, Minister for Public Health and Women's Health; Ian Vickerstaff, solicitor, food, health and social care division, Scottish Government; and Stephen Hendry, head of labelling and standards, Food Standards Scotland. I invite the minister to make a brief opening statement.

The Minister for Public Health and Women's Health (Jenni Minto): I am pleased to join you this morning to consider the draft Food Supplements (Magnesium L-threonate monohydrate) (Scotland) Regulations 2026.

As the committee will be aware, food safety, standards and labelling are areas on which I am advised by Food Standards Scotland. Magnesium L-threonate monohydrate, as a novel form of magnesium, may be used to make food supplements only following approval under the novel food regime along with the approval of an SSI under the food supplements regime. Magnesium L-threonate monohydrate has been approved as a novel form of magnesium for use in food supplements in Scotland and, in the wider context, across Great Britain, having received a positive safety assessment by the food safety authorities.

The ministerial determination that approves the substance as a novel food was made on 7 January and will come into force at the same time as the draft regulations that the committee is considering today. The draft regulations will allow the substance to be used to make food supplements for sale to consumers in Scotland as intended, by amending the list of permitted mineral substances that is set out in schedule 2 to the Nutrition (Amendment etc) (EU Exit) Regulations 2019. The draft regulations will also set the purity criteria for the mineral substance, as required by the Food Supplements (Scotland) Regulations 2003 and in accordance with the novel food safety assessment specification.

I stress that the amendments are technical in nature and do not amount to a change in policy. They are necessary to ensure that this form of magnesium can be used in the manufacture of food supplements as intended. This is a business facilitative measure, and there is no negative impact on businesses or any other stakeholder group. In alignment with Scotland, comparable regulations have been laid in Wales and are expected to be laid in England in summer 2026.

I ask the committee to support the draft regulations. I am happy to take any questions.

The Convener: No member has indicated that they have questions. Do you want to add anything, minister?

Jenni Minto: No. I am content.

The Convener: We move to agenda item 4, which is the formal debate on the instrument on which we have just taken evidence. I remind members that officials may not speak in the debate. Minister, I ask you to move motion S6M-20368.

Motion moved,

That the Health, Social Care and Sport Committee recommends that the Food Supplements (Magnesium L-threonate monohydrate) (Scotland) Regulations 2026 [draft] be approved.—[*Jenni Minto*]

Motion agreed to.

The Convener: That concludes consideration of the instrument. I briefly suspend the meeting to allow a changeover of witnesses.

10:42

Meeting suspended.

10:47

On resuming—

Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Amendment Order 2025 (SSI 2025/405)

The Convener: The fifth item on our agenda is oral evidence on a negative Scottish statutory instrument. The purpose of the instrument is to extend voting rights on integration joint boards to include service user, unpaid carer and third sector representatives. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 13 January 2026 and made no recommendations in relation to the instrument. No motion recommending annulment has been received in relation to the instrument.

The committee previously considered the instrument at its meeting on 27 January and agreed to invite selected stakeholders to give oral evidence on it at this week's meeting. For our first panel on the instrument, I welcome Matt Crilly, policy manager, and Councillor Paul Kelly, spokesperson for health and social care, from the Convention of Scottish Local Authorities; and Stephen Smellie, chair of the social work issues group with Unison Scotland.

We will move straight to questions.

Paul Sweeney: Several local authorities and COSLA have argued in correspondence that the amendment risks diluting democratic accountability by placing elected councillors who sit on integration joint boards in a minority. Will you explain and outline why the change would be viewed as undermining the mandate of local government representation and what consequences you therefore see for democratic oversight of the boards?

Councillor Paul Kelly (Convention of Scottish Local Authorities): I thank the committee for inviting stakeholders to provide views on the instrument—COSLA certainly welcomes that. Before I start on the specific question, I want to say that COSLA, councils and all our partners very much value the voice of lived experience, third sector representatives and carers. They are vital partners, not just across integration but in everything that we do in councils, and I know that that will be the same for many of our NHS colleagues on boards.

However, COSLA, council leaders across the board and councillors, including those on my health and social care board, have taken the view that the change would dilute our political and democratic accountability. Like MSPs, we are accountable to the public democratically. We sit on integration joint boards and we leave our council hat at the door and represent the interests of health and social care partnerships, as we should. However, we are accountable publicly, and members of the public come to us about the decisions that we take on integration.

Our concern is that, when major decisions are being taken, we will be in a minority as democratically elected members, and that will have a significant impact on our accountability. As you know, the public want greater accountability, at both local and national levels, in those decisions. That is our significant concern.

Integration authorities across the country regularly work in partnership. Very few votes take place, and there is a good partnership environment. Vitally, that includes our third sector partners, our carers reps and those with lived experience in determining and driving forward the directions that come from integration authorities. We are absolutely committed to continuing to build that role and support for everybody who is around the table on integration joint boards.

Paul Sweeney: Mr Smellie, do you have a perspective on that?

Stephen Smellie (Unison): Yes. Thank you very much for inviting us to give evidence. First of all, as a trade union representative, I want to put on record that, as a patient, a service user and, indeed, a carer, I—like most other people—have lived experience as well. We do not just come to this with a narrow workers' interest; we have a broader interest.

We share COSLA's concern about the diminution of local democratic accountability. When questions were asked about whether trade union reps should have votes on IJBs, we said, "No, we don't think so." We seek influence, but we understand and support the principle of democratic accountability.

Frankly, if members of IJBs, councils or Parliament are making decisions that are wrong, we want the ability to hold them to account for that and vote them off. We cannot do that if we appoint people from other organisations. Fundamentally, we believe that community care services are local services or community services and that they should be properly democratically accountable to local voters. Taking away the current 50:50 set-up would further weaken the democratic accountability.

Paul Sweeney: Mr Crilly, I do not know whether you have anything to add on the dilution of democratic accountability, but perhaps you can tell us what practical impact it would have if all members of IJBs had voting rights. Will you talk us through your thinking on that?

Matt Crilly (Convention of Scottish Local Authorities): To add to what Councillor Kelly said about democratic accountability, the instrument raises questions about how accountability could work. COSLA and local authority colleagues raised those questions in the Scottish Government's consultation previous to the instrument being introduced.

On top of the questions about how accountability would work, the instrument introduces the ability for new voting members to identify suitably experienced proxy members, and we are not sure about that. We have questions about the accountability of the members, and we have further questions about how that would work with the identification of proxy members, who could attend IJBs and vote in public decisions on the allocation of public resources.

From an officer perspective, I note that that element of proxy voting was not included in the Scottish Government's original consultation prior to the introduction of the instrument.

Paul Sweeney: Integration joint boards have been subject to increasing financial pressure in recent years. Disagreement and possibly divisive votes are more likely on boards when difficult decisions are being made and dilemmas are being faced. How would the shift in voting composition affect responsibility for budget setting and public accountability? Perhaps Councillor Kelly could set out the implications of that.

Councillor Kelly: That is a key point. The top challenge that integration authorities and partnerships across the country face right now is the financial aspect. Health and social care partnerships have said that there is a £500 million deficit nationally, which has an immediate impact on decisions that are having to be taken at a local level, including on work to do with carers. It also has a direct impact on social care. So, straight away, these are difficult decisions.

As you say, as we move forward into that territory and into the financial outlook for the future, there could be more votes taking place, and public democratic accountability is important. Councillors are representing the views of integration authorities and health and social care partnerships, but they are very much publicly accountable for those decisions.

The focus of councillors and council leaders in any conversations with third sector organisations and carers reps is the impact of the social care crisis and the fact that the real issue that we face is that we need investment in social care. What an improvement we could make to integration authority decisions across the board by bringing social care spend on that journey from health into preventive and community spend.

Stephen Smellie: There is another aspect to this. I sit on the South Lanarkshire IJB, and, as Councillor Kelly says, the vast majority of the time, a vote is not taken. But when difficult decisions have to be made because of financial pressures, that is when these things happen. When difficult decisions are being considered, trade unions and other bodies, as we said earlier, will seek to influence the outcome. We will lobby Councillor Kelly's opposite numbers in South Lanarkshire. We will speak to the health board and so on. We will seek to influence, put pressure on, campaign, lobby and demonstrate—the usual sort of thing—in order to deal with particular pressures. If we extended voting rights to service users and people from carers organisations, they would have to be subjected to a similar kind of influence and be held accountable. Submissions from other organisations raised the issue that, were votes to be extended to those people, there would have to be a significant amount of resource for those people, to enable them not just to cope with the scale of the papers that they would get at every meeting but to deal with the outside influences, such as ourselves and other organisations.

In our case, a couple of care homes were proposed for closure, and residents and their families were campaigning and organising all sorts of activities directed at trying to influence the people on the board. They would expect their service user and carer representatives to be held accountable in similar ways. That would open up a whole different kind of local tension and conflict within communities, and I do not think that the resources are there to support people in that position.

Councillor Kelly has the resources of his council and the health board, and non-executive members have support from their officers and so on, but carer reps and service user reps would not have that support unless significant financial resources were made available for them—and there is no suggestion that they would be. They do not have that kind of support or back-up, and there would also be, frankly, the possibility—which many councillors and MSPs face—of their being spoken to on the street about what they are doing about such and such.

Extending voting rights would corrupt democratic accountability and would put enormous pressure on those people, who would need to be held accountable in ways that are not completely clear.

Paul Sweeney: Thank you. Mr Crilly, do you have any final points to make on that subject?

