The Scottish Parliament
Pàrlamaid na h-Alba

# Official Report

# HEALTH AND SPORT COMMITTEE

Wednesday 8 September 2010

Session 3

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# Wednesday 8 September 2010

## CONTENTS

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## HEALTH AND SPORT COMMITTEE
### 23rd Meeting 2010, Session 3

**CONVENER**

*Christine Grahame (South of Scotland) (SNP)

**DEPUTY CONVENER**

*Ross Finnie (West of Scotland) (LD)

**COMMITTEE MEMBERS**

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

**COMMITTEE SUBSTITUTES**

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Nanette Milne (North East Scotland) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

**THE FOLLOWING GAVE EVIDENCE:**

Margaret Duncan (Scottish Government Health Delivery Directorate)
Suzanne Dyer (Citizens Advice Scotland)
Christine Lang (Citizens Advice Scotland)
Liz Macdonald (Consumer Focus Scotland)
Jim Martin (Scottish Public Services Ombudsman)
Fiona Montgomery (Scottish Government Healthcare Policy and Strategy Directorate)
Kathleen Preston (Scottish Government Legal Directorate)
Alastair Pringle (Scottish Government Healthcare Policy and Strategy Directorate)

**CLERK TO THE COMMITTEE**

Douglas Wands

**LOCATION**

Committee Room 5

# Scottish Parliament

## Health and Sport Committee

*Wednesday 8 September 2010*

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

## Decision on Taking Business in Private

**The Convener (Christine Grahame):** Good morning and welcome—the word “back” should not apply to MSPs, because I know that you have been working very hard elsewhere during the vacation.

I remind everyone to switch off mobile phones and other electronic equipment. No apologies have been received. I welcome everyone to the 23rd meeting of 2010 in the third session of the Scottish Parliament.

Agenda item 1 is a decision on whether to take item 4, which is consideration of a candidate list for the post of budget adviser, in private. Do members agree to do that?

**Members** *indicated agreement.*

## Subordinate Legislation

### National Health Service (Discipline Committees) (Scotland) Amendment Regulations 2010 (SSI 2010/226)

### National Health Service (Tribunal) (Scotland) Amendment Regulations 2010 (SSI 2010/227)

### Scottish Dental Practice Board Amendment Regulations 2010 (SSI 2010/228)

### National Health Service (Vocational Training for General Dental Practice) (Scotland) Amendment Regulations 2010 (SSI 2010/229)

### National Health Service (Tribunal) (Scotland) Amendment (No 2) Regulations 2010 (SSI 2010/266)

10:01

**The Convener:** The next item of business is consideration of five negative instruments, which consist of regulations for discipline committees, tribunals and dental services within NHS Scotland. Members have copies of the instruments, as well as a cover note from the clerk summarising their purpose. As the Subordinate Legislation Committee had no substantive points to make on any of them, I do not propose to go through them one by one. Are members content not to make any recommendations on any of the instruments?

**Members** *indicated agreement.*

# Patient Rights (Scotland) Bill: Stage 1

10:02

**The Convener:** Item 3 is our first oral evidence session on the Patient Rights (Scotland) Bill. Two panels of witnesses will give evidence today, the first of which consists of officials from the Scottish Government's bill team. I welcome Lauren Murdoch, bill team leader; Fiona Montgomery, head of patient support and participation division; Alastair Pringle, head of patient focus and equalities; Margaret Duncan, waiting times policy lead; and Kathleen Preston, health and community care solicitor, who is from the Scottish Government legal directorate.

As we have a series of extremely helpful cover notes from the bill team, as well as a regulatory impact assessment and an equality impact assessment, as part of our papers for the meeting, I do not think that the committee requires any opening statement. We are under time pressure today, too, so we will move straight to questions.

**Helen Eadie (Dunfermline East) (Lab):** I would like to ask the bill team a question about the evidence that we have received. A number of submissions questioned the concept of providing rights with no sanctions in the event that those rights are not met. Some organisations—in particular, Age Scotland—went as far as to question whether they could be considered as legal rights at all. I invite the bill team to respond to that.

**Fiona Montgomery (Scottish Government Healthcare Policy and Strategy Directorate):** The Government feels that patient rights are extremely important. One reason for having a bill is that we want to put patients at the heart of the NHS, and we think that having rights in primary legislation gives them the priority and prominence that they require.

In an early debate that was held on the bill, members in the Parliament made it clear to us that they did not want a lawyers' charter around the bill, so we have tried hard to develop a bill that will give people rights but which will not take it to the next stage, which could result in there being a lawyer by every bedside, with people suing any time they think that their rights have not been met.

**Helen Eadie:** I hear what is being said, but I will make my own mind up on that issue and so will everybody else.

The rights in the bill will not be legally enforceable, but a patient could still seek a declaratory judicial review. People may or may not know that that is a pronouncement that an individual or a body has a specific right or duty. It is a useful remedy when the petitioner wants to establish that a particular right exists or that a particular status applies when that has been doubted or denied. The judicial review usually has various other legal remedies available alongside declarators, but in this case other remedies—damages, specific implement, interdict and suspension—would be removed by section 18. Therefore, not only does the bill not introduce any new sanctions, it removes sanctions. This is one of those worrying situations in which patients are, in effect, having rights removed.

**The Convener:** A lawyer here was about to answer the question, but I remembered that, as I am in the chair, I must not answer it.

**Kathleen Preston (Scottish Government Legal Directorate):** Perhaps I could answer it.

The bill will not remove any rights that patients have under the existing law. At the moment, patients have the right to seek judicial review in certain circumstances when there was a question about the legality of a decision or the process by which it had been arrived at. That is a general principle that applies to decisions of public bodies and that will not change.

What we are saying in the bill is that there will not be a right to claim the remedies that we have excluded—for example, damages—for any alleged breach of the rights that are set out in the bill, so the rights that are in the bill will not in themselves give rise to a set of legal remedies. That is the Government's position.

**Helen Eadie:** Convener, I am grateful for that answer and I have no more questions, but I do not think that the witness really answered the point that section 18 in fact removes the legal remedies. However, we will have to leave that as it is perhaps more of a political question.

**The Convener:** You are right. I think that Ross Finnie is on the same trail.

**Ross Finnie (West of Scotland) (LD):** Yes, I would like to pursue the issue a little, if I may.

I make it clear at the outset that I do not contest the importance of patient rights. I do not contest the need for the patient rights that currently exist to be brought together and codified in a more easily understandable way, but I have concerns about the legal import, because the committee is after all being asked to consider a parliamentary bill, which will become law, and I think that we are entitled to ask why we are doing that.

I have two documents in front of me. One you will instantly recognise as the Patient Rights (Scotland) Bill. I hope that you will also recognise the other, as it is “The NHS and You”, which is the currently available publication by the health rights information Scotland initiative setting out existing patient rights, such as they are. The body is financed by the Government. My question to the bill team is this: from the perspective of the ordinary citizen, what would the difference in law be between the status of the document published by the health rights information Scotland initiative and the bill, were it to become law?

**Fiona Montgomery:** Maybe my answer will be more about the importance to the person. What we have found is that the—

**Dr Richard Simpson (Mid Scotland and Fife) (Lab):** Convener—

**The Convener:** Let the witness finish her evidence and you can cross-question her after that.

**Fiona Montgomery:** The difference is that, although “The NHS and You” and various other things in the past have given people certain expectations of what the health service will give them, we still find that patients do not always know or exercise their rights.

**Ross Finnie:** No—I am sorry, but I must interrupt you. My question is very simple. From the perspective of the ordinary citizen, what would be the difference in law between the status of the bill, were it to become law, and the status of the HRIS document?

**Kathleen Preston:** From the legal perspective, the leaflet that has been issued by HRIS, in itself, has no legal status. It is an information document that pulls together statements of rights that exist in many places. I do not have the document in front of me, but I recall that it sets out certain rights, including both statutory rights, for example under discrimination law, and common-law rights, such as the right to confidentiality. It also sets out certain expectations that I, as a lawyer, would not call rights at all—certain expectations about how one would be dealt with in the health service. As a matter of law, that publication, in itself, has no legal effect. Where it restates the law that is found elsewhere, it is simply information; where it outlines expectations, it is not really a statement of the law but just some factual information.

Of course, if the Patient Rights (Scotland) Bill were enacted by the Parliament, it would become primary legislation and the law of Scotland. Therefore, it would be part of our statutory base and would be a statement of the law. The rights that are contained in the bill will become law if it is enacted.

**Ross Finnie:** I am grateful to you. That is very helpful.

Of course, a number of these statements are also based on declarators made by the Secretary of State for Scotland and, now, the Cabinet Secretary for Health and Wellbeing under the National Health Service (Scotland) Act 1978. Therefore, yes, we have certain rights and, yes, there are other expectations. You are telling me, as a citizen, that the rights in the bill would be different because they would be the law. However, as my colleague Helen Eadie has just pointed out and as you are well aware, section 18(2) would remove any rights of enforceability. Therefore, although those rights would become law, what in effect would be the difference to me?

Those matters that are restatements of the current law or declarators made by the secretary of state or the cabinet secretary concerning waiting times or other matters have the authority of the cabinet secretary and she has powers to make those under the 1978 act. I do not want to personalise this, so I will talk just about the cabinet secretary. If that is the case, then, although what is marshalled together in the leaflet might not confer on me a particular right, it tells me what I can expect. If the bill is passed, it will become the law, but it is unenforceable, so what, in effect, will be the difference between the two documents?

**Kathleen Preston:** You have said that the bill would be unenforceable, but my colleagues would disagree with that, as I would.

