OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 19 November 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 19 November 2019

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HEALTH AND SPORT COMMITTEE
27th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Adedokun Adenipekun
Rosemary Agnew (Scottish Public Services Ombudsman)
George Burton
Bob Doris (Glasgow Maryhill and Springburn) (SNP) (Committee Substitute)
Hugh Dunn
Jeane Freeman (Cabinet Secretary for Health and Sport)
Craig Henderson
Iain Laing
Fiona McQueen (Scottish Government)
Martin Misovic
Alan Morrison (Scottish