Matt Crilly: I support what Councillor Kelly said. Integration authorities across Scotland are under enormous financial pressure. That reality is being faced across the entirety of Scotland. In that context, it is important to note that integration authorities also have financial and statutory responsibilities to set a balanced budget. In considering the voting membership of IJBs, we need to be alert to those responsibilities.

In relation to the instrument itself, COSLA noted that a business and regulatory impact assessment accompanying the instrument is absent on the basis that it will have no financial effect, but it is worth considering whether the instrument will have any financial implications. We have been talking about potential revised appointment processes and training.

The Convener: We are going to move on to some of those issues. Other members have questions on them, Mr Crilly.

Matt Crilly: Okay—that is no problem.

Paul Sweeney: I appreciate that. Thank you.

11:00

Carol Mochan: Thank you for your evidence so far on the democratic process that exists to ensure that we have accountability. We want to hear the voices of the third sector, carers and users of services, and Mr Smellie touched on trade unions. How can we make sure that that is part of the process, and how does it add to the accountability of members who vote currently?

Councillor Kelly: That is a critical point. Throughout the discussions that we had with the Government about a national care service, council leaders and COSLA made the point that we are keen to look at how we can improve integration and the experience of councillors and non-executive health members around training and support, as well as hearing the voices of those who have lived experience, such as carer reps, who are critical to the role that has been played in integration across the country. We are keen to do that, which is why we were slightly surprised that this complex voting rights issue has come up and that it is going through Parliament with such speed, given its possible unintended consequences.

That is to take nothing away from our commitment, which the committee will see in some of the local authorities' submissions. One example is the work that Glasgow is doing around IJB support and how it reaches out to different areas. Orkney has also openly welcomed doing more. We want to go further and do more to support the voices around the table, to make sure that integration works. They are the critical voices that tell us what is going on with services, so there is an absolute commitment to doing that. We were having discussions with the minister before we got to this point, and I welcomed being able to do that in those discussions.

The real issue that we are facing in health and social care is the funding crisis and the impact that it is having on the lives of individuals, including those with lived experience, carers and those in the third sector. Third sector organisations that play a vital role in our communities are also feeling that pressure. That is the real issue that we are all grappling with.

As you say, this is a complex matter, but local government and our health colleagues are absolutely committed to improving the role of integration. It is a journey and a process that we would like to take part in.

The Convener: I have a couple of questions for clarification before we move on. You have spoken about whether voting rights should be given to those organisations and individuals, and you have said that councillors would be in a minority. How many people on an IJB typically vote?

Councillor Kelly: There is equal representation between councillors and non-executive NHS board members, so, right now, it is 50 per cent each. The democratically elected part of the board would be councillors like us. We would be in a minority, but we would be very much publicly accountable for the decisions that integration authorities took and their impact on councils.

The Convener: You are looking at elected representatives being in a minority if there were three members from the NHS, three councillors and three from other organisations.

Councillor Kelly: Yes, we would be in a minority. Right now, we are not in a minority.

The Convener: It is not that there is a majority of new voters potentially being added to the IJB board. Councillors are appointed to IJBs, not elected—am I correct in saying that?

Councillor Kelly: Yes. The local authority goes through its democratic process to appoint members to integration authorities.

The Convener: I am asking for the record, because some of the language that has been used so far has insinuated that councillors are elected to these roles.

Brian Whittle: From the discussions so far, it seems that we all agree that the third sector and those with lived experience should be heard, but you have highlighted the potential risks in extending voting rights to the individuals that we are talking about. How would you manage conflicts of interest if voting members were also providers or users of services under discussion, particularly when, as you mentioned earlier, financial decisions are being made? How would you deal with that?

Councillor Kelly: I will come in before I pass over to Matt Crilly.

That is a very good point. Legally, integration authorities take big decisions, and a lot of third sector lived experience reps will come from organisations that might, in some ways, have a financial role in decisions that are taken. That will immediately result in a conflict of interest, and we are not certain about how that process will be managed. It is quite a complex area. As Stephen Smellie said, we want individuals across the board to be supported when making such decisions, but we are not clear on how the process will be managed.

The same is true with proxy voting. As Matt Crilly outlined, an individual who had not been involved in the process that an integration joint board had gone through might have a vote on the matter.

Matt Crilly: Members of IJBs note their interests at times. Generally, the IJB's standing orders set out how that process should be managed. Often, such issues are dealt with on a case-by-case basis in an IJB meeting, alongside the wider register of interests. I think that the register of interests is relevant in relation to Councillor Kelly's point about proxy voting.

Generally, during a meeting, a judgment is made on whether people can contribute to the discussion and take part in the vote. I am mindful that, in integration authorities' written submissions to the committee, some partners have reflected that, with the current make-up of IJBs, which includes lived experience and carer reps, even when an interest is noted, carer reps are still able to contribute to the discussion during the meeting.

If we are talking about changing the voting composition of IJBs, we need to be mindful of such conflicts. As I said, such issues would need to be dealt with on a case-by-case basis.

It is not just COSLA that has noted, in particular, the role of third sector representatives. In its response to the committee, the Coalition of Care and Support Providers in Scotland noted that it is interested in understanding what the changes will mean in relation to conflicts of interest involving third sector representatives.

Stephen Smellie: The issue about providers being involved is a significant one. How are those people selected by their organisations? In effect, they are contractors who are commissioned to provide services, so giving them voting rights will immediately result in a conflict of interest, which will not be easy to resolve.

I think that the CCSP made the comparison with council representatives, but councillors are not on IJBs as service providers. They take off their council hat and put on their IJB hat. I remind everyone that, historically, councillors have awarded lots of contracts to the private sector and the third sector, so they are not on IJBs only to protect in-house services. From a union perspective, I wish that they were, but they are not.

At the moment, there is no guidance for when such conflicts of interest arise. I refer back to my previous point: it is not just about formal conflicts of interest. Conflicts within communities can be significant. Communities are not homogeneous; there are differences of opinion. Therefore, conflicts need to be managed outwith the IJB structure, but there is no clarity on how those conflicts should be managed or how people would be supported to cope with them.

Brian Whittle: Mr Crilly, you suggested that, if there was a conflict of interest, there would be the potential for somebody to not take part in a discussion or a vote. Who would make the decision on whether the conflict of interest merited such action?

Matt Crilly: I would need to check the standing orders of each IJB, but, generally, such decisions would be taken within the individual IJB, and I would anticipate the chair of the IJB having a role in that regard. When an interest is noted, it is about whether it is appropriate for that person to participate in the discussion and/or the vote. If we change the voting composition, it might change that slightly.

Emma Harper: I am interested in representation on the boards. Among the written submissions that we received, Glasgow City IJB raised the issue of

> "how members representing large, varied and possibly complex networks",

which Stephen Smellie has described, can manage to have a

> "singular voice and vote".

I would be interested to hear witnesses' thoughts on what nomination and accountability arrangements would need to be mandated nationally to ensure that we have transparent and representative appointments, in order to have third sector voting or care experience representation and things such as that.

Councillor Kelly: I will start, and perhaps Stephen Smellie or Matt Crilly will want to come in. This is a complex area, and you—and we—have highlighted some of the issues that could come up. Given the speed at which the legislation is going through, it is difficult to answer some of those questions.

In reference to previous responses, I would say that we would be keen to give maximum support, as we always do, to all integration authority members who are around the table. We have been working with the Scottish Government on what that support for people looks like. The health and social care document, "Planning with People: Community engagement and participation guidance", was recently updated, and the integration boards' role in that is really important. If there is a decision to go ahead with IJB voting rights for lived-experience third sector organisations, complex and difficult decisions could be taken, and these issues would have to be looked into and managed.

Right now, we are just highlighting our concerns about the democratic dilution of the role of councils, which is really important for public accountability. Integration authorities across the country work in close partnership with NHS colleagues, third sector carers reps and us, and we are all committed to that approach, despite the really difficult financial position that we face and the crisis in social care on which we are urgently looking for action, as you know.

Emma Harper: I know that Matt Crilly might also want to come in. Openness, transparency and the ability for people to have their voice heard is important. I know a councillor who is also a full-time carer, so that councillor's ability to vote would mean that their lived experience as a carer is brought in, as well. Is this not about having a broad representation of voices and ensuring that people are represented?

Councillor Kelly: I think that we have that—that is what integration authorities provide. As you say, councillors all have lived experience, and, rightfully, that has an impact on our roles in terms of the decisions that we take. That is what happens in integration authorities right now. We have non-executives from the health side, our carers reps, third sector reps and councillors coming to the table. They all have lived experience, of course, and they deal with the issues that we face and the decisions that we have to take.

Councillors have a unique role, in that they are democratically elected, and the public absolutely want to talk to us about decisions that have been taken by integration boards and councils. I know that, recently, pressure has been felt by non-executive colleagues about some decisions that have been taken by integration boards, and we certainly want to support them.

Matt Crilly: Just to add to Councillor Kelly's point, I note that everyone has the right to be able to shape the design and delivery of services in their area, including those services that impact them. It is important to note that unpaid carers reps and lived-experience service user partners currently hold membership of integration authorities, although the particular organisations and partnerships often differ locally. The arrangement might involve the IJB working closely in partnership with its local carers centre, for example, to ensure that the unpaid carers rep on the IJB is well supported or it might involve assisting with the appointment process for that carers rep.

We are conscious that IJBs do a lot to support the public partners that are on boards, but we are also aware of research published by our national partners, such as the Health and Social Care Alliance Scotland, that recommends that more could be done to support reps on IJBs, whether through improving the training that is available, or by ensuring that, as Ms Harper has suggested, they have greater connections into the community and access to wider networks of, say, unpaid carers to support them in their role on the IJB. That is certainly something that both local government and, I am sure, integration authorities are keen to pick up and do more on to help improve the situation.