**Ross Finnie:** The Law Society of Scotland has said that it would be unenforceable.

**Kathleen Preston:** The Law Society is entitled to its view, but the Government’s position is that the bill will specify in primary legislation rights that patients will have. The treatment time guarantee—

**Ross Finnie:** I know what it will specify, but how will it be enforced? What power in the bill makes it enforceable?

**Kathleen Preston:** Within the bill there is a set of remedies that would be available to patients. My colleagues will be able to expand on that. The policy is that the new rights will not lead to court actions by individual patients. No doubt, my colleagues can give you more information on that policy. That does not mean that the rights will not be legal rights.

**Ross Finnie:** With respect, I did not say that. I did not say that they would not be legal rights; I said that I would have no opportunity to enforce them. They would be legal rights—fine, but that would not affect me one jot. They would be no different from what is stated in the HRIS document. I even have rights of judicial review according to that document.

**Kathleen Preston:** Those rights will not be removed, but there will be a statutory right to complain and a statutory treatment time guarantee. Those rights will be matters of law. Health boards, as a matter of law, will be obliged to comply with the provisions of the act. However, it is not the policy that individual patients will be able to sue in court for individual remedies for alleged breach of these rights. I think that that is probably as far as I can go.

10:15

**The Convener:** I think that the cabinet secretary might have to answer other parts—

**Ross Finnie:** It is a matter of law—

**The Convener:** I heard the law bit.

**Ross Finnie:** I accept that we are getting terribly close to a policy issue rather than a legal issue. However, the 1978 act gives wide powers to the cabinet secretary—obviously, it refers to the secretary of state—in terms of the establishment of health boards, the amount of care that is to be provided and the right of the cabinet secretary to do such things as will ensure the procurement of those services. I am not entirely clear about what is now different, as a matter of law. The things that are contained in the HRIS document might not have the force of law in the sense of being part of primary statute, but they have all been made by the utterances either of a secretary of state or a cabinet secretary under the powers that those individuals have under the 1978 act. I am not sure what difference will be made by our having a non-enforceable series of regulations.

**Kathleen Preston:** I can only respond to that on the legal side; other responses would be for others to give. The legal answer to your question is that, as I said earlier, the bill will set out those provisions in primary legislation and Parliament will have decided on the content of the bill and the rights in the bill. As you have correctly identified, ministers have wide powers under the 1978 act. However, those are powers of the Executive that ministers must exercise as they see fit, within the provisions of the law. They are powers that are being exercised by the Government. However, the provisions and rights in the bill are rights that are set out in primary legislation, as sanctioned by Parliament.

That is probably about as far as I can go in that explanation.

**The Convener:** I think that we have clarity now that nothing in the bill is enforceable in a court of law.

**Kathleen Preston:** That is correct, other than the normal judicial review—

**The Convener:** However, if there were an action for damages for medical negligence and it rested on a failure to obtemper the waiting time between agreement on treatment and start of treatment, could this be relied on as persuasive?

**Kathleen Preston:** I think that, in answering that, I might be straying into giving legal advice to the committee, which is, of course, not within my remit. I should make it clear that nothing in the bill will affect any existing rights of patients to sue for medical negligence.

**The Convener:** But it might be persuasive. I am not asking you to give a definitive answer, but is it something that could be relied on by solicitors, who might say to their clients, “You weren’t treated within 12 weeks; you had to wait 20 weeks, and that was a substantive factor in the deterioration in your health”?

**Kathleen Preston:** I think that it would be wrong for me to speculate on the arguments that my colleagues might or might not make.

**Dr Simpson:** Like Helen Eadie, I am concerned about the rights that people will ultimately have. Section 18(2) states:

> “Nothing in this Act gives rise to—
>
> (a) any liability to pay damages,
>
> (b) any right of action for specific implement,
>
> (c) any right of action for interdict,
>
> (d) any right of action for suspension.”

I want to be clear about this. If I want to claim a right under the bill, whether it is a new right or not, and I want compensation, I cannot claim for damages even if I am suing on the ground that failure to provide me with my right was negligent; nor can I claim for specific implement, interdict or suspension.

**Kathleen Preston:** Yes. The intention is that if the only ground of claim is an alleged breach of one of the rights in the bill, that in itself will not give rise to any of those remedies. However, if someone has suffered personal injury as a result of some fault or negligence on the part of someone in the health service, that is not within the terms of the bill and is not affected by the provisions of the bill.

**Dr Simpson:** The point that Ross Finnie was trying to make was about what the ordinary punter is to understand by the bill. All members deal with complaints about the health service, although not daily, I am glad to say, because there are not that many complaints relative to the turnover in the health service. Are you saying that, when we advise our constituents, we will have to decide whether their complaints fall within or outside the scope of the bill? Will we have to consider which bit of someone’s complaint is related to the bill and is therefore unenforceable and which bit might be enforceable and can be pursued? It seems to me that the bill is complicating and not simplifying things for ordinary members of the public.

**The Convener:** Ms Preston, let me give you a break. I know that you are perfectly capable of responding and I am not undermining you in any way, but perhaps the other witnesses want to pitch in.

**Fiona Montgomery:** The bill is the first part of the exercise; there will be regulations, directions, guidance and information for the public. People will not have to decide whether their complaint is in or out just by looking at the legislation; there will be more guidance and advice. That is why the bill provides for patient rights officers, who will help people to make their way through the system.

**Rhoda Grant (Highlands and Islands) (Lab):** I—

**The Convener:** Hang on a minute, Rhoda. May I let Mary Scanlon in? She has been waiting patiently to come in after Richard Simpson asked his B-list supplementary question.

**Mary Scanlon (Highlands and Islands) (Con):** Like other members, I am struggling to understand why the bill is necessary. The sceptics are not just round this table. Consumer Focus Scotland said:

> “Consumer Focus Scotland starts from the position that patients in Scotland already have rights in relation to the healthcare they receive. These rights go well beyond those mentioned in or created by the Bill.”

I found the evidence from Consumer Focus quite persuasive.

We also heard from the Scottish Public Services Ombudsman, who works well with health boards on complaints—I have always found his office to be exceptionally helpful when I have been dealing with complaints from constituents. The SPSO set out a list of recommendations that he has made to NHS boards and said:

> “The provisions in the Bill do not address the above issues in detail”.

Like members, Consumer Focus and the SPSO seem to be striving to find a justification for the bill. The complaints system that we have is good and, in the areas in which it is not so good, it is improving by the day. Will the witnesses respond to the evidence from those organisations, from which we will hear later this morning?

**Fiona Montgomery:** The SPSO said elsewhere in his submission that the bill

> “confirms and makes explicit rights”,

which may be

> “a useful addition to current initiatives to assure and enhance the quality of health services”—

**Mary Scanlon:** Sorry, but the point is—

**The Convener:** Excuse me, Mary, hang on a second, please.

**Mary Scanlon:** I asked a question. I did not ask the witness to quote from another part of the submission. I asked her to respond to the point that I raised.

**The Convener:** Before the witness does that, I ask members to let witnesses conclude what they have to say. Members might not be happy about what is being said, but let the witnesses conclude and then challenge, just so that the *Official Report* of the meeting is not broken up with interruptions.

**Mary Scanlon:** I just want an answer to the question.

**The Convener:** Ms Montgomery, will you finish your answer, after which Mary Scanlon can come in and challenge?

**Fiona Montgomery:** Okay. As I said, there are existing legal rights. For example, people can see their health records. Some things are out there already. There are also what we could call expectations, rather than legal rights. However, we have found that people still have difficulty exercising those rights, which is one reason why we are moving forward. We want mutually beneficial relationships. As all the health interactions go on, we want patients to be active participants in them, so that they have a shared understanding that leads to better health outcomes, because people will be better informed.

We have been making progress on complaints. We commissioned a report a couple of years ago to find out about barriers to making a complaint, which found that many people have issues with the health service but do not raise them for a variety of reasons. We have been working hard to bring that into what we might call the bill package—some issues will be dealt with in regulations, directions, guidance and so on. Although we believe that the health service complaints process is a good one among the public service complaints processes, we still think that there are issues for patients in using it. If we give people a legal right to complain, they might feel that they can exercise it more than they have done, as there has been a barrier in the past.

**The Convener:** Now is your moment, Mary. I was always going to let you back in.

**Mary Scanlon:** Thank you.

I am speaking on behalf of the Scottish Public Services Ombudsman, who is in a good position to make these points. His submission states:

> “With the exception of the treatment time guarantee, the Bill does not appear to provide any significant extension to existing rights and expectations in relation to the quality of NHS services provided in Scotland. Instead, it confirms and makes explicit rights and expectations that currently exist.”

Given that we are arguing about the law, I point out, if I may, that the SPSO goes on to state:

> "The notion of enshrining these rights and principles within primary legislation carries the risk of an unwelcome increase in legalism and litigation in disputes between members of the public and the NHS."

I do not see that as a positive way forward, or that it will help patients in any way. I ask for a response to that.

**Fiona Montgomery:** Throughout the process, including the consultation, we have said clearly that the bill is not about creating a new set of rights for people. There are one or two new rights, such as the treatment-time guarantee and a legal right to complain, but we are bringing together a range of things, some of which, as Ross Finnie said, were in "The NHS and You", and which were expectations in the past.

**Ross Finnie:** I am sorry to witter on about this—

**The Convener:** You never witter, Ross.

**Ross Finnie:** What exactly do you mean by the phrase "legal right to complain"? You have used the phrase two or three times now. Can you please point out to me which section in the bill gives people a legal right to complain?

