Patient Safety Commissioner for Scotland Bill — Stage 2

Schedule 1

Tess White

11 In schedule 1, page 12, line 11, leave out <8> and insert <5>

Tess White

12 In schedule 1, page 17, line 17, at end insert—

<( ) a review of the performance of the Commissioner, as assessed against the performance monitoring standards under section (*Performance monitoring*).>

Tess White

13 In schedule 1, page 17, line 19, at end insert—

<( ) As soon as practicable after the annual report is laid before the Scottish Parliament, the committee of the Scottish Parliament into whose remit patient safety falls must propose a debate on the annual report.>

Section 2

Jackie Baillie

14 In section 2, page 1, line 12, at end insert—

<( ) to advocate for those affected by a major incident in relation to the safety of health care.>

Jackie Baillie

15 In section 2, page 2, line 3, at end insert—

<( ) Subsection (3) does not apply to major incidents.>

Section 3

Paul Sweeney

16 In section 3, page 2, line 11, at end insert —

<( ) The statement of principles must include the principle that the Commissioner will seek to involve categories of people that the Commissioner considers to be under-represented in health care in the Commissioner's work.>

Tess White

17 In section 3, page 2, line 11, at end insert—

<( ) The statement of principles must include the principle that the Commissioner will seek the views of staff working in the National Health Service Scotland on patient safety concerns and take account of their concerns.>

Tess White

18 In section 3, page 2, line 11, at end insert—

<( ) The statement of principles should include—

(a) the types of issue that are likely to come under the Commissioner's purview,

(b) how such issues will be identified,

(c) the threshold for opening an investigation,

(d) that, in exercising the Commissioner's functions, the Commissioner must take account of—

(i) existing legislation,

(ii) how the Commissioner's role fits together with the existing patient safety landscape,

(e) any other issue the Commissioner considers appropriate.>

Tess White

19 In section 3, page 2, line 11, at end insert—

<( ) Before producing a statement of principles, the Commissioner—

(a) must consult on a draft of it with—

(i) the stakeholders that the Commissioner considers to have an interest,

(ii) the Parliamentary corporation,

(iii) the advisory group established in accordance with section 16,

(iv) the committee of the Scottish Parliament within whose remit patient safety falls,

(b) may consult on a draft of it with any other person the Commissioner considers appropriate.>

After section 3

Tess White

20 After section 3, insert—

<Performance monitoring

(1) The Commissioner must—

(a) have a statement of the standards that are to be used for performance monitoring, and

(b) make the latest version of the statement publicly available.

(2) Before producing a statement of standards, the Commissioner must consult on a draft of it with—

(a) the Parliamentary corporation,

(b) the advisory group established in accordance with section 16, and

(c) the committee of the Scottish Parliament into whose remit patient safety falls.

(3) As soon as practicable after producing a statement of standards, the Commissioner is to lay a copy of it before the Scottish Parliament.>

After section 7

Tess White

21 After section 7, insert—

<*Work programme*

Duty to have a work programme

(1) The Commissioner must—

(a) have a work programme, and

(b) make the latest version of the work programme publicly available.

(2) A work programme is a document setting out the work that the Commissioner intends to undertake in the next year.

(3) Before making a work programme, the Commissioner must consult on a draft of it with—

(a) the Parliamentary corporation,

(b) the advisory group established in accordance with section 16, and

(c) the committee of the Scottish Parliament within whose remit patient safety falls.

(4) As soon as practicable after making a work programme, the Commissioner is to lay a copy of it before the Scottish Parliament.>

After section 11

Paul Sweeney

22 After section 11, insert—

<Special report

(1) This section applies where recommendations have been made in a report under section 10.

(2) If, following the making of the report, it appears to the Commissioner that any of the recommendations have not been, or will not be, implemented, the Commissioner may make a special report on the issue.

(3) The Commissioner must—

(a) send a special report made under subsection (2) to the persons to whom the report was sent under section 10(3), and

(b) lay a copy of the report before the Scottish Parliament.

(4) The Commissioner may, in whatever manner the Commissioner considers appropriate, make publicly available (in full or in part) a special report made under subsection (2).>

Katy Clark

23 After section 11, insert—

<Investigation into the use of surgical mesh

(1) The Commissioner must undertake a formal investigation under section 8 into the use of surgical mesh to treat hernias by the National Health Service in Scotland.