11:15

Gillian Mackay: Everyone has mentioned practical issues that need to be overcome, such as workload, but I am keen to understand whether it is just the practicalities that are the issue here, or whether there is an opposition to lived-experienced voting rights as a principle in itself.

Councillor Kelly: Whatever decision is taken, we will obviously have to work with any practicalities that arise—I think that what we are trying to articulate is the possibility for a dilution of the political and democratic accountability of elected members. We think that that is significant, and that it will have a significant impact on the role of integration authorities.

When we were discussing this with the Scottish Government and the minister, one of the things that was said back to us was that councillors would still have the final and ultimate say, and that the Scottish Government regularly hears examples of councils blocking IJB decisions. Now, council leaders in COSLA have decided to take some legal views on that, because it is quite a significant statement to make that it will still be up to councils to block these decisions. I think that that has happened on two occasions with regard to eligibility criteria, and it is something that we absolutely want to avoid.

Therefore, I do not think that it is helpful to the role of integration authorities to say that there could be an opportunity to block decisions; indeed, hearing that is not helpful for those who have lived experience—for example, the carers reps who are on the boards right now. As I have said, we are seeking some legal support and views on that position, because it really is significant with regard to this decision, and it came from the minister. That is not what we understand the situation to be, and it would not help the role of integration authorities right now and the very difficult decisions that they are having to take in order to try to support our communities, the people whom councils represent and others.

Gillian Mackay: I do not think that I heard you say whether or not you are opposed to that position. I come back to the principle: notwithstanding what is on the table right now in terms of numbers on IJBs and all that sort of thing—and I understand the issues around dilution and the numbers game on the boards—is there an ideological opposition to having lived-experienced or third sector voting rights on IJBs?

Councillor Kelly: COSLA, and councillors and leaders across the board, have made it clear that, right now, given the current situation and for the reasons that we have outlined, we do not want to see voting rights for people with lived experience, the third sector and carers reps. That is partly because it is a complex area, as we have again outlined, and what we are discussing here is obviously a very quick way of putting through a change that is very significant for integration authorities.

However—and I hope that this has been articulated today—we want to make those improvements to integration authorities across the country, to give support to everybody who is on the boards and to absolutely amplify the voices of those with lived experience. I was on an integration board for 10 years—since the start, in fact—and I came off it last year. I was deputy leader of a council, I am a councillor and I have my COSLA role, and I know—as you will know, Ms Mackay—that the vital voices in our communities are those with lived experience. They are the people who determine and drive our policies—as they should, and as they will continue to do.

The Convener: So you want to hear their voices, but you do not want them to have the votes.

Councillor Kelly: I do not think that that is what we are saying. I think that we have made clear the complexities of this—

The Convener: I think that that is what you are saying. In answer to Ms Mackay, you said that COSLA, at the moment, is against giving voting rights to these organisations and individuals.

Councillor Kelly: And we have outlined the reasons for that. This is a very complex area. Moreover, as I have said—and I do not want to repeat it—the major challenge facing integration authorities and the decisions that they make involves the financial aspects. Right now, there is a deficit of half a billion pounds, and these partnerships are having to take tough decisions, and we just want to focus on how we improve—

The Convener: But with respect, Councillor Kelly, that is not what we are looking at. We are here to look at a specific piece of legislation.

Councillor Kelly: That is a part of it.

Carol Mochan: Can I come in on that point, convener?

The Convener: Of course you can.

Carol Mochan: I really appreciate that.

Councillor Kelly, what I am hearing is that you really want to hear from the third sector and the voices of carers and people with lived experience, but that there are issues around accountability in relation to how we do that. Is it fair to say that?

Councillor Kelly: As I said at the outset, the key thing is that there have been very few votes at integration authorities and, to be honest, there has been very little discussion about that. The big discussions that are happening are around the social care crisis and its impact on the decisions that integration authorities are making and what we need to do collectively in relation to that.

We have been committed to hearing from those voices from the outset, through the national care service process, and more recently in the discussions with Government about what we can do to improve the roles of and support for those with lived experience, carers reps and those in the third sector. We are absolutely committed to doing that but we are trying to outline the complexities, the unintended consequences, and the impact that the decision around voter rights will have.

It is not as simple as saying that we just do not want it. It is clearly not the case that we want a dilution in any way of the voices of those individuals; we want to amplify those voices. What we are saying is that the issues that we are facing are significant, and the decision around voter rights is a part of that.

Paul Sweeney: It seems to me that the issue is the question of what mandate the members of the IJB have. Previously, there have been debates about whether health boards should be directly elected—we have not had a recent debate on that. However, it seems that your point is that there should be a direct public mandate for any representation on these IJBs, given that the IJBs make financially significant decisions about public services.

Councillor Kelly: Yes, and that was the case when the integration authorities came into place in 2016, in relation to the role of non-executive health board members and councillors, given the significance of those decisions and the impact that they can have on our communities.

As I said at the outset, the integration authorities across the country are operating with a shared role across the board, in terms of the voices of those with lived experience, carers reps, councillors, and non-executive members, to try and take the best decisions for our communities in the most difficult of times.

Joe FitzPatrick: I will ask about proxies later, but first, looking at this from the perspective of those with lived experience, including third sector partners, it is clear that there are some integration boards where the experience of carers and third sector members of the board is really positive. They feel engaged and they feel involved. However, we know that that is not the case everywhere; in fact, that is the exception. In other integration boards, folk with lived experience feel that, because they are not voting members, they are not valued in the same way as the voting members. That is the problem. Without this legislation, how can we get to the point where, right across Scotland, those people with lived experience, including third sector partners, can feel that they are genuinely part of the decision-making processes that affect their lives so much?

Councillor Kelly: That is a critically important point. As you say, there are great examples across the country of people who feel very much valued in their integration authority boards, and there are cases where there is a more difficult conversation and more difficult journeys because of some of the decisions that have been taken. However, we are absolutely committed to improving those opportunities for those with lived experience and we have outlined today some of the ways that we could do that in terms of support with the information that they get and the training that is available within the communities, and in terms of amplifying their voices in the integration boards.

We are committed to doing that and, in the lead-up to this process, we were having good discussions with the Government around it. We have certainly signed up to various different measures to look at improving integration, and it is something that we have continually talked about. The current arrangement has been in place for 10 years, so it is still relatively new and it is still developing, but there is an absolute commitment to making sure that any individual who attends an integration authority gets the right support and opportunities and that their voice is heard. That is something that we are committed to and, as you know, local authorities have a statutory obligation to do that.

Joe FitzPatrick: You talked about speaking to the Government about how you can do these things better. Have you thought about speaking to the carers organisations and the third sector organisations about how you can improve? There are good examples of boards in which non-voting members feel that they are absolutely part of the decision-making process, but such examples are almost unique.

Councillor Kelly: Going back to my point—

Joe FitzPatrick: You are failing right across the country.

Councillor Kelly: Both as an elected councillor and in my role as a COSLA spokesperson, I spend the majority of my time, and the most valuable time, talking to our third sector organisations, our carers reps, and those with lived experience. That is an important part of our role, and we will continue to do that. It is something that councillors do on a daily basis—as I think that Ms Harper said, that is closely aligned to councillors' lived experiences and roles in their local communities. That is a key point in the journey that has led to the point that we are at in the discussions with the Government on third sector and lived-experience partners.

Joe FitzPatrick: I want to focus on proxy voting. Matt Crilly has covered a bit already, but Paul Kelly and Stephen Smellie, do you want to say anything about your concerns on the proxy voting provisions?

Councillor Kelly: Matt Crilly has outlined the work that would need to be done on proxy votes and individuals who might be asked to make decisions at integration authorities without having attended the previous meetings. Matt covered most of the complexities around registering their interests and the organisations that they represent.

Stephen Smellie: We oppose the measure. To go back to Ms Mackay's question about a point of principle, we believe, as a point of principle, that the services should be managed by democratically accountable people, and at the moment that means councillors.

The discussion about practicalities illustrates that the proposals, if we go through with them, will not address the fundamental issues that have been raised. I am not aware of the research that Mr FitzPatrick referred to about people not feeling that the engagement is sufficient but, frankly, I do not think that giving two or three people voting rights will address that fundamental issue. If IJBs have failed to properly engage service users, carers and providers in the process, simply giving one or two people a vote will not address that. That would be tokenistic and it would weaken democratic accountability.

It is a principle that Unison has always argued for that local services and financial decisions should be democratically accountable, but the proposals would make decisions less democratically accountable. We have argued for that principle in the discussions about the national care service and in various other discussions that we have had over a number of years. We believe that democratically accountable local processes are important, and simply giving a few other people votes is tokenistic and will not address that.

I accept that there is a deficit. My background is in community development, and I worked for many years with service users and carers groups, trying to get them a voice in councils and other areas. There is a lot more work still to be done, but simply giving some people a vote will not address that fundamental issue.

The Convener: On proxy voting, for clarification, can councillors have someone vote for them as a proxy if they are unable to attend an IJB meeting?

Councillor Kelly: No, I do not think so, but I will check with Matt.

Matt Crilly: I understand that, if a councillor is temporarily vacant from a meeting, their vote would be decided by the two other elected members on the IJB.

The Convener: So, essentially, someone else can vote for them.

Matt Crilly: Yes. They are ultimately appointed by the local authority. Maybe that gets us to the issue of the lines of accountability of representatives on IJBs but, as they are nominated by the local authority, if a councillor is absent, it would be for the other two councillor members of the IJB to determine their vote. Some of that might be set out differently in the specific standing orders of different integration authorities but, in the standing orders that I am aware of, that is how the process is set out.