**Kathleen Preston:** Perhaps I can answer that. Section 1(3) states:

> "It is the right of every patient to make complaints and otherwise raise concerns and give feedback about health care received."

**Helen Eadie:** But there are no sanctions.

**The Convener:** Go on, Ross.

**Ross Finnie:** Is that a new right?

**Kathleen Preston:** It will be the first time that the right has been set out in primary legislation.

**Ross Finnie:** So the rights that are referred to in the document to which I referred earlier should have had a health warning saying, "We're telling you in this patient rights information leaflet that you have a right to complain but, actually, you don't"? Is that what we are saying?

**Kathleen Preston:** No, that is not what I am saying.

**Ross Finnie:** So we already have the right—it is not a new right.

**Kathleen Preston:** I am saying that it will be the first time that the right has been put on the statute book in primary legislation.

10:30

**Ross Finnie:** Will you help us out and explain the difference? Previously, I was told that I have a right to complain; it is set out in the pamphlet, "The NHS and You" and, indeed, in every pamphlet published by every health board. What is the difference between the rights that have been conveyed to me in those pamphlets and this new legal right? What difference will that make to me as an ordinary citizen?

**Kathleen Preston:** As I said, the difference is that the new legal right will be set out in primary legislation. The consequences of having in the Patient Rights (Scotland) Bill the right to complain are set out in further sections of the bill that deal with complaints procedures, on which my colleagues are able to expand.

**The Convener:** May I clarify something? You are saying that a patient will not have more or less of a right than they already have; you are simply putting that right into a document that is like a road map. It says, "Here are the things that already exist for you, but we have put them here so you can find them more easily", including in future guidance and subordinate legislation. Is that your point?

**Kathleen Preston:** All that I can say about the right to complain is that the policy is to put the right in primary legislation.

**The Convener:** We are on to policy matters now. I do not want to stray into that area because it is not your territory—it would be unfair to go into the Government's policy.

**Helen Eadie:** It is not about a lack of accuracy. The bill will remove one of the sanctions under section 18—the path to judicial review. Patients do not have any rights if they do not have sanctions.

**The Convener:** I do not think that you can remove judicial review per se, but I do not want to give legal advice from the chair.

**Helen Eadie:** It is in the Scottish Parliament information centre briefing; it does not come from me.

**The Convener:** I sometimes have issues with SPICe, but I am not going to deal with its briefings at the moment, although I hasten to add before I offend some of the personnel that I do not refer to the briefing that has been mentioned by Helen Eadie. I have already offended many people including cricketers of the world and God knows who.

I want to move on.

**Rhoda Grant:** My question is about the treatment time guarantee in the bill. We have a current waiting time guarantee delivered by the ministers. My understanding is that if the NHS is in breach of your waiting time guarantee as it currently stands, you can use that fact in a court of law if you suffer detriment. Going by the answers to other committee members' questions, to have a treatment time guarantee in the bill appears to be a retrograde step because it would remove a patient's right to legal redress if there were a breach.

**Kathleen Preston:** I cannot express an opinion on what the position is if the existing waiting time targets are breached. I am afraid that I cannot comment.

**The Convener:** We accept that we are not here to seek counsel's opinion from you.

**Rhoda Grant:** Currently, nothing prohibits a member of the public from going to the courts if their waiting time guarantee has not been met and they have suffered detriment. It is clear in the bill, however, that if your treatment time guarantee is not met you cannot do that. It seems to me that the treatment time guarantee and the waiting time guarantee are one and the same thing.

**The Convener:** Perhaps we should raise with the minister that conflict about removing rights or not. I think that members will agree that we have exhausted the topic with the witnesses who are present. However, it is certainly a concern that we should raise with the cabinet secretary and her ministerial team when they appear before us.

What is Rhoda Grant's next question?

**Rhoda Grant:** My next question is about the patient advice and support service, which I understand will take over in part the role of the independent advice and support service. Does every health board area currently have an independent advice and support service?

**The Convener:** Are there any other volunteers to answer that question? You do not get a cup of tea if you do not answer a question—you will be out of the tea brigade. Some of you are too comfortable sitting there.

**Fiona Montgomery:** Every health board has an independent advice and support service, although they all started at different times. We have asked boards to extend those contracts until the end of March 2011.

**Rhoda Grant:** Other than being a national body, how will the new service differ from what is already in place?

**Fiona Montgomery:** One of the main differences is that the service will be nationally consistent. Because each board has had a different contract, some of the contracts differ slightly in respect of access to and availability of the service. One of the main changes will be that the service will be consistent under one contract. That does not necessarily mean that there will be one provider—there may be an umbrella of providers—but there will certainly be one contract.

The other difference is that patient rights officers will have a slightly wider remit. Alastair Pringle may want to say something about that.

**The Convener:** Ah—you have brought in Mr Pringle. That was neatly passed.

**Alastair Pringle (Scottish Government Healthcare Policy and Strategy Directorate):** I have been waiting patiently.

**The Convener:** I know.

**Alastair Pringle:** Patient rights officers will have some specific roles, which will include promoting an understanding of rights and responsibilities for both patients and staff and helping to clarify both existing patient rights and those that the bill will introduce, if enacted. Patient rights officers will be there to provide advice and support for patients in relation to local resolution and mediation if things go wrong, and to provide an objective and independent insight into health services and areas for improvement, working with health boards. They will also be able to signpost to advocacy services where appropriate, and to provide an independent source of advice and information to boards to support the development of advocacy plans. The patient rights officers who will staff the patient advice and support service will have a range of new specific roles and responsibilities.

**Rhoda Grant:** Their role appears to be quite similar to that which the advice and information service plays currently. I understand that the service is run through citizens advice bureaux, which provide an holistic service that is not limited to health services. If people have concerns about welfare, benefits and the like, those can be dealt with in one visit. The services that you describe are available through the service that is in place at the moment, but what will happen to the rest of the holistic package that is provided—albeit that it will not be paid for by the health service? The health service may pay for the services that you have described, but will the new service be able to provide the whole package of services that patients need, including benefits advice and financial advice?

**Alastair Pringle:** It is important not to duplicate the excellent service that citizens advice bureaux already provide throughout Scotland. Although the evaluation of the current IASS indicates that many elements have been really good, we want to ensure that there is greater consistency across all health boards, for all patients. That is one of the important ways in which we want to build on what you have already identified as a good service.

The independent patient advice and support service will be specific to health and wellbeing but will recognise the broader range of issues that may impact on someone's health and wellbeing, beyond just their use of the health service. It is important that the service signposts effectively to the range of advice providers that are available, instead of duplicating existing citizens advice provision. The service will be able both to provide elements of broader holistic advice and information, and to signpost to other existing sources.

**Rhoda Grant:** That seems to be a retrograde step, from the patient's perspective. We should look at the service that is available to people. Instead of meeting one person who will deal with all of their concerns and worries, people will have to meet one person who will deal with their health service complaints. That person may be able to advise them on other issues, but they will have to find someone else who can help them to deal with those issues. By definition, patients are people who are not feeling well and may be at their lowest. They need help and support almost immediately and do not need to have to go rooting around, speaking to different people and making appointments.

The new service will cost in excess of £3 million per annum. It seems to me that there would be a way of changing the contracting arrangements to a national contract rather than several local contracts, which would surely have a cost saving as you would be contracting once rather than several times. There could be an opportunity to amend the system, deal with the problems that exist, save money and ensure that the service to the patient is not affected in any detrimental way.

**Alastair Pringle:** Much of what will be in the patient advice and support service is still being developed as part of the national service specification. That is being done by building on the evaluation of the independent advice and support service and working in partnership with health boards and others. Some of the detail of what will be in the PASS has still to be developed.

I acknowledge Rhoda Grant's comments about a national contract being able to save money. One issue from the evaluation was that a lot of patients are not aware of the service and that there are not necessarily enough staff available for patients. The key aim of the independent patient advice and support service is to offer advice and support to patients individually, so any increase in funding is directly aimed at being able to offer greater accessibility and quality of service.

I reiterate the points that we do not want to duplicate the existing good practice but that the independent patient advice and support service will use sources of advice, such as NHS inform and Citizens Advice Scotland, and draw on their information. Both provide holistic health and wellbeing information, and none of the sources sits in isolation from the others. The Scottish Government believes that the system is building on what exists rather than isolating it or taking a retrograde step.

**Rhoda Grant:** It just seems to me that the service is another layer that someone has to deal with. Although I understand and commend the wish to improve and develop the service, I cannot help but think that there is an easier and more holistic way of doing it than by setting up a new bureaucracy with the costs and so on that are involved. However, that is a policy issue, so I should not be asking about it.

**The Convener:** In the impact assessment, you talk about legal aid and the impact on the legal advice and assistance system. I note that PASS will assist patients to make a complaint or raise feedback about the health care system, so do you think that it could save money for the advice and assistance part of legal aid?

**Fiona Montgomery:** Those are obviously difficult things to quantify, but we definitely think that helping people to get through the first part of the process—which includes complaints, feedback and possibly disciplinary or negligence cases—will make a difference to how cases go forward. I am not saying that we will reduce the number of complaints, but we are interested in getting early resolution for people on issues that have arisen. We hope that the patient rights officers will be able to help with that.

Complaints and feedback are obviously important to boards in learning and improving services, so we want to get that information, and to resolve issues, as quickly as possible.

**The Convener:** I appreciate that you will not give legal advice to people on whether they have remedies and so on, as that would not be the role of PASS. I am just interested to see whether, once PASS is in place, constituents will go to it instead of to MSPs or to legal advice and assistance to ask what they can do—reducing, we hope, the advice and assistance bill. Also, advice and assistance is means tested, so people who would normally have to pay for assistance will get it, too. Is that one of the aspirations for the PAS service?