(2) The investigation under subsection (1) must be initiated within one year of the first appointment of a Commissioner under paragraph 4 of schedule 1.

(3) The terms of reference of the investigation under subsection (1) must include—

(a) the scale of the use of surgical mesh to treat hernias,

(b) the number of patient readmissions as a result of complications related to the use of surgical mesh to treat hernias,

(c) the number of patient complaints to regional health boards related to the use of surgical mesh to treat hernias,

(d) consideration of whether the use of surgical mesh to treat hernias should be suspended,

(e) any other matters which the Commissioner considers appropriate.>

Section 12

Paul Sweeney

24 In section 12, page 5, line 29, after <section> insert <—

"health care provider" includes a person who provides medicine or medical devices>

After section 12

Carol Mochan

25 After section 12, insert—

<Information under the Health and Care (Staffing) (Scotland) Act 2019

(1) The Health and Care (Staffing) (Scotland) Act 2019 is amended as follows.

(2) In section 2 (guiding principles etc. in health care staffing and planning), in subsection (3), after "Ministers" insert "and the Patient Safety Commissioner for Scotland".>

Section 15

Carol Mochan

26 In section 15, page 7, line 14, at end insert—

<( ) professional regulators,

( ) the Health and Safety Executive,>

Tess White

27 In section 15, page 7, line 14, at end insert—

<( ) professional healthcare regulatory bodies,>

After section 15

Carol Mochan

28 After section 15, insert—

<Duty to co-operate

Duty to co-operate in exercise of functions

(1) Each person named in section 15(2)(d) must co-operate with the Commissioner in the exercise of their respective functions.

(2) The Commissioner must co-operate with each person named in section 15(2)(d) in the exercise of their respective functions.>

Jackie Baillie

29 After section 15, insert—

<Information sharing: major incidents

Reports following major incidents

(1) Where the Commissioner has completed a formal investigation under section 8 into a major incident, the Commissioner must provide a copy of the report prepared under section 10 to—

(a) the chief constable of the Police Service of Scotland,

(b) the Crown Office and Procurator Fiscal Service.

(2) For the avoidance of doubt, information contained in such a report may be used for the purposes of legal proceedings, whether civil or criminal, including for the purposes of investigating an offence or suspected offence.>

Jackie Baillie

30 After section 15, insert—

<Major incidents

Major incidents

(1) On becoming aware of a major incident, the Commissioner must take such steps as the Commissioner considers appropriate to—

(a) contact patients affected by the major incident and the families of patients who died as a result of the major incident,

(b) provide relevant information including—

(i) sources of support for affected patients and bereaved families,

(ii) information on accessing legal advice and representation,

(iii) details of any investigations or inquiries relating to the major incident,

(iv) information for whistleblowers on how to disclose information relating to the major incident.

(2) Within one year of becoming aware of a major incident, the Commissioner must consider whether to initiate a formal investigation under section 8.

(3) Any formal investigation in relation to a major incident must include consideration of whether public bodies complied with their duties under the major incidents charter produced under section (*Charter for those affected by major incidents*).>

Jackie Baillie

31 After section 15, insert—

<*Major incidents charter*

Charter for those affected by major incidents

(1) The Commissioner must produce and publish a charter for patients affected by major incidents and families of patients who died as a result of major incidents.

(2) The charter must include, in particular, the obligations of public bodies in relation to affected patients and families of patients who died as a result of a major incident.

(3) Before producing a charter under subsection (1), the Commissioner must consult with any person the Commissioner considers appropriate.>

After section 17

Tess White

32 After section 17, insert—

<Review of ways of working

(1) Within 3 years of section 1 coming into force, the Scottish Parliament must make arrangements for one of its committees or sub-committees to undertake a review of how the Commissioner and pre-existing patient safety landscape are working together.

(2) The review must consider, in particular, how any recommendations made by the Commissioner have been implemented.

(3) As soon as practicable after the review has concluded, the committee or sub-committee must produce a report on that review in such form and manner at the committee or sub-committee considers appropriate.

(4) The Scottish Parliament must publish a report made under subsection (3).>

Section 21

Paul Sweeney

33 In section 21, page 9, line 14, at end insert—

<( ) social care services to the extent that they intersect with the services described in paragraphs (a) and (b) above,>

Jackie Baillie

34 In section 21, page 9, line 14, at end insert—

<"major incident" means a specific incident in connection with health care safety that resulted in the death, injury or serious harm of multiple patients.>