The Convener: So, no substitutes are allowed. Is the situation similar for the NHS voting members?

Councillor Kelly: We can come back to you on that, but that is my understanding. Certainly, when I was on an integration joint board, we did not have substitutes. As Matt Crilly said, if someone could not attend, the councillors who were there, or the non-executive members, would have to take decisions.

Stephen Smellie: I am not sure that that is standard practice across the board. From my experience in South Lanarkshire, substitutes are allowed. The councillors and the non-executive members can nominate a substitute, but they have been identified previously and they go through the same amount of training and rigour in relation to codes of conduct and so on. They are not just parachuted in on a one-off basis—they are part of the process. I am pretty sure that most of the substitutes attend the IJB meetings anyway. They do not vote when they are there simply to observe, but they are part of the process.

The Convener: What I am trying to get at is whether there are some double standards when it comes to third sector organisations, service users and so on being able to have a proxy, given that councillors or people who represent and vote for the health board can have a proxy. I am trying to get underneath that. There are practical ways of overcoming that issue. As you said, Mr Smellie, there can be someone else who has been trained or another councillor who has been nominated as a substitute and who then has voting rights—we have something similar on committees in the Parliament. There are ways and means of navigating some of those issues.

11:30

Elena Whitham: Good morning. I want to spend a bit of time exploring how lived-experience influence could be supported and amplified, especially now that we are in an age of participatory governance reform. Given the difficult decisions that locally elected councillors are taking, we have made moves to try to mainstream participatory budgeting, to power share in that difficult decision making and to give parity of esteem. If voting is not the preferred route for COSLA, what alternative would most effectively strengthen lived-experience influence?

That influence exists at the moment, as has been outlined. However, although votes might not be taken very often, when they are taken, it is a critical marker of parity of esteem if certain individuals can vote and some cannot. I want to explore parity of esteem and how we can increase influence if we do not extend voting rights.

Councillor Kelly: That is a good point. There is a whole host of things that we want to do and could do, and we are on a journey to do that. We have outlined the complexities around the voting rights issue. That journey involves supporting all representatives in governance through the recruitment and induction processes. You made good points about the current work at local level, outwith integration authorities, where there is excellent partnership with third sector, carers reps and those with lived experience.

We all want to do more to improve participation—I know that that is a commitment of Government, COSLA and local authorities across other areas. However, we have stopped having that conversation, because we are now focused on the IJB voting rights issue and not on how to improve the experience of all individuals on integration authorities from the outset.

We know IJBs face really tough choices and decisions. We have arrived at those tough, complex and difficult decisions because of the background, which is the £0.5 billion deficit that local partnerships have this year, which is having an immediate impact on the representatives round the table and the decisions that they take, and because of the outlook for the future, given the social care crisis. That has an impact on the voices and experiences of those with lived experience and carers reps. In my experience, a lot of the issues arise because of the difficult position that we are being put in. That means that we cannot focus on what we want, how we transform integration and develop it 10 years on. We all want to improve the lives of those with lived experience, and we want to ensure that that can happen through the health and social care partnership, while we address the crisis and the funding elements.

Elena Whitham: Do you agree that everybody who is on an IJB, whether or not they have voting rights, once they leave that sphere and go back to their communities and organisations, is still held accountable for the decisions that have been taken by those who have the voting rights?

Councillor Kelly: When integration authorities take difficult decisions, councillors are more likely to be approached in their communities about those decisions, because they are democratically elected and are there to carry out that role—the situation is probably similar for MSPs. That is what happens now. Concerns have been raised about the unnecessary pressure that the proposals could put on individuals with lived experience and carers reps when boards have to take very difficult decisions.

I do not know whether that answers your question, but that is the current position with a lot of integration authorities when the members leave the board.

Elena Whitham: I am thinking about the issue in the context of the expansion of participatory budgeting and governance. That was about everybody coming together and having a stake, with power-sharing of difficult decisions. The argument that was put forward at the time by local government, in conjunction with communities, was that that would strengthen decision making and strengthen democracy. I am trying to square that with the path that you are treading now, which is maybe not looking to extend the democratic ability of those who are on IJBs to have influence on decisions via a vote rather than just soft power.

Councillor Kelly: Matt, do you want to answer that first?

Matt Crilly: Sure. Elena Whitham is right that how we get that participatory community engagement right has been a big part of the likes of the local governance review. How do we strengthen community engagement? Local authorities have a long history of engaging with their communities in a democratic and participatory way. Engagement might look different in different local areas, and that will be based on the local circumstances and which community organisations are based in the local area. From COSLA's perspective, we need to get that community engagement right, and we have a role in spotlighting good practice where good community engagement takes place. We have different models, so we have different opportunities. An example is the lived experience expert panels for specific pieces of work and policies. However, we also have wider participatory structures.

Getting that community engagement right is important, but so is the conversation that we have had today about ensuring that the lived experience reps on boards are well supported. Colleagues in integration authorities across the country put in a lot of work to support their lived experience members but, of course, we are also discussing how that can be improved.

Councillor Kelly: I understand Elena Whitham's point. It is important to consider the development of that other work, outwith participatory budgeting, and what work is going on within communities.

I go back to the point that I made about the minister's response. From a Scottish Government point of view, councillors still have the ultimate, final say, and we regularly see examples of councils blocking IJB decisions. I do not think that that is in the spirit of what Elena Whitham outlined. We are getting legal views on the matter, but I think that that situation undermines the whole process. We do not want to be in that position. We want to ensure that all the voices are heard and that the decisions that are taken at the integration level are respected.

If there are to be IJB voting rights for lived experience representatives, we do not want to be in a position where, in the minister's opinion, the councils will still have the final say. We want to make sure that those voices are heard.

Elena Whitham: I note that we still have religious reps with voting rights on our councils, which is an issue for some.

Gillian Mackay: Councillor Kelly, I want to follow up on what you said about plans being under way to improve the IJB process. Will you outline some of the ways in which it will be improved? Like Joe FitzPatrick, I have heard that the majority of carers do not feel that their input and the time that they are spending are leading to outcomes that will improve things for them. It would be great if you could outline what is planned in that regard.

Councillor Kelly: Sure. That is a good point. I will start from the beginning. The experiences of the lived-experience members are based on the current pressures that the system is facing, which we are not really discussing today. The social care crisis and the £0.5 billion deficit are having direct impacts on those with lived experience, and the integration authorities are having to make cuts to services that they certainly do not want to make. We need to prioritise social care and those lived-experience voices across the country by looking at the financial position and the financial pressures, because—

Gillian Mackay: Regardless of the financial situation, some of the concern is purely that they do not feel that they are being represented. That is what I am trying to get at.

Councillor Kelly: Sure. As you will see in the submissions that I referenced from Orkney, Glasgow and other areas, the integration authorities are working on what they can do to improve those people's experiences and make sure that their voices are heard. That is part of everyday life, particularly for councillors, and it is something that we want to do.

On health and social care planning at the national level, in May 2024 we published "Planning with People: Community engagement and participation guidance". I repeat that because it is a really important document that looks at making improvements and it is something that we want to take forward. Whatever the outcome of this process is, we are committed to working with the Scottish Government on what you referenced—the experiences that individuals across the country have in accessing healthcare, social care and council services.

I give the commitment that that has been and is being looked at. We have not just arrived here to look at this; it has been looked at extensively in the build-up to where we are today. That is why I was surprised that that particular element has come up, as opposed to the wider role of integration authorities and the challenges in amplifying the voices of those with lived experience and carers' representatives—and also the third sector organisations, which play a vital role.

Gillian Mackay: Beyond that guidance document, what practical things are going on to improve things? That is what I am trying to get at. Do you have an example of what is going on in a local authority? Do you have an example of a particular initiative beyond that guidance that COSLA is taking forward?

Councillor Kelly: I give the Glasgow example of the expert panels and the models of engagement that are being used to look at things differently there. I think that that was included as part of the submission.

My reflection from my discussions with council leaders and councillors is that such work is happening across the country, so there are lots of different practical examples. Matt Crilly made a good point about what we can do collectively to ensure that good practice in the health and social care environments is shared. As Mr FitzPatrick referenced, there have been good experiences of engagement and of the processes of integration authorities, and we make sure that they are shared.

I assure you that that work is on-going. I do not know whether Matt Crilly wants to touch on any specifics.

The Convener: Will you respond briefly, Mr Crilly? We are already running well over our allotted time.

Matt Crilly: Sure. COSLA has had active discussions with partners such as Health and Social Care Scotland, NHS Scotland and, previously, the Scottish Government to look at the recommendations that have been made by our third sector partners such as the Health and Social Care Alliance and the Coalition of Care and Support Providers in Scotland on the changes and improvements that they would like to see. We have had active discussions about considering those recommendations and taking them forward.

My final point is that, locally, people will have different experiences, so it is also important to share best practice.

Gillian Mackay: Thanks, convener.

The Convener: I thank the panel for their attendance. I will suspend the meeting briefly to allow a further changeover of witnesses.

11:42

Meeting suspended.

11:46

On resuming—

The Convener: I welcome our second panel of witnesses to give evidence on the same negative instrument: Sandra Auld, service user member at Perth and Kinross integration joint board; Rob Gowans, policy and public affairs manager at the Health and Social Care Alliance Scotland; and Natalie Masterson, chief executive officer for Stirling, Third Sector Interface Network Scotland. We will move straight to questions from Paul Sweeney.