**Fiona Montgomery:** Yes—but, as you say, it would not be full legal advice. It would be something to get them over the first hurdles, which some people find difficult and which are sometimes why people do not complain.

**The Convener:** Richard Simpson has a different question.

**Dr Simpson:** Part of my question is actually a supplementary to Rhoda Grant's question, but then I have my main questions.

The supplementary question is just for clarity. You talked about mediation and advocacy, which are important elements of what we need to provide for patients to help them through the system. You said that the patient rights officer will signpost mediation and advocacy but not actually undertake them. Is that correct?

10:45

**Alastair Pringle:** Yes. The officers will not undertake those very different activities. An advocate stands beside someone to help them to negotiate systems. It is complex for a patient even to understand what is available. The independent patient advice and support service and the patient rights officer will work with an individual to help them to identify the best possible mechanism for them.

In the work that we have done on NHS complaints, we have found that most people do not necessarily want to make a complaint, but want to feed back or enter mediation-type activity. The role of PASS is not to undertake that work, but to understand someone's issue and to signpost them, or introduce them, to the appropriate mechanism, be that mediation or advocacy. It has a role in providing an independent view on the advocacy provision that is available within health boards, so it is not a totally hands-off role. It is about standing beside the patient, helping to identify the issue and then identifying the most appropriate route through which to address their concern or feedback.

**Dr Simpson:** Does that differ from the IASS role?

**Alastair Pringle:** It builds on it.

**Dr Simpson:** The CAB will act as an advocate and will mediate.

**Alastair Pringle:** IASS will not act as an advocate for a patient.

**Dr Simpson:** It may not do it specifically within that part of its contract, but because it has an integrated, holistic service—which is the point that Rhoda Grant was making—it will assign somebody who will be able to act as an advocate although not as a mediator, which is something slightly different. It will more than just stand by a patient's side; it will promote that patient through the CAB, although it may not do that formally as the IASS.

The point that Ross Finnie and all of us are trying to make is that we want patient rights and we want the patient to understand them, but we must treat the individual patient holistically and get away from silo services. The individuals who come to me have problems with community care that are partly to do with health services, partly to do with social work and partly to do with benefits. I am concerned that we are creating a new set of officers who are simply going to say, "Health is my role and that's what I'm going to deal with. I've got nothing to do with benefits or community care. It's a community care package that's part health but, I'm sorry, I don't deal with the other bits." I am concerned that we are creating another stand-alone silo.

**The Convener:** I am trying to get short questions from members, remembering the earlier conversation that we had. Who will pay for PASS? Who will pay the people who will be acting for PASS?

**Fiona Montgomery:** Currently, health boards pay for the independent advice and support service. We have said that we expect that contribution to continue and that we will pay the additional money from central Government funds. We think that the final bill for the PASS service will be £2 million.

**The Convener:** Mr Pringle kept using the term "independent". If someone is paid within the system, there could be seen to be a conflict of interests when they challenge that system on behalf of patients.

**Fiona Montgomery:** We are producing a national contract, and the funding will come through that national contract. It is important to have a local understanding between the service and the board. For local resolution and to know what is going on in the board, there needs to be some sort of local interaction. The service will be very much independent.

**The Convener:** That is the key. I am not complaining about local knowledge or local this, that and the other, but local people can sometimes get too pally. When we are using the term "independent", we want something robust. We do not want patients to feel that he who pays the piper calls the tune; we want them to feel that they are speaking to somebody who is independent and who will give them straight advice. I just want you to confirm on the record that that will be the case.

**Fiona Montgomery:** Yes.

**Mary Scanlon:** I have an A-list question that has not been raised. It is about the exclusions from the treatment time guarantee, which are important. I will list one or two. Assisted conception is one, but there is obviously an age bar to that. The three exclusions that concern me are direct access services such as X-rays, diagnostic tests and outpatient treatments. Given that there is a treatment time guarantee of 12 weeks, health boards could easily extend the waiting times for X-rays, diagnostic tests and outpatient treatments so that patients could wait as long as the boards wanted for those, which would ensure that the treatment time guarantee of 12 weeks could be adhered to. They are surely integral parts of patients' treatments, but they are all excluded from the treatment time guarantee. Will you explain why?

**Fiona Montgomery:** Certainly. The 12-week treatment time guarantee is within the 18-week referral-to-treatment time. I pass you over to Margaret Duncan for further explanation.

**Margaret Duncan (Scottish Government Health Delivery Directorate):** As Fiona Montgomery said, the 12 weeks will be incorporated in the 18 weeks. To achieve an 18-week referral-to-treatment time, we will need short waits for outpatients for diagnostics. Most patients will be treated much more quickly than 12 weeks because the whole journey should be 18 weeks, but diagnosis takes a while for a few patients' conditions; such patients may need four, five or six different tests before we can diagnose their conditions. Their journey may exceed the 18 weeks, and the idea of introducing a legally binding treatment time guarantee is to ensure that, once they have been diagnosed for treatment, they will receive it within 12 weeks.

Our view is that most patients will be seen much more quickly than within 12 weeks for inpatient day-case treatment because we need that to deliver an 18-week referral-to-treatment time.

**Mary Scanlon:** I hear everything that you say, but do you agree with the points that I am making? Unless a patient has had an X-ray and a diagnostic test and has been at an outpatient clinic, we do not really know what treatment they need. Although most patients may be treated within 18 weeks, the treatment time guarantee could be manipulated to build in a delay that could be detrimental to patients. Why do you exclude diagnostic tests and outpatient treatment from the treatment time guarantee? That is not beneficial to the patient journey. I still do not understand that.

**Margaret Duncan:** The 18-week referral-to-treatment time is the big policy.

**Mary Scanlon:** I understand that.

**Margaret Duncan:** We know that there will be a tolerance on that because it will not be possible to treat every patient within that time because of the complexity of some cases. However, to deliver that time, all the individual steps within it must be as short as possible and we will continue to monitor that, even as part of the 18 weeks, so we will get feedback if people wait a very long time for outpatient appointments. The diagnostic four-week target will still stand, so we will expect most diagnostic tests to be done within four weeks.

We will still have those targets behind the treatment time guarantee, but we are not making them legally binding because, if we have an 18-week target, it may be appropriate for a patient, based on the referral system, not to be seen until 10 weeks down the line. It is not until the consultant has seen the patient that they need to get the diagnostic test, so we need to ensure that the patient gets the diagnostic test quickly and then goes on to treatment.

**The Convener:** Could we leave it there, Mary? We can put the question to the minister.

**Ian McKee (Lothians) (SNP):** As I am sure you are aware, the vast majority of patient contacts with the health service are with independently contracted general practitioner practices. The bill says:

> "For the purposes of this Act, a 'relevant NHS body' is—
>
> (a) a Health Board,
>
> (b) a Special Health Board,
>
> (c) the Common Services Agency".

Do any of those categories cover independent contractors who are contracted to health boards rather than employed by them?

**Fiona Montgomery:** I am sorry—I missed part of the question.

**The Convener:** Will you repeat the question, please, Ian?

**Ian McKee:** A large number—the vast majority—of patient contacts with the health service are with independent GP practices that provide a service under contract to health boards. They are not directly employed by health boards. Section 3(2) of the bill defines the relevant NHS bodies, but I am not 100 per cent convinced that independently contracted GP practices are covered. Are they covered or not?

**Kathleen Preston:** Perhaps I could come in on that. Section 3(1)(b) provides that each relevant NHS body must

> "ensure that any person with whom it enters into a contract ... to provide health care has regard to the health care principles in so far as they are relevant to the service being provided."

The health care principles will therefore apply to independent contractors. Section 1 states that every patient has the right to receive health care that complies with the description. If the patient receives health care from their GP, the provisions of the bill will apply. There are also provisions regarding the complaints procedures, and relevant bodies will have to ensure that the persons whom they contract to provide health care have compliant complaints procedures. The bill has been drafted on the basis that the provisions will apply where health care is provided by independent contractors within the NHS.

**Ian McKee:** I am not a lawyer, but my work on the Subordinate Legislation Committee has led me to be wary of certain words. Can you tell me the legal meaning of “has regard to”? Does it mean that you have to do it or just that you have to take it into account and you could then decide not to do it?

**Kathleen Preston:** It is not mandatory. “Has regard to” means that the relevant NHS body must take the principles into account. It cannot ignore them and its final decision has to be justified in terms of the principles. In each circumstance—in each individual case of treatment—the person who provides the care will have to consider the principles at that stage.

**Ian McKee:** If the person is in a hospital, it would be mandatory. Is that correct?

**Kathleen Preston:** It is the same. “Has regard to” applies wherever care is received, so it also applies to hospitals.

**Ian McKee:** So, as long as the NHS body shows that it has had regard to the principles, it can go against what the bill says.

**Kathleen Preston:** I am talking only about the health care principles, because that is where the term “has regard to” appears. Other provisions in the bill are differently worded.

**Ian McKee:** Would independent contractors have to obey those other provisions in the bill? The link seems more tenuous than it is for health boards and hospitals.

**Kathleen Preston:** Health boards have to have contractor arrangements for the provision of primary care services. When they make those arrangements or enter into those contracts, they will have to transfer the obligations, if I can put it in that way, so that the independent contractors are obliged to comply in the same way as hospitals would be.

**Ian McKee:** Is that just to have regard to the principles rather than to obey them?

**Kathleen Preston:** Yes, because the circumstances will be different for each patient.

**Ian McKee:** So it is the same for patients throughout the health service. Anyone in the health service just has to have regard to the bill rather than obey it, to put it in simple terms.

**Kathleen Preston:** There is a duty to have regard to health care principles. They cannot be ignored. If someone makes a decision in a particular way, they will have to justify their actions.

**Ian McKee:** Okay. I turn to a point that Consumer Focus Scotland made. Several suggestions were made about the wording of the schedule to the Patient Rights (Scotland) Bill with which I agree. However, a more important point was made about paragraph 16 of the schedule, which states:

> “Waste of resources in the provision of health care is avoided.”

We all want such waste to be avoided, but does that statement really have a place in the bill? It is a motherhood-and-apple-pie statement that relates to all aspects of the health service. Given that the bill is about patient rights, it is wrong to focus at the end on waste of resources.

11:00

**Fiona Montgomery:** The issue of responsibilities has not come up much, but one of the things that we looked at when we were looking at patient rights was what we can do about patient responsibilities, to give both sides of the picture. Part of that is about a patient’s responsibility to avoid waste. It is about how we get the information across to patients to ensure that they attend appointments, so that we do not have so many missed appointments, and so that they take the drugs that they are required to take for the length of time that they have been told to and therefore do not require a repeat prescription because they have not finished the treatment. It is partly about patient responsibilities, resources and waste.

**Ian McKee:** I appreciate all that, but patient rights seems to be a different field. However, I will leave it there.

**The Convener:** I am in your hands. Helen, please make your question short.

**Helen Eadie:** You will be pleased to know that Ian McKee has covered my point.

**The Convener:** Richard, make your question tiny.

**Dr Simpson:** My first question, which you superseded with questions about money, was a supplementary to Rhoda Grant’s question.

**The Convener:** Am I being blamed for something there, Richard?

**Dr Simpson:** Yes—but do not worry about it.

**The Convener:** I am not.

**Dr Simpson:** Does the bill confer on patients in primary care any rights to have a patient participation group in primary care, so that they can alter the services provided by their general practitioner? For example, only 60 per cent of practices in Scotland provide advance appointments, which is of concern to many patients. Does the bill confer on patients any rights to influence that?

Does the bill give patients any rights to be represented in community health partnerships or equivalent bodies?

Does the bill give patients any right to drug treatment as is contained in the English NHS constitution, which lays out 27 rights for patients, which are quite clear, including a right

> "to drugs and treatments recommended by NICE for use in the NHS ".

**The Convener:** Those were three straightforward questions. Can I have three yes-or-no answers, please?

**Fiona Montgomery:** The answer to the first two questions is no. Other work is going on about patient participation and involvement.

**The Convener:** The answer is no. What about the third one?

**Fiona Montgomery:** The right to drug treatment is not included. We also have similar Scottish Medicines Consortium guidance.

**Dr Simpson:** Yes, but it does not confer a right as in England.

**Fiona Montgomery:** The English right is not in primary legislation.

**The Convener:** Right. You got that in at last. I am sorry to hurry you, but I want to bring this evidence session to a close. Thank you very much for taking questions. I will suspend for a few minutes to allow the next panel to take their seats and members to exercise their feet.

11:03

*Meeting suspended.*

11:10

*On resuming—*

**The Convener:** I am sorry to rattle on so fast. There are various demands on members' time this afternoon. I welcome our next panel of witnesses, who sat through the evidence that we heard this morning. Christine Lang is the independent advice and support service development worker at Citizens Advice Scotland; Suzanne Dyer is an IASS caseworker at Peebles citizens advice bureau; Liz Macdonald is senior policy officer at Consumer Focus Scotland; and Jim Martin is the Scottish Public Services Ombudsman. Thank you for your written submissions. We move straight to questions.

**Mary Scanlon:** Given that I asked the first panel about comments that were made by Consumer Focus and the SPSO, it is only reasonable to give the second panel an opportunity to comment. I probably do not need to repeat the passages that I read out earlier. The SPSO also said:

> "the Bill does not appear to provide any significant extension to existing rights and expectations in relation to the quality of NHS services provided in Scotland. Instead, it confirms and makes explicit rights and expectations that currently exist."

He said that the approach in the bill could lead to an increase in legalism and litigation.

Consumer Focus Scotland said:

> "patients in Scotland already have rights in relation to the healthcare they receive. These rights go well beyond those mentioned in or created by the Bill."

Citizens Advice Scotland expressed concern that there might not be a consistent approach to the provision of advice. Will the witnesses comment on those points and say whether they think that the bill is justified?

**Jim Martin (Scottish Public Services Ombudsman):** The submission that we made speaks for itself, by and large. I am delighted that it has been quoted so often in the meeting.

The anti-legalism approach in section 18 is to be welcomed. My biggest concern in relation to complaints in the NHS—and I think that the complaints system in the NHS works well—is that there seems to be a view that people who have to respond on behalf of health boards and others cannot say sorry, for fear of litigation. If we could change that culture in the NHS, that would be a big boon. Anything that suggests that we move to legalism should be opposed.

**The Convener:** A shudder has just gone down the spine of every lawyer out there.

**Liz Macdonald (Consumer Focus Scotland):** We welcome the bill in the sense that it might give additional status to the idea that patients have rights. As we said in our submission, patients already have an extensive body of rights. Some of those rights derive from legislation, such as disability discrimination legislation and legislation on how to see our health records. Some rights derive from the common law, such as our right to consent to treatment, so that we cannot be assaulted by a doctor.

There is also the body of things that I think can legitimately be described as rights although they are not legal rights in the sense that the Scottish Government lawyer described. Those are things that people are entitled to expect when they are in contact with the health service. The health care principles that are set out in the bill reflect those kinds of rights. The publication, "The NHS and You", which was referred to earlier, sets out those kind of rights. For example, people have a right to be treated by a doctor who is properly qualified. I am not aware that that is set out anywhere in legislation, but there is a professional regulatory body that ensures that all doctors are properly qualified. So it is legitimate to describe that as a right.

For us, the real issue is not that all those rights are brought together, because I do not think that a bill can do that, and the bill does not try to do that. The bill is valid in so far as it says that patients have rights, and I would like something to be added to the bill that says that not all the rights that patients have are in the bill: the bill is simply flagging up the importance of patient rights.

Moving on from that, how people's rights are made a reality is important. How do we ensure that people are more engaged in their health care, and that when they have the right to make choices and be involved in decisions, they do that? How do we change the culture so that that is more of a reality?

11:15

**Christine Lang (Citizens Advice Scotland):** Citizens Advice Scotland, or CAS, is in favour of policy and practice that helps people to understand and exercise their rights. The current set-up for the independent advice and support service is inconsistent in different health boards because of how it was funded and the way in which its structure was set up. We would welcome more consistency.

**The Convener:** Do you want to add to that, Ms Dyer?

**Suzanne Dyer (Citizens Advice Scotland):** We want to advise patients on their rights. The bill will be worth while only if it offers a completely holistic and person-centred service.

**Mary Scanlon:** Convener, no one answered the question that I asked about whether the bill is necessary or justified.

**Christine Lang:** The bill would make the independent advice and support service—or the patient advice and support service as it would be—statutory, so health boards would have to fund it. That has been an issue during the past year when some health boards have cut the funding for the service.

**The Convener:** Does anyone else want to comment on whether the bill is necessary or justified?

**Jim Martin:** We said in our submission that, with the exception of the treatment time guarantee, there is really nothing new in the bill. Earlier today, the Scottish Government representatives talked about wrapping up rights in primary legislation. It is a matter for you as parliamentarians to determine whether that is the right way to go with all the debates that that approach throws up. So with the exception of the treatment time guarantee, there is nothing new in the bill that confers a new right.

**Rhoda Grant:** How does the new patient advice and support service differ from the current service? In evidence that we have received, and from comments that we heard this morning, it is clear that two improvements could be made to the current service. It could be contracted nationally, and Ms Lang said that it would be good to have the same level of service in every health board area. Also, the current service is not seen as proactive in advising people of their rights, and it should be going out there. The comment was made that the bulk of the money that has been set aside for the new service is for advertising the service and getting involved in making people aware of their rights. Could the current service be changed to take into account those improvements without the need for a whole new bureaucracy and raft of spending? I imagine that the witnesses would welcome additional finance, but could the new service be set up more easily and cheaply, allowing patients to access a holistic service as they do at the moment and not just a service centred on patient health?

**Christine Lang:** That would be possible. As I said, it would be easier if the service was contracted at the national level and if changes were made so that proactive marketing could be included. I know that many health boards have found it difficult to get the message out there, and because so many people work in the NHS, it is difficult to get those higher up in the NHS to buy in and support the service.

**Suzanne Dyer:** At present, marketing activity in the Borders includes newspaper articles and appearances on BBC Radio Scotland. We have given presentations to associations such as Parkinson's UK and the carers forum, and we have leaflets for people to pick up in our citizens advice bureaux, of which there are six in the Borders. In addition, we have delivered leaflets to the NHS. The idea was that they would be distributed in all hospitals, cottage hospitals and GPs' surgeries. Activity in that area could be strengthened on a national basis.

**Rhoda Grant:** My reading of your responses is that you would welcome changes to the current service that would remedy your concerns, but health boards' lack of buy-in might be causing issues with getting the service out there and recognised by patients.

**Christine Lang:** Yes, that has been a problem. IASS is starting to make a difference in some health boards where it has been established for longest. The first health board came on board four years ago. There, relationships between the NHS complaints officers and the IASS workers are extremely good, to the point that the complaints officers were phoning me up to ask for leaflets to distribute.