Paul Sweeney: Thank you, convener, and thanks to members of the panel for joining us today. Supporters of the order to change the voting composition of integration joint boards suggest that giving those with lived experience and the third sector voting rights would close a democratic deficit for those voices, which have a significant stake in decisions made by IJBs. How do you define that deficit locally, within an IJB area, and what practical change in accountability do you expect if those representatives are given voting rights?

Rob Gowans (Health and Social Care Alliance Scotland): The ALLIANCE has consistently advocated for IJB voting rights to be extended to representatives of service users, unpaid carers and the third sector, as the order will do. That will fulfil the recommendation of the independent review of adult social care that every member of an IJB should have a vote. The ALLIANCE also called for that in the consultation on a national care service, in its written evidence to the NCS expert legislative advisory group, and in its response to the committee's call for views at stages 1 and 2 of the National Care Service (Scotland) Bill.

The ALLIANCE supports the meaningful engagement of people with lived experience throughout health and social care. We host the IJB lived experience reps network, which was set up because a need was identified for representatives of those with lived experience across the country to be able to support each other. From speaking to them, we know that a common view is that they do not feel fully included or that they are equal members. Although this is not the only issue, a whole range of things could be done to better support those representatives. Not having voting rights is a barrier to their feeling fully involved and included.

As the provider of about a third of social care services, the third sector is a major stakeholder and it should be included. It also delivers an invaluable perspective in community-led health approaches across the country. Those vital perspectives need to be included, and not having full voting rights is a barrier to those representatives feeling fully included as equal participants.

Paul Sweeney: Ms Masterson, do you have any thoughts on the democratic deficit?

Natalie Masterson (Third Sector Interface Scotland Network): Absolutely. The key thing that we need to consider is that having fewer voices around the table will not mean that we will make better decisions. Having more voices of lived experience will result in better and more democratic decisions.

A lot of the analysis suggests that there is a fundamental misunderstanding as to why we have different people sitting on an IJB. The boards were constituted in the way that they were to reflect the totality of how health and social care services are delivered in our communities. Some of those services are the statutory function of social care, and some are the health services that are provided in large hospitals and in our communities. However, health and social care services also include those that are supported within our communities by the third sector—the lunch clubs, the gardening clubs and so on that contribute to people staying safe, happy and well in their communities. Those services are how patients and service users keep themselves well in their communities and how our unbelievably valuable unpaid carers support their families and their loved ones. They are the totality of the health and social care system, and it creates a democratic deficit if we afford voting rights to only some of that system.

Paul Sweeney: Ms Auld, do you have a perspective on this?

Sandra Auld (Perth and Kinross Integration Joint Board): Yes, thank you. I am really glad to be here today. Developing parity of membership of those on IJBs has seemed like a logical evolution for some time, and my resolve has been strengthened by the recommendation in the Feeley review.

The IJB in which I am involved—Perth and Kinross—has really raised the bar with its lived experience member reform, which has been moving towards addressing the inequality in the legislation. I have been democratically elected as a service user and my views have evolved from my experience of being excluded from IJB business as a non-voting member. I am happy to give some examples of that.

I believe that the hurdles described in the submissions are eminently surmountable, and are not reasons to halt progress. The order represents the best opportunity to move towards parity of membership since the original legislation was passed. What is required is a change of attitudes and values, which would be driven by these representatives gaining voting rights.

I have read in many of the submissions that votes are not taken all that often, and I am aware of the view that more votes would be had if the order were to go through, but this is about more than voting; it is about parity of esteem and parity of voice. That is what is missing. It would be hugely disappointing if at this stage elected or appointed officials were to oppose the opportunity to remove a two-tier system and not allow us to move instead to having meaningful and effective involvement for service users, the third sector and unpaid carers.

Paul Sweeney: Thanks. You mentioned that you were democratically elected to the IJB. Can you explain the context of that election?

Sandra Auld: I am happy to do so. In Perth and Kinross, we looked at how service user representatives were elected and, working with the community engagement team, we ran a campaign to inform people that an election for service users was forthcoming. There were posters as well as an online campaign, using the community council's Facebook pages et cetera; candidates were asked to put themselves forward and to make a statement as to why they should be elected; and we worked really hard to try to describe the role and to reasonably describe the time commitments and what was wanted, needed and required.

A date was then set. I think that the election period was longer than a fortnight. We tried to make the process as accessible as possible. People could vote online, in person or by telephone. Obviously, resources were required to allow the election to happen, but we felt that it was necessary in order to make the process as democratic and inclusive as possible.

Paul Sweeney: It strikes me that connecting membership to a mandate is quite a useful innovation, so perhaps we need to further consider that.

Critics have raised concerns that elected officials—primarily, councillors, although the occasional person on a health board might be directly elected—would become a minority on integration joint boards. On the line of accountability from the public to the decisions that are made, which might often involve a fraught financial dispute or a dilemma about which services to fund and defund, how will representatives of the public be held accountable? How will the extension of voting rights strengthen, rather than dilute, accountability for decisions on the allocation of public funds?

Sandra Auld: I feel strongly that it will benefit accountability. There is no doubt that training and support—which should already be provided but are not—need to be put in place, particularly for new members. I chair a service user reference group, which allows information to flow to and from the IJB and allows views and concerns to be raised not only at the IJB but at some of the groups that feed into it, such as the strategic planning group, which is co-chaired by a public partner. That has been quite a forward-looking move in Perth and Kinross.

This is all about engaging with and trusting communities and the people for whom the services are provided, not ignoring them or shutting them up. The difference is that, as well as public partners being involved in the discussions, they would be able to vote on such matters.

Is it okay for me to go on?

Paul Sweeney: It depends on how pressed we are for time.

The Convener: We need to move on.

Paul Sweeney: My colleagues might ask questions that will allow you to elaborate, but we need to keep the discussion pacey.

Are there any further points about whether the changes will dilute or strengthen accountability?

Natalie Masterson: I highlight that there is no suggestion that the level of councillor representation will be reduced. Their representation on IJBs will remain equal to that of health boards.

We must consider what is needed for transformation. The previous witnesses highlighted that difficult financial decisions have to be taken. I could not agree more. Audit Scotland has highlighted major fiscal and operational pressures, so transformation is not optional but essential.

Early intervention and prevention measures are the only things that will save our health and social care system. That requires the voices of people with lived experience to be represented properly. Eighty per cent of IJBs are in financial difficulties—they are overspending, relying on one-off savings or drawing down reserves—so we must transform health and social care services. To do that, we must involve the voices of the people who are most affected by the health and social care system.

Rob Gowans: Currently, IJBs include NHS board reps, who are not democratically elected, as voting reps. When the ALLIANCE was trying to contact the members of an IJB about a decision, we found that it was hardest to track down the contact details of the NHS board members, not those of the service user, third sector or carer representatives.

12:00

I think that it is not currently the case that all members of IJBs are democratically elected. As Sandra Auld highlighted, there is some good work going on in parts of the country to ensure that the lived experience reps are representative of the community. We are doing some evaluation of the project in Perth and Kinross with a view to sharing examples of good practice. It is not necessarily the case everywhere, but where lived experience reps have not been connected to communities, that has been partly due to a lack of support or infrastructure, or there not necessarily being an induction process to take them through what their role is and what is there to support them.

One of the other reflections that I would make is that, as part of our health and social care academy work, we have set out five ambitions for the future of health and social care, in order to deliver transformational change, particularly around supporting integration. One of those ambitions is sharing power and ceding power. We see that as vital to ensure that everybody is involved and that power is not restricted to particular groups of representatives. That has been happening across the work. An ideal example of sharing power would be ensuring that all members of IJBs have voting rights and can be treated as equals.

The Convener: We are extremely tight for time, so I ask members to be succinct with their questions. It is vital that we hear the witnesses' evidence, but I would be very grateful if they could be as succinct as possible in their answers.

Brian Whittle: We know that there are third sector representatives who may also be commissioned providers and that there are lived experience members who may receive some of the services. What governance safeguards should be put in place for such situations? When there is a conflict, how do we make sure that there are safeguards in place for those who are sitting on the panel, so that we mitigate risk?

Natalie Masterson: I am happy to go first and then I will pass over to Sandra Auld. I really appreciate that question, because it gives me the opportunity to clarify a misunderstanding. At the moment, there are both voting and non-voting categories of IJB members. As a non-voting member, I am subject to the same governance, code of conduct and accountability requirements as any voting member. That means that I need to register my interests and ensure that, on any paper coming up, I cite where I have a conflict. What would change in the future? I absolutely concede that voting brings that issue into sharper focus, so we might need to improve training and support. However, the important point is that the existing provisions for how we manage conflicts of interest will be carried on. Every piece of training that I have received over the years has reiterated the point that, at the moment, I, as a non-voting member, am subject to the standards in public life by sitting on this board.

Speaking on behalf of a third sector interface and those in the TSI Scotland Network, I would say that third sector organisations—if they are providing a commissioned service—are very capable of ensuring that they manage their conflicts of interest.

However, no one questions the legitimacy of the health board reps when they are voting on the importance of maintaining hospital beds. No one comments on the legitimacy of our councillor reps when they are voting on maintaining the current in-house delivery of day services as opposed to other models. The issue of conflicts of interest cannot just be put to third sector organisations as a way to keep them quiet.

Brian Whittle: I will layer a question on top of that before I bring in Sandra Auld.

I was suggesting that, if you had a conflict of interest in a situation, you would forego your voting rights on that matter. My only issue with what you say, Ms Masterton, is that councillors are voted in; they are public servants and have an accountability to the public. The suggestion is that there could be people on the board who would not be accountable to the public in the same way. That is the only thing that I would say about that.