In other areas, people from within the NHS who have come across IASS through other routes might or might not contact me. People are saying that they have not got enough work, so they are not marketing that service. I think that that is partly because they have poor relationships with the NHS board, which does not see the value of the service.

**Suzanne Dyer:** In the Borders, we have a very good relationship with NHS Borders. In fact, I get referrals from the board when it has a client with specific problems whom it may not have enough time to deal with. I can dedicate time to such people.

**Rhoda Grant:** When you deal with a person, can you advise them on broader issues—for example, if they have debt or welfare benefit issues—or can you direct them to other people in the citizens advice network?

**Suzanne Dyer:** I am able to advise people on benefits to do with illness, such as disability living allowance or attendance allowance. There are people who are more expert on other benefits in our office. I would sit with the patient while the other person came in, to ensure that the patient got a person-centred approach and dealt with the same person right the way through their care.

**The Convener:** You have dealt with a supplementary that I was chewing over. It seems that PASS will be much more restricted. Even though the provision of IASS can vary throughout Scotland, in general it has a greater range than PASS. It is not as constricted as it appears that PASS will be. Is that correct?

**Suzanne Dyer:** I do not think that that is for me to say.

**The Convener:** Please feel free to say it—that is why you are here.

**Suzanne Dyer:** IASS offers an extremely broad range of services to clients.

**Christine Lang:** I add that the service that is provided varies, depending on the background of the IASS caseworker. A caseworker who has a CAB background will be able to provide more holistic advice; someone who does not will have to refer a patient to a colleague.

**The Convener:** So, if we improved IASS and standardised its provision throughout Scotland, we might have a better service than the one that the bill proposes. Is that the point that you are making?

**Christine Lang:** Yes.

**Ross Finnie:** I am sorry, but I would like to go back to the issue that Mary Scanlon raised; it is not the same point, but it is related.

As a member of the committee, I am finding the bill difficult. Let me explain that. I am absolutely clear in my own mind about the importance of patient rights, but I am concerned that the agenda that has been set for members of the committee, in which you are participants, almost suggests that unless one believes that patient rights should be contained in an act of Parliament, one is somehow guilty of believing that patient rights are not important. I am concerned about that. I am also concerned that people watching or listening to today’s proceedings might get the impression that unless patient rights have the status of being enshrined in an act of Parliament, the Parliament is somehow not dealing with them adequately.

I do not want to put words into Ms Macdonald’s mouth, but I was very taken by the response in which she said that she did not believe that it was possible to encompass every patient right in a single act of Parliament, even if one wanted to. I am interested in your views, as people who deal directly with the individuals affected, about the curious perception that is emerging that, unless the Parliament makes acts of Parliament to deal with matters, those matters will somehow not have the appropriate status. I have never believed that an act of Parliament is a status symbol; I have always thought that it is a matter of law that could be enforceable in a court. One or two principles emerged in this morning’s evidence session, and I would be interested to know whether you think that it is essential that there be an act of Parliament or whether there are other ways in which the current body of rights could be expressed that would be equally effective.

**Liz Macdonald:** The position of Consumer Focus Scotland is that it is not essential to have legislation. As I said earlier, we have said that perhaps the fact that there is legislation gives the matter some status in some people’s eyes. That might be more the case in relation to people within the national health service rather than members of the general public. I do not think that it makes a great deal of difference to the general public, except that, when you try to raise people’s awareness of the rights that they have, it might make the message slightly stronger if you can say that all patients in Scotland have rights in certain areas, and that that is, in some way, endorsed by the Parliament or Government.

Legislation adds value only in so far as it can lead to stronger messages about what people’s rights are. However, in terms of making people’s rights a reality, how you communicate with them is more important, as is the support that is in place to help make those rights a reality. Those issues can be dealt with through an independent advice and support service—which we feel is clearly essential—or through mechanisms that the NHS puts in place in its premises. In our evidence, we have argued that there is some value in attaching the fairly strong title of patient rights officer to the people in the NHS who are currently described as patient liaison officers or complaints officers. Having them as a more visible and accessible presence in NHS premises would be useful, and would mean that issues could be dealt with when they arose, which would avoid them becoming complaints or going anywhere near litigation, which you discussed earlier. The aim must be to solve things as early as you possibly can.

Sorry if that was a bit of a long-winded answer.

**Ross Finnie:** No, that was helpful.

**Jim Martin:** The best way to answer your question is to consider how the bill would make a difference to the way in which a patient or a patient's family approached my organisation. It would make no difference. It might impact on how the providers of the service across the NHS think about how they go about things. However, there is no new route by which rights can be pursued, which means that someone who had a complaint about the NHS and wanted to take it to the ombudsman would be in the same position that they are in at the moment, were the bill to be passed.

There are a number of dangers in the bill. One of the dangers that I see is that, as far as complaints are concerned, the structure could become more bureaucratic than it need be. There is a danger that people might see their rights as being confined to the rights that are set out in the bill. More important, there is a need to manage carefully the possible impact on the culture of the NHS and the relationship between patients and families and health care providers. Earlier, Dr Simpson made a point about people having contact with the NHS but also with a range of services that need to be included. That is a considerable concern that needs to be taken into account.

The only thing in the bill that I would have regard to that I do not currently have regard to might be the treatment time guarantee. It is important to remember that the PASS and PRO set-up that is proposed in the bill is building on the strong base that IASS has put in place. Therefore, we are talking about a possible improvement rather than anything new.

11:30

**Mary Scanlon:** Section 8 of the bill outlines what happens where there is a breach of the treatment time guarantee. It states that the health board must

> "make ... arrangements ... to ensure that the agreed treatment starts at the next ... opportunity, ... provide an explanation ... as to why the treatment did not start within the maximum waiting time, ... give the patient details of ... advice and support"

and tell them "how to complain". Is that any different to what patients have just now? How is that a move forward? That already happens if the treatment time guarantee is breached.

**Jim Martin:** I am sorry—I am not sure whether that is a rhetorical question.

**The Convener:** Mary is good.

**Mary Scanlon:** There is no legal redress, but that is basically what the patient rights are at present.

**Jim Martin:** I think that is right.

**The Convener:** I think that you have given evidence, Mary.

Jim Martin said that only the treatment time guarantee was new, but I think that the bill does something else new. I am thinking about what Christine Lang said about the variability in the provision of IASS in Scotland. New section 10ZA of the National Health Service (Scotland) Act 1978, which is inserted by section 14 of the bill, states that the agency "must" ensure the provision of the patient advice and support service—it is mandatory. Christine Lang said that some health boards are cutting IASS back, but the bill will prevent that.

New section 10ZA(4) also states that

> "The patient advice and support service is not to be provided by ... a Health Board, ... a Special Health Board,"

or

> "the Agency."

So the independence of the service that I was bothered about is secured by the bill, and its provision is mandatory. Do you agree, Mr Martin, that although that is a small part of the bill, it will change things in terms of the adequacy of the service that provides patients with independent advice prior to coming to your organisation?

**Jim Martin:** I prefaced my response to Mr Finnie's question by saying that I start by asking which elements of the bill would make a difference to patients. I am reading the section on PASS, which will build on the existing IASS. In a legal sense, you are correct that the inclusion of the word "must" makes things different but, in practical terms, it would not make a difference to how my organisation considers a complaint.

**The Convener:** That is not the point that I was making. I was saying that because there is variability throughout Scotland, people may come to you directly—although I do not know about the specific cases that you deal with—because the service is not provided in a particular NHS board area. The bill will make that service mandatory throughout Scotland and independent of NHS boards. That must—I am using the word "must" rather a lot here—make it better for the patient or their family or friends at the first stage if they feel that something is not right and that they want independent advice.

**Jim Martin:** I see many complaints systems throughout the public service in Scotland. Among the 32 local authorities in Scotland, which work against roughly the same legislative background and on the same delivery, there are many variants in terms of how things are delivered. They are complying, because they have done what they must do, but when things come to me, I see breakdown and failure. You may be right that we will start to get complaints about that, but currently we do not.

**The Convener:** I do not know—I am just proposing that as something that is different in the bill. I see that Christine Lang—who raised the point initially—is nodding her head.

**Christine Lang:** Yes. The fact that the service "must" be provided is important to us, because that is not the case at present.

**Michael Matheson (Falkirk West) (SNP):** Mr Martin, you said that the provisions in the bill will not change how you consider a complaint. I understand that, on the basis that the bill contains nothing that is new or substantially different from the current situation. However, I think that you said in your submission that you will be able to uphold complaints with regard to the rights in the bill, which you cannot currently do. Will you explain that? Are you saying that although the bill will not change how you look at a complaint, the net outcome will be different? That is what I took from your submission.

**Jim Martin:** That is not exactly what I meant. I meant that if there were an act we might make reference to it when we issued a report or made a decision on a case—that would be different. The bill contains no new rights, however, so there is no change in that regard. Currently, when someone comes to us with a complaint we find for or against them. If the same complaint were to come to us once the bill had been enacted, we could make reference to the act. That is all.

**Michael Matheson:** Thank you for that helpful clarification.

Mary Scanlon mentioned your concern that the enshrining of rights in legislation has the potential to light up pound signs in the eyes of Scotland's solicitors. Are the provisions in section 18 sufficient to address your concern that the approach in the bill might result in more litigation?

**Jim Martin:** The answer to that is a broad yes. I have been ombudsman for about 15 months—maybe a bit more—and I have seen many cases in the NHS, some of which have been horrendous. Many cases have involved deaths, sometimes of young children, but I have never yet had a complainer come to me with a view to going to litigation. My concern is that we should not move to the kind of system that there is in the United States and other places, where the first thing that people do when something goes wrong is lift the phone to the lawyers. I am not a lawyer, but my reading of section 18 is that it protects against such an approach; others might want to ensure that that is the case.

**Michael Matheson:** People have argued that section 18 fundamentally undermines the bill, in that it will prevent people from taking legal action to enforce their rights. Has the Government got the balance right between enshrining rights in legislation and preventing us from going down the avenue of generating a great deal of litigation?

**Jim Martin:** When we consider whether we have got the balance right we must comment on two parts of an equation. In this context, the second part of the equation is the desire to avoid a litigious culture in the NHS. If that is the Government's intention it is doing the right thing. It is for you to determine whether the other side of the equation is right. The question for parliamentarians is whether, given the presence of section 18, the rest of the bill is worth having and is in any way enforceable with methods other than those that we currently have.

**Liz Macdonald:** The question whether people want to get involved in litigation is separate from the bill. As Mr Martin said, section 18 explicitly takes away that possibility in relation to enforcing the treatment time guarantee, but nothing in the bill stops people going to court to ask for damages, or for a range of other reasons.

As I said, people do not really want to go to court. That is partly because they want to continue to have a good relationship with the people who provide their health care and partly because they want not financial compensation but an apology and an assurance that what happened will not happen again—there is good evidence that that is what people want. They want a proper investigation and an explanation of what went wrong and why. It is important that we take opportunities to strengthen the ways in which people can deal with issues as quickly as possible rather than worry about litigation.

**Suzanne Dyer:** I would like to add to that. The majority of my clients are not looking for litigation;

they are interested in feedback from the NHS to give some meaning to the suffering and loss that they might have endured. This is probably outwith what is being discussed, but there is also a case for no-blame compensation for cases in which people are not trying to blame someone, but they end up with a lasting disability due to some misadventure in hospital that may be no one's fault. For those people, it is very important to have information about how a service has been changed or improved so that there is no chance of the same thing happening to someone else.

**The Convener:** I am just reminding myself about this issue, but I think that the Government is looking at no-fault compensation schemes. That is a piece of information from the convener, with the vice-convener's assistance.

**Rhoda Grant:** The committee is struggling with the lack not of legal redress but of redress anywhere in the bill. Everyone is happy that we are not entering into an American-style NHS in which people are sued all the time, but it is clear that the bill gives people rights but no way of enforcing them. Is there a way to enforce people's rights? The Scottish Public Services Ombudsman obviously carries out some of that work, but it involves a long process. If someone is waiting for treatment, they do not want to have to go through a complaints procedure and then through the ombudsman, by which time they will have either died or had their treatment. They want some way to remedy the situation immediately, so that they get their treatment and pass through the service. Do the witnesses have any thoughts about how that remedy could be found other than through legal redress?

**Jim Martin:** The NHS complaints structure has two times: one is three days for an initial response and the other is 20 days for a substantial response. By and large, health boards are very good at meeting those targets. The problem in the NHS is that by the time that someone has reached the point at which they want to complain, usually the damage is done and we are looking at what happened rather than how to prevent things from happening.

After that stage, we often get into a situation that I was appalled by when I arrived as ombudsman, in which the health board takes as its first position that it will not find in favour of the complainant on anything that is clinical. One or two health boards do that. I have been astounded by the number of cases that have come to the ombudsman in which we have taken independent medical advice, played it back to the health board and the board—this has happened in more than one—has then said, "Yes, we now accept that you are right."

The difference is that I am the ombudsman and I have independent medical advice while the ordinary family does not. If we are going to go down the route of complaints, we must take account of the fact that it is far more complex and that the ordinary citizen, who becomes a patient only when they engage with the national health service, does not necessarily have the technical knowledge to discuss, explore and reach a solution on medical issues without considerable assistance. One thing that IASS has been very good at is guiding people through that process; one hopes that PASS would build on that.

**The Convener:** May I interrupt on that point? I am not saying that this is a whole solution, but is it possible for an individual patient to then seek legal advice? There are huge issues about access and finance, but an independent opinion would be available through advice and assistance, as I understand it, or by paying for one to determine whether someone has a substantive case.

**Jim Martin:** I note that the question related to the long process of taking a case to the ombudsman. I hope that we are no longer in the position of having three-and-a-half-year delays, as we did a year ago or more. However, we notice that when someone takes a complaint to the average solicitor, it tends to add not only time but expense. The complaint usually goes to a solicitor whose knowledge of NHS procedures is, to be kind, rudimentary.

11:45

**The Convener:** Having once acted in medical negligence cases, I declare an interest and wince at that comment. I will let it go past because it was many years ago. We will move on.

**Liz Macdonald:** Rhoda Grant asked whether the bill should provide for some means of enforcing the rights. We can look at the matter positively or negatively. At the minute, there is a range of rights, such as the right to see one's own health record. However, if a patient does not know that they have that right or how to exercise it, it will have no impact on their health care or their life. Part of the answer is to consider how we enforce rights positively. How do we help people to realise that it is a good idea to see their health records and to ask how to go about doing that? We need to support people to be involved. How do we support and encourage them to use their rights to be involved, participate and consent?

That is a positive approach. I think that Rhoda Grant is looking at enforcement more negatively. She is thinking of penalties for rights—waiting times in particular, I suppose—not being enforced. However, it is important to think about the matter positively, not just negatively. People's rights are so varied and different that there is no single way of ensuring that they can be enforced.

**The Convener:** I have—

**Suzanne Dyer:** Can I add—

**The Convener:** Oh, I am sorry, Ms Dyer. You are from Peebles, too.

**Suzanne Dyer:** Rhoda Grant asked whether anything could be added to improve the situation for existing patients. If I complain on behalf of a patient who is already in treatment, NHS Borders is good at speeding up the matter and it moves as quickly as it can. However, perhaps there could be a fast-track rule for people who are in treatment, otherwise we would have to take them through the whole procedure and, potentially, on to the SPSO. Patients like that, because they get an independent view on their treatment, but usually after the treatment has been received.

The expense of litigation and the quality of advice about medical issues that is offered if patients go on to litigation have already been mentioned. We can refer clients to an organisation called Action against Medical Accidents—AvMA. If we send it all the case papers, it will review the case and offer independent legal advice free of charge to the client, who can then decide whether they wish to go down the legal route.

**The Convener:** I have a feeling that there will be a queue of people who want to know the contact number for that free legal advice. Mr Martin may regret some of his words, but I will leave that to the Law Society.

**Christine Lang:** I will add to what Mr Martin said about health boards meeting timescales. I have had anecdotal feedback from IASS case workers that NHS boards often do not meet timescales. Sometimes, clients get feedback on the reasons for that and are told that there will be a delay. Often, the delay goes on for a long time. Sometimes, if a person is receiving treatment, they are told that they cannot access their health records. Sometimes, the case is not dealt with quickly enough and the person ends up outwith the timescale for complaining to the SPSO, so they are stuck between a rock and a hard place in pursuing their complaint.

**The Convener:** We will keep a note of the points that are made.

**Ross Finnie:** I have a question that I should have asked earlier. It was, again, prompted by a remark that Ms Macdonald made. I think that she was present in the earlier evidence-taking session, during which I referred to the document that tries to set out the range of rights that we have. It comes from the health rights information Scotland project, which was established in 2003. It is a project within Ms Macdonald's organisation, Consumer Focus Scotland, and is funded by the Scottish Government health directorate. The bill aims to replace that service by setting everything down in an act of Parliament. What is wrong with the current service? I do not think that anything is wrong with it.

**Liz Macdonald:** I do not think that the bill is seeking to replace the information that the health rights information Scotland project produces. It produces information for members of the public about their rights. When the bill is passed, information will still need to be given to members of the public about their rights. I hope that the health rights information Scotland project will be involved in that, because it has expertise in and understands rights and how to produce information for members of the public. I do not see those two things as alternatives.

**Ross Finnie:** Indeed not. Your answer is interesting, and I share the view that you require a slightly different version of the HRIS document. For those people who want to find out what their rights are, perhaps the document is not publicised well enough or the organisation is affected by funding restrictions.

You said that you believe that you need both HRIS and the bill. I asked the Government's lawyer what the difference is between them. The bill will set out patients' rights but, because people do not want to enter into litigation, they will not be able to act on it. The HRIS document sets out where a patient has rights at law, so it is almost more valuable. That was rhetorical.

**The Convener:** I was beginning to wonder.

**Ross Finnie:** I got that trick from Mary Scanlon.

**The Convener:** I think that we will be able to dispense with witnesses. They are surplus to requirements. We will ask the questions and answer them.

**Liz Macdonald:** The bill seeks to set out broad health care principles in different categories, so we have things that are to do with participation and people being involved in their own care, and things about communication and safe and effective care. People have to be treated in certain ways in different areas. "The NHS and You" sets out simple, clear information that tells people what that means in practice and what they should expect. If it is passed, the act will require such information. Should people expect there to be a patient participation group? What should they expect the board to be doing? That is equally true for staff. What will the law and HRIS mean for how staff do things? We are looking for guidance on what those broad health care principles will mean in practice and what people are entitled to expect.

**Ross Finnie:** Yes, but, Ms Macdonald, the cabinet secretary could issue a direction under the 1978 act about those matters, and that kind of guidance would still be required, but a separate act of Parliament would not be required.