Sandra Auld: I concur with a lot of what has just been said. As a service user member, I am accountable via the codes of practice, the council standing orders, the IJB, the Public Bodies (Joint Working) (Scotland) Act 2014 and so on. In relation to confidentiality and conflicts of interest, declarations of interest are absolutely in place and have been in place, so conflicts of interest are manageable, and they do not apply only to certain members of IJBs; they apply to all of them.

I will pick up on the finance and budgetary aspect of the issue. We have heard quite a lot of discussion about the difficulty of decision making on budgets. I feel strongly that, as I said earlier, the proposed change would drive behaviours whereby public partners and the third sector were involved in discussions leading to decisions being made, rather than being excluded, as has happened previously.

I became aware that there was a budget review group in Perth and Kinross. When I asked whether I could be part of it, because I am a member of the audit and performance committee, I was told that the budget review group was only for voting members.

That example supports my view that this is not just about voting and raising your hand around the table; it is about what you can be excluded from before you even get to that.

Brian Whittle: I do not know whether there is anything to add, because I know that we are really short of time. I have lots to talk about, but I will leave it there, given that we are so short of time.

Emma Harper: I take on board what Natalie Masterson said about the voices of people in the third sector and the conflict of interest that Brian Whittle asked about. I know that there is a diverse range of people with lived experience and that hearing different stakeholders' voices needs to be part of the process. How could we make sure that everybody was represented? How could we make sure that that process was open, engaged and transparent so that those voices could be heard?

Natalie Masterson: That is an important point. From the inception of integration, it has been stated that support should be provided to members with lived experience to engage with their communities and the people they represent. The TSI Scotland Network response indicated that it is important to put greater focus on that aspect. This is an opportunity to bring more of a focus on voting rights.

We have heard great examples from Perth and Kinross on service user elections. We in Stirling and Clackmannanshire operate a third sector forum, which ensures that we listen to the voices of people from a variety of groups.

That is just one tool that we can use to ensure that we hear more diverse voices and embrace deliberative democracy just as the Parliament has done. However, it is not the only tool. Its use should go hand in hand with the proper participation and engagement structures that must be embedded right through our health and social care system.

Rob Gowans: We agree that adding voting rights would help to enhance the work that is being done to support and improve representation and representative structures. At the moment, a number of areas have vacancies among the lived experience and carer representatives. We found that there is a lack of consistency in the selection processes and the support provided and in whether there are community forums or similar things for people to engage with as Sandra Auld described earlier.

Our report, “More than Equal—Valuing and supporting the expert contribution of people with lived experience”, makes a large number of recommendations to address those issues, such as recruiting proactively and inclusively to the roles, providing clear information on them and on the support that will be given to reps when they are in those roles, ensuring that recruitment processes are inclusive, monitoring representation and ensuring that proper induction training and succession planning take place. We are keen to share existing good practice across boards to encourage that approach.

Adding voting rights will probably add impetus to that, if boards are carrying vacancies among voting members or are having difficulty recruiting because of a lack of available support or a lack of clarity on the role. Voting rights could be very positive in that respect.

Sandra Auld: I mentioned the service user reference group. I also want to mention that my carer colleagues on the integration joint board link closely with the local carers’ voices group, which means that there is a two-way exchange of information. The group is able to reflect not just concerns but successes, as the exchange is not all about the negative things.

I am also a member of the ALLIANCE national group, and it has been very interesting to hear about the good practice that exists among the IJBs in Lanarkshire, for example, as well as wider examples of really poor practice. For instance, we hear of public partners and lived experience representatives not even being allowed in the same room to have coffee after meetings or during breaks. That kind of practice is on-going and certainly could do with being changed. I suggest that if public partners had voting rights, that practice just would not happen.

It would be helpful to have a baseline not of standards—I steer away from saying that—but of requirements and to look at the ALLIANCE’s work to draw out and learn from the excellent practice that is happening.

Emma Harper: Why would people be segregated during coffee breaks?

Sandra Auld: Because the voting members do not want to be with the others. It is shocking.

Emma Harper: Okay.

Gillian Mackay: I have a quick question, but the answer to it might not be quick. It is on the support, training and resourcing required to ensure that extending voting rights would be meaningful and not tokenistic, and what form of support would be most important. I will go to Sandra Auld first, because of her experience as a voting member. Sandra, what support do you currently have? If you were doing this again from scratch, what support do you think it would be good for other people to have?

12:15

Sandra Auld: There is a real need, from the outset, for lived-experience representatives to become part of IJBs, with an induction programme initially and then on-going training and support. In Perth and Kinross, our administrative support comes from the community engagement team, but that also has to be balanced with its capacity issues. Therefore, there are pulls on that support, and we have to defer to them. A balance has to be struck, and it would be helpful if there were some sort of ring-fenced budget, so that that team did not have to feel guilty about supporting us.

My colleagues and I are only able to do what we do because we have that support. Otherwise, it would be difficult to do it properly or well. The legislation that is in place means that the support is available, though not as much as would be preferable.

Rob Gowans: One of the things that the ALLIANCE has done, in partnership with the Coalition of Carers in Scotland, is put together a report on providing support for the unpaid carer representatives on IJBs. The report, the main title of which is “More Than Equal”, looks specifically at what support is needed and should be put in place. Its recommendations are titled “strengthen recruitment and representation”, “build capacity”, “support equity of involvement” and “evaluate impact”, and it explores continuous improvement.

The report covers practical steps that could be taken, such as having pools of carers or people with lived experience who can share the load and “populate strategic groups”. It also contains a bit about the support that is available on meetings. If jargon or technical points are contained in papers, someone should be able to explain what they mean. The report also covers how to support people with caring responsibilities and ensure that full expenses are covered, including for placement care. The process can be improved in lots of ways. I recommend reading the “More Than Equal” report for many other reasons besides.

Natalie Masterson: I agree with everything that the other witnesses have said, so I will keep my remarks brief and speak from a third sector perspective. In most areas across Scotland, the third sector interface supports or represents the third sector on the IJB and has the expertise to facilitate third sector forums and bring together people with a variety of voices. One key aspect to consider is that it is not only third sector organisations that identify themselves as health and social care third sector organisations; activities such as taking part in community groups and singing in choirs also keep people well. We have seen the success of recognising those small groups through the community mental health and wellbeing fund distribution.

I want to highlight that TSIs have been on static funding for the vast majority of the time since they were set up. Since integration, that has not been reflected on nationally. Many TSIs are funded locally by their HSCPs, as is the case in the Stirling and Clackmannanshire area. We are funded to support the representation and the voice of the third sector by having a forum and reaching out through our networks.

Joe FitzPatrick: You will have heard that witnesses on our previous panel had concerns about proxy voting, so it would be helpful to hear why you feel that it is important that such voting is included in the instrument, and how we can address concerns around governance, training and conflict checks for proxy voters. Rob, would you like to go first?

Rob Gowans: Other witnesses might be able to speak more about specific examples, but one thing that we have heard is that it would be beneficial for members with lived experience to have access to other members. In practice, some roles have been shared to ensure that members with lived experience can be fully involved in meeting time commitments and that the load can be shared. Sandra Auld has a good example of that, which she might want to speak about.

Sandra Auld: Effective processes are already in place in that substitutes and proxies can be brought in for NHS and council colleagues. There is no reason why something similar could not be put in place for members with lived experience.

Joe FitzPatrick: Would you encourage those proxies to be predetermined and trained in the same way?

Sandra Auld: Yes, that is important.

Joe FitzPatrick: That is good. Thank you very much.

The Convener: We probed the issue quite a lot in the previous committee session. I tried to tease out from witnesses the existing arrangements for councillors who cannot come to a meeting, for example because they are on holiday or unwell. The same is true for health board representatives. I could not quite get my head around why the same systems could not be used for third sector organisations, unpaid carers and so on. Do you envisage any issues with being able to access proxies who have the relevant information to fulfil the role?

Sandra Auld: No. As I said, it is eminently doable; it would just require a little bit of foresight—thinking ahead, looking at the agenda items that are coming up, determining whether a vote might be necessary and acting accordingly. It is absolutely surmountable.

Brian Whittle: On that point, there are precedents for that, even within this committee. We have substitute committee members, who receive the same training as regular members. It is the same for people in the NHS and for councillors who sit on IJBs. My only question is about whether there would be a cost implication from your members having a proxy.

Sandra Auld: As was mentioned earlier, an adequate expenses policy should already be in place, and that could be applied to the proxy member as well. I am aware that some of my colleagues do not claim travel expenses at all, but that facility absolutely should be available because the process needs to be inclusive.

Brian Whittle: There would be a training cost as well, would there not?

Sandra Auld: Yes, but that could be part of succession planning. A proxy could be someone who steps into the role at a later time, so I suggest that the training cost would be money well spent and would have been used effectively.

Elena Whitham: Beyond the extension of voting rights, would any other changes address the current power dynamics on IJBs?

Sandra Auld: As I said earlier, establishing parity—which goes beyond voting rights—is fundamental. I absolutely believe that having voting rights will be the driver to take parity forward and allow lived-experience voices to be heard, included and considered as part of the decision-making process.

It is all about people being treated respectfully. Those things are all part of upholding standards and should already be happening; part of the reason that they are not is the lack of parity. I deeply believe—I am sure that you can hear this from the way that I speak about it—that it would be a welcome way forward.

Elena Whitham: Do our other witnesses agree that there is no way to achieve parity without the extension of voting rights?

Natalie Masterson: I whole-heartedly agree with that, but I would take it one step further. The power imbalance in the IJB reflects the power imbalance in how we design and deliver public services. In the current power situation we are simply replicating the status quo, which is not sustainable. We need to transform.

For my last point, we asked our fellow IJB reps and people involved in the HSCP to share their thoughts. My Argyll and Bute colleague passed on a quote from Becs Barker, who manages the community contacts project. She said:

> "We understand the lived experience of people we support because we are embedded in their daily lives. This deep, authentic connection means that we are uniquely placed to have community-driven insights, but our voice is not equal."

I believe that voting rights are the only way to ensure that.

Elena Whitham: Does that demonstrate that governance reform is the only thing that would lead to true public service reform?

Natalie Masterson: I believe that that is the case.

Elena Whitham: Thank you.

Rob Gowans: We agree. Although lots of steps could be taken to correct the power imbalance, voting rights are vital to ensuring that people are equally valued as part of IJBs.

The Convener: Thank you all for your attendance and evidence. I apologise that the committee ran late and that we held you up. I will briefly suspend the meeting for a changeover of witnesses.

12:27

Meeting suspended.

12:31

On resuming—

The Convener: For our third and final evidence session on the negative instrument, I welcome Tom Arthur, the Minister for Social Care and Mental Wellbeing, and the following Scottish Government officials: Imogen Lambert, team leader for national care service participation policy; John Paul Liddle, deputy director for the national care service; and Lucy McMichael, head of branch in the social care legal services unit.

I invite the minister to make a brief opening statement.

The Minister for Social Care and Mental Wellbeing (Tom Arthur): Thank you, convener. I thank the committee for the invitation to discuss the order, which covers an important issue.

I am pleased to have been able to respond to the call from people with lived experience of social care on the matter of voting rights on IJBs. The message has been loud and clear: lived-experience members have not felt included as equal and valued members of IJBs. The order is a step in the right direction to change that.

From the hundreds of people who attended our co-design sessions, participated in the lived-experience experts panel and responded to our survey during the development of the national care service, from the multiple organisations representing those with lived experience that responded to our consultation and participated in the expert legislative advisory group, and from the lived-experience representatives who took the time to speak with my officials during the development of the order, I have heard clearly and consistently that they want a more effective voice at the table.

To that end, I must address the criticism from COSLA and others that the order was laid without sufficient consultation. That overlooks our sustained engagement on the specific issue of voting rights over the past five years, including intensely throughout the past year. Quite frankly, I believe that a whiff of paternalism runs through many of the hesitations that have been raised. As one of our existing lived-experience representatives put it, we are yet to encounter a problem or concern that could not be understood and resolved with appropriate training and guidance.

Since the Public Bodies (Joint Working) (Scotland) Act 2014 was introduced, lived-experience representatives have been involved in discussions on planning and budgeting in IJBs. IJBs already have a responsibility to ensure that lived-experience representatives can understand and contribute to those discussions. That is not new.

I reassure the committee that the concerns that have been raised are being taken seriously. My officials are wasting no time and have already established a short-life working group to support the implementation of the order. The group, which had its first meeting last month, is made up of representatives from across Scotland, including those with lived experience and public sector leaders. The group will look at what else can be done to address barriers to full participation on the boards.

As I have set out in correspondence, I am committed to reviewing recruitment processes for IJB members with lived experience to mirror processes for other public body board members. My officials are working with the Standards Commission for Scotland to ensure that codes of conduct reflect the responsibilities of voting members. The Standards Commission is represented on our short-life working group and we are working closely with it as part of implementation.

We also intend to introduce investment and greater support to help representatives with lived experience to discharge their added responsibilities. That will involve greater input from our third sector partners—most significantly, the ALLIANCE and the Coalition of Carers in Scotland, which provide excellent support for the current cohort of lived-experience representatives and have been crucial and critical friends in our development of the voting rights proposal.

People with lived experience provide valuable insight into the challenges and opportunities that should be considered during IJB planning. Through this proposed change, we expect to see more inclusive, collaborative and improved decision making. It is not credible to suggest that strengthening the role of people with lived experience in decision making will somehow make the IJBs less democratic. I hope that the committee agrees that the order that is being considered can play an important role in strengthening the voice of lived experience.

The Convener: Thank you, minister. We will move straight to questions from Paul Sweeney.

Paul Sweeney: Thank you, minister, for your opening statement. I want to establish what specific problems in the current governance framework the order is intended to solve, and how extending voting rights will deliver those outcomes.

Tom Arthur: As I touched on in my opening statement, there has been a consistent call from the voice of lived experience; indeed, the issue was referenced in the Feeley review. The Scottish Government and COSLA recognise the vital and important role of lived experience across a wide range of policy areas in having a more participative approach to democracy. The order will help to change the dynamic in the way in which IJBs conduct their business.

We have reflected on the fact that we have heard directly from individuals who have lived experience and have been on IJBs that they feel that they have not been fully included in the process and that their participation can be somewhat tokenistic. The order changes that. Enabling those with lived experience—that class of representatives—on IJBs to have voting rights changes the dynamic and the conversation and, crucially, it empowers. That can lead to more effective governance and decision making at the local level.

Paul Sweeney: The concern was raised that the lack of a link back to a public mandate might be a concern. We know that is there is certainly a public mandate in relation to councillors, but that is maybe less the case with health board members, most of whom tend to be appointed. There was an interesting discussion earlier about people from certain care-experienced or lived-experience backgrounds who would have sought a democratic mandate of sorts if they had the right support—there was an interesting example from Perth and Kinross. Have you looked at how you would deepen that level of democratic legitimacy in light of the change to IJBs and whether that can be woven into the structure?

Tom Arthur: There are two points to make. One is about the specific measures that we are considering to extend voting rights, and the other is more broadly about ensuring that the voice of lived experience is able to engage and participate fully in the democratic process. On that latter point, we would all agree that we need to continue to ensure that full support is provided to all people who wish to participate and engage in our democratic process by seeking elected office, whether to a local authority, the Scottish Parliament or the UK Parliament.

What we are looking at specifically around voting rights strengthens the democratic process. In general terms, democracy is not just a one-off event at the ballot box every five years. We have seen good working between the Scottish Government and local authorities through COSLA to strengthen participatory democracy in other areas, such as participatory budgeting and the democracy matters work. The order is an example of how we can strengthen decision making at the local level by ensuring that the voice of lived experience, which is already present on IJBs, has additional power through voting rights. That will change the dynamic in discussions and decision making.

We absolutely need to ensure that all who wish to participate in our democratic process and seek elected office are supported to do so. Indeed, as I said in my opening remarks, in terms of enhancing voting rights, we will be paying particular attention to and focusing on ensuring that those lived-experience members are fully supported so that they can fully engage and discharge their responsibilities on the board.

Paul Sweeney: Do you have any examples of good practice that you have seen? I mentioned Perth and Kinross. Is there a gold standard that you have seen that you want to become the standard everywhere? If we are introducing such a structural change, we will want to see standing orders, if you like, or certain procedures being embedded, with good practice carried out. Should there be a wide consultation within the community to seek candidates and endorsements of individuals to represent groups on the IJB, for example?

Tom Arthur: I appreciate the point that you are raising, Mr Sweeney. If I identify some practitioners and omit others, there is a risk that people might infer from that a criticism directed at any individual body that I do not mention, so I will resist doing that. However, I would always encourage good practice to be widely shared through the existing collaborative approach.

The order will certainly change the overall dynamic that exists within IJBs as a result of the additional rights that lived-experienced members will have. Where there are areas that already have strong existing practice, I know that they will appreciate and understand the value that that will confer. In areas where there have perhaps been more challenges and there has been negative feedback from lived-experienced members, I think that the change can be particularly impactful.

Carol Mochan: I can tell how keen you are to get that voice of lived experience—that is great to hear, because I know that that is what people are trying to do. It is just about seeing how we can get there.

Somebody on the previous panel talked about lunch clubs and gardening groups, and about thinking of the third sector and lived experience in that really wide way. To build on Paul Sweeney’s point, is the range of different lived experience on IJBs across Scotland mapped out at all? Your officials might have done that work. It would be good for us to get that information—not necessarily today, but at some point.

My other point is about accountability, which links to the mapping issue. We want this to happen, but we also want to know that there is accountability, that people have representation and that they can go back and forward. Some of the work that has been talked about is great, but how do we make sure that it is happening across Scotland?

Tom Arthur: I warmly welcome the sentiment that you express, Ms Mochan, and I appreciate that you are seeking assurance around the process. I sought to touch on that in my opening statement. Through the working group that we have established, we will of course want to provide assurance around the process. A number of things will need to be taken account of in terms of governance, standing orders and procedures, but these are not novel issues. We are all familiar with operating within a parliamentary environment. Those processes are well established on public bodies, and the engagement of the Standards Commission, through the working group, will assist us in ensuring that we can provide that full information and consistency of approach so that people are able to participate fully and so that rights and obligations are fully understood.

You asked about the range of lived experience. There is a huge amount of lived experience, and being able to tap into that is one of the strengths of our current model, which I think will only be strengthened by the conferring of voting rights.

With regard to mapping the range of lived experience that exists across IJBs at the moment, I do not have that information to hand. I would be happy to come back to the committee on that—unless any officials want to say something.

Imogen Lambert (Scottish Government): We can come back to the committee on that.

Tom Arthur: We will come back to you on that, rather than giving you information off the cuff. If there is a desire for it, we can certainly look at what we have available and provide an update to the committee.

Carol Mochan: Perfect. Thank you.