**Liz Macdonald:** Yes, I agree.

**Dr Simpson:** I wonder whether the witnesses would like to comment on a few points. First, my view is that no-fault compensation is the elephant in the room, because it is about changing the provider's culture to focus on the individual. We are all keen on patient rights and on the concept of mutuality, but no-fault compensation means that the provider often does not act in a way that allows such mutuality to proceed if something has gone slightly wrong.

Secondly, I do not know whether the witnesses are aware of the system within the state hospital, which I commend to my colleagues. It operates on the basis of three Cs—compliments, concerns and complaints. It has three different levels of approach, and it has radically altered what happens within the state hospital, which works under difficult circumstances. Now, lots of issues are brought up as concerns, and the number of complaints has dropped enormously.

People are concerned because they want to change the service to ensure that something that has gone wrong does not go wrong the next time, and having a system that embodies that mutuality is important. That is the first point in my two-part question.

**The Convener:** Is there a question?

**Dr Simpson:** My question is whether the bill will achieve anything in relation to redirecting the provider and ensuring that the provider acts timeously, not just in respect of people who are receiving treatment but subsequently, to ensure that the systems are corrected to allow the patient to be a mutual participant in the improvement of the service.

**Christine Lang:** That is why we have raised the point about feedback. We have found that some IASS workers are now getting feedback—either directly or through their clients—explaining the changes that have been made to policy and practice as a result of complaints that have been made. From what you say about the state hospital, it sounds as though that is happening there: the number of complaints is decreasing and instead concerns are being raised. We would welcome the inclusion of that in the bill; otherwise, people will not know whether any changes have been made as a result of complaints.

**Suzanne Dyer:** In our system, we always try to go in at the lowest level to resolve issues in the best way possible for both parties. We would never go in, or encourage our clients to go in, with all guns firing. We see raising a concern as more about working with the NHS to get good outcomes for patients. A lot of my clients are bereaved, and it is a question of trying to resolve the loss in some way, working through it on a good level.

I agree that no-fault compensation is a completely different issue. In the three and a half years for which I have been in post, I have had probably only one client in that position, and it was a terrible situation.

I totally agree with you on the need to go down the concerns route before making a complaint. In that way, we will get more information from the NHS and a better outcome for the patient. However, I am not sure how much the bill will assist with that.

**Jim Martin:** I am not certain that the bill sets out what you have set out. The bill reads to me as almost a consolidation of rights and a move into primary legislation. Yesterday, we finished a consultation on setting standardised complaints procedures across the whole public service. One thing that we are exercised about is the need to enable front-line staff to meet concerns head on before they become complaints and to empower those people to find solutions. That is a cultural thing. The General Medical Council's advice on apology is very good, and the no-fault compensation debate must be had more openly. I would very much welcome our looking at that seriously. As far as the bill is concerned, however, I am not certain that it sets out to deal with the problems that you have set us.

**Dr Simpson:** The second part of my question is the question that I asked the first panel of witnesses. Under the new system, should the patient rights officer be involved in advocacy—in trying to solve problems—or will they be only rather expensive signposters?

**Suzanne Dyer:** I can tell you about the situation in our area. My role is to act on behalf of the patient in any way that the patient requires in order to empower them. I may write letters on behalf of the client, attend meetings with the client and make phone calls on behalf of the client, if necessary. I do not know whether you would call that advocacy.

**The Convener:** Do you ever tell people that they have no case or no complaint? Do you sometimes have to tell people tough things?

**Suzanne Dyer:** Yes. One of the most important requirements of the role is not to raise expectations inappropriately. However, the client has to decide whether they wish to take their complaint forward, although I can give them my best advice based on my experience and training.

**The Convener:** MSPs do the same in our profession. When we are asked questions, we give our advice, but what to do is up to the constituent. At the end of the day, they might not have a real issue that they can follow through. We have to be tough and give them our advice.

12:00

**Jim Martin:** As I read the bill, PROs are designed for signposting. My worry about PROs and, to an extent, PASS stems from my experience in setting up the Police Complaints Commissioner for Scotland. For about the first six months, the first question that 80 per cent of callers to that commission asked was, “Are you, or have you ever been, a police officer?” In positioning PROs and PASS, we will have to be careful that, although they are funded by health boards and Government, they are capable of giving independent free advice.

**Christine Lang:** We see it as a benefit of basing inquiry centres in bureaux that we will be able to do that.

**The Convener:** We have dealt with the independence and robustness of PASS.

I give Helen Eadie the glory of the last question, knowing that it will be short and to the point.

**Helen Eadie:** Maybe it will be two questions, convener, as Alex Neil would say.

**The Convener:** Make it a two-part short and to-the-point question.

**Helen Eadie:** Mr Martin’s comment about apologies is important. However, very often, it is where the apology comes from that matters. I had a dreadful case of an elderly man who lost his entire family—his wife and two sons—as a consequence, he believed, of NHS actions. His apology came from an official, not from the chairman of the board, which was disgraceful. That was Lothian NHS Board.

Ross Finnie was absolutely right to say at the outset that anyone who views this process should be absolutely certain that we are trying to improve patients’ experience of complaints. I was interested in Liz Macdonald’s answers. At first, I got the impression that she feels that the bill will change things significantly, but I was glad when, under questioning by Ross Finnie, she arrived at a point at which she did not think that the bill will change things. I will quote something and ask her to comment on it. It states that the bill deals with

> “the way a person should be treated by the NHS rather than what they are entitled to from it.”

Will you expand on that point?

**Liz Macdonald:** Sorry, but what were you quoting from?

**Helen Eadie:** In your paper—your evidence—you said that the bill deals with

> “the way a person should be treated by the NHS rather than what they are entitled to from it.”

**The Convener:** Was that in the written submission or in the evidence that has been given today?

**Helen Eadie:** It is in the evidence given today, by Consumer Focus Scotland. It is on page 3, under the heading “Healthcare Principles”.

**The Convener:** So it is in the written submission.

**Helen Eadie:** Yes. I am concerned that Liz Macdonald, speaking on behalf of Consumer Focus, believes that the bill does not address what patients are entitled to from the NHS.

**Liz Macdonald:** Your quotation relates specifically to the health care principles. One of the rights that we could say people will be given by the bill is the right to be treated in accordance with the health care principles, whatever that means, so when we say that the bill gives people the right to be treated in a certain way, that relates specifically to the principles. The bill also claims to give people a right to complain and a right to treatment within a treatment time.

**Helen Eadie:** But you have said that the bill is about the way people should expect to be treated, rather than what they can expect to get from any complaints. That is the substance.

**Liz Macdonald:** We are saying that that is what the health care principles attempt to do—they set out how people should be treated.

**Helen Eadie:** But with that statement you are saying that the bill does not address the issue of what people can expect to get from it.

**The Convener:** Let us have Ms Macdonald’s final answer.

**Liz Macdonald:** As an example, imagine that somebody says, “Does the bill give me a right to an NHS dentist?” The bill does not deal with what rights people have in relation to accessing services; that is outside the bill’s remit. The bill restricts itself to how people should be treated—in other words, in accordance with the principles. It covers the right to complain, which we argue people already have, and the treatment time guarantee, which is one specific guarantee in respect of one kind of treatment in the context of lots of other things.

**Helen Eadie:** You are saying that the bill does not tell people what they can do if they do not receive such treatment.

**Liz Macdonald:** I do not think that that is what we are saying there. As I said earlier, people’s rights are varied, both in the bill and beyond, so they might seek to enforce them in a wide range of ways.

**The Convener:** I am going to stop you—

**Helen Eadie:** I have one last question on a different matter. Before becoming an MSP, I was involved for numerous years with an NHS primary care complaints committee. It offered one way of dealing with NHS complaints, but it was changed. When the Scottish Parliament was established, the minister decided that we would not have a complaints system that went through the local health councils, which were then abolished and replaced with the Scottish Health Council. Then CAS was given the contract for dealing with patient complaints. That takes us back to the independence question. I would like CAS to comment on its experience, because I do not believe that making PASS independent in the NHS is the right way to go. The right way to go would be to have PASS or its equivalent within CAS rather than as part of the NHS. In my opinion, it is wrong to have a system that deals with complaints about the NHS in the NHS.

**Christine Lang:** Yes, I agree.

**The Convener:** I knew that you were going to say that. That is a yes from you, but I see that Mr Martin disagrees.

**Jim Martin:** No, I just did not want to contribute.

**The Convener:** He does not want to contribute—that is a nice thing to hear at this time of the day.

**Suzanne Dyer:** That independence is important for my clients, a lot of whom feel, rightly or wrongly, a little anxious about going in to complain about a doctor or medical staff. They really need to come to an accessible place. We have offices in virtually every town, where people can come and feel that they are in a totally independent environment. It is fine whether people go to a CAB or another independent location, but to have NHS complaint officers in NHS buildings would not be helpful.

**Helen Eadie:** The location of the buildings is not the issue; it is a question of who pays the piper and provides the funding. It would be better for adverse comments about the NHS to come from a totally independent, voluntary organisation, rather than from someone who is funded by the NHS and is feeling pressure from on high about next year’s funding.

**Suzanne Dyer:** Our funding comes from the NHS, but I guarantee that we are totally independent, to the extent that recently we were able to take NHS Borders right through the ombudsman process. There was no feeling of—

**Helen Eadie:** That is not universal in Scotland. I have spoken to independent advice and support services who say that it is not the same in every part of Scotland.

**The Convener:** We are kind of going round in circles now. We have taken a view that we want the service to be independent. Independence must be not only a reality but a perception.

I thank committee members for asking their questions at a brisk pace and I thank the witnesses for their evidence. We will now move into private session, as previously agreed.

12:09

*Meeting continued in private until 12:20.*

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