Brian Whittle: I have been looking at governance, codes of conduct, ethical standards and accountability frameworks. How does the Government plan to ensure consistent standards across all voting members? How will the Government ensure that the order encapsulates the issues around potential conflicts of interest for third sector organisations that are involved in commissioned services or individuals with lived experience who receive direct support?

Tom Arthur: Those are important questions, and I fully appreciate that the committee wants to explore them. My first point, as I touched on in my previous answer, is that those are all things with which we are quite familiar and have established processes for. If we think about how we conduct ourselves as MSPs in this Parliament, we have a register of interests and we need to declare any interests. Similarly, on public boards, there are long-established processes for dealing with conflicts of interest.

12:45

We have established a working group, which has already met. Subject to Parliament not standing in the way of the order, that working group will continue. There is a Standards Commission representative on the group, which will work through the specific areas pertaining to the points that Mr Whittle raised about processes and conflicts of interest, to ensure that clear guidance is provided and we can have full confidence in the process that will be undertaken when voting rights come into effect at the beginning of September.

I do not know whether there is anything that officials want to add to that.

John Paul Liddle (Scottish Government): The only thing that I would add is that some of that is already happening. People who are currently lived-experience IJB members—and have no voting rights—have a code of conduct that applies to them because, although they do not have a vote, they are already part of discussions around the planning and commissioning of services, which might have an impact on services that they access directly or have a role in delivering. It is about working with the Standards Commission to ensure that the code of practice that is already in place can be revised to include the issue of voting rights.

Brian Whittle: The only caveat that I would add to that is that the people who are currently voting members of the IJB are elected members, who are accountable to the public. If we give voting powers to other members, the scenario might not be the same. I know that the issue is not insurmountable, but there is a slight difference.

I will quickly ask one question that has occurred to me. Minister, you know that I am a big advocate of the third sector, of hearing the voice of the third sector and of the impact that the third sector can have on communities. We have a healthcare system that is already bloated. In my opinion, there are too many people in our healthcare system who can say no, and now we are looking at adding more people to committees. If your plan is to bring the third sector and commissioned services into that scenario and to give them a vote, why not reduce the number of voting members in the other two categories—the NHS and the council—to keep the numbers down? We seem to be adding more and more people into the system.

Tom Arthur: The first point, of course, is that a class of lived-experience members—third sector, unpaid carers and service users within the local area—are already on the IJB. The order is about changing their status on the IJB to one in which they will have voting rights. The second point is that there will be variation in the composition of membership of different IJBs, based on the size of the area in which they are working.

More broadly, on wider questions and looking at the overall governance structure, we had an extended debate earlier in this parliamentary session on the national care service proposals. Parliament arrived at a particular position, and there was a commitment between the Scottish Government and local authorities, through COSLA, to work constructively and collaboratively across a number of areas in order to strengthen not just performance but the voice of experience. I come back to the point that this change can play an important role not just in enhancing and strengthening local accountability with regard to governance, but in ensuring that the voice of lived experience—and the expertise that is contained within it—is fully brought to bear on decision making.

Brian Whittle: My point is that, if we are going to bring in that lived experience, why add to the numbers rather than replacing members?

Tom Arthur: These individuals are already around the table. Rather than just being in a position where they can be consulted and contribute, they will have a vote, and that is an act of empowerment. We are not proposing adding members to the discussion forum, but increasing the proportion of members who have votes as part of the decision-making forum. The order will give those members a vote, which will empower them. The overall size, composition and structure of IJBs is obviously a much larger question that goes beyond the scope of what we are considering today. The order is ultimately about enhancing the rights of a category of members who already sit on IJBs.

Emma Harper: We heard this morning about the diversity of the people that would be required in order to ensure that there would be proper representation of those with lived experience and so on. Not all non-voting members are included in the order, so I am interested to hear about the decision to include members with lived experience but not staff representatives, who have been omitted, although, when I look at the membership of Dumfries and Galloway's IJB, I see that there is a staff representative on the NHS part of that list. I would be interested to hear about the inclusion or otherwise of certain groups in the order.

Tom Arthur: The order responds to calls for the inclusion of those with lived experience: service users, third sector workers and unpaid carers—that is the particular focus. I am happy to give wider consideration to the issue. The role that you are talking about is distinct from the role of the lived-experience representatives, and other matters would have to be taken into account, so that is not something that the Government is close to giving further consideration to. The order before us responds to the specific calls for voting rights for those with lived experience.

Emma Harper: Will people with lived experience need to demonstrate their links to their wider communities and stakeholders, so that there are good feedback loops?

Tom Arthur: There are already established practices. The legislation that governs this is now 12 years old. I think that 2016 was the point at which all areas had to conform with that legislation and establish local integration authorities.

We now have a decade's experience and established processes for people with lived experience being members of IJBs. What the order fundamentally changes is their status from that of non-voting members to voting members.

Emma Harper: Will there need to be national guidance about how members will be selected, so that there is consistency across IJBs, or do we already have processes in place that would allow that?

Tom Arthur: There are already established processes in place. What I have touched on with regard to the work of the working group is a recognition of any additional guidance, advice and support that will be required, given that change of status of people with lived experience from being non-voting to voting members.

Gillian Mackay: I have just one question. The previous witnesses told us about the resources that people need to feel supported in being able to be full voting members. We heard that Perth and Kinross Council has already done work to make people with lived experience full voting members of the IJB, but that the support that is required in order to make that happen represents an additional cost, as it involves things such as accessible papers, early circulation of documents and administrative support. What resource package will be provided by Government to support the extended voting right, so that it is not tokenistic, and to ensure that the policy outcome is achieved?

Tom Arthur: That is an important question. A right is only a right if it can be realised. We recognise that those with lived experience, whether users of social care or unpaid carers, will potentially face additional challenges and require additional support. The points that you make about things such as accessible documentation are important, and there is a range of other issues that we have to look at to ensure that people are fully supported to be able to participate. Participation involves not only their attending a meeting, but having the time to consider the papers, form an opinion and consult on the issues, if they wish to do so, just as we do in our roles as MSPs.

As I touched on in my opening remarks, an important part of the work that we do ahead of implementation in September will involve consideration of the support that we provide and engagement with partners such as the ALLIANCE and the Coalition of Carers in Scotland, and that includes identifying what additional resources will be required. Obviously, we want to work with our partners to identify what the specific needs will be. We can have an idea of what they might be, but we want to work that out in more detail, so that we are in a position to ensure that the appropriate support is provided.

I agree with you entirely that it is not enough simply to have the right, and that support has to be in place to allow people to participate fully and to be able to exercise that right to the fullest extent.

Joe FitzPatrick: I have a quick question about proxy voting. You probably heard the witnesses from COSLA, who were on the first panel, complaining that there was a lack of consultation on the proposals for proxy voting and saying that they were concerned that proxies would not be suitably experienced and trained. The witnesses on our second panel said that people with lived experience would expect their proxies to be suitably trained. First, can you address the consultation issue and, secondly, can you say whether there will be national guidance around what training and experience would be required for proxies?

Tom Arthur: On the point about consultation, I refer back to my opening remarks. An extended piece of work has been undertaken on this over the past five years, and some intense work has been done over the past year as well. The fundamental question before us today is on the principle of whether we think that people with lived experience should be voting members of IJBs. The Government's position is that they should be.

The questions of process are important, and we are committed to engaging fully with partners ahead of implementation. That is why we established the working group and extended an open invitation to COSLA to participate fully in that.

I appreciate the importance of these particular issues and technicalities, and I do not want anything that I have said to be construed as being dismissive of them. However, the point that I would make is that these are well-established and well-understood practicalities in terms of the process of having suitable governance arrangements within any public body. They are not things that are beyond our ability to address; they are process issues that can be worked through methodically. That is what the working group is there to achieve, and we will be able to identify effective solutions to ensure implementation that everyone can have confidence in.

Elena Whitham: Supporters of the proposal to extend the voting rights, including you, minister, talk about the proposal being inclusive and helping to embed participatory governance. Could you share with us what outcomes you expect from the move? Do you think that it will bring about earlier co-design? Is it expected to ensure that there are prevention-focused decisions? What are the outcomes that the Scottish Government wants to see?

Tom Arthur: All of the points that you have touched on are examples of the positive impact that the proposal could have. Of course, the order is about the enfranchisement of people with lived experience who are members of IJBs and, ultimately, there is a degree to which we cannot pre-empt the outcome of decisions that might be taken—in any democratic structure, we cannot pre-empt the outcomes that will arise from people having the opportunity to exercise their vote. What I hope will happen is that the proposal will help to address the feeling on the part of those with lived experience that they were not fully included in the decision-making process of IJBs and that their role was almost tokenistic. That situation will come to an end, because, if the order comes into effect, they will have voting rights, and that will change the dynamic entirely. It is not just about having the opportunity to exercise a vote; it is about what having that voting right does to the status of the individuals on the IJB, and the absolute need for their full inclusion and engagement in that process.

I do not want a situation where anyone with lived experience who is a member of an IJB does not feel fully included in the decision-making process or feels that they are there in a tokenistic capacity. If the order goes through, those days will be over, because they will have full rights. It will effect a cultural change as well. I recognise that examples of good practice have been highlighted by the committee, but I have heard far too many examples of that not being the case, and the order is about bringing that situation to an end.

The Convener: Minister, I thank you and your officials for attending our meeting and giving evidence.

At our next meeting, we will take further oral evidence on the Scottish Government's draft climate change plan. That concludes the public part of our meeting.

12:58

Meeting continued in private until 13:12.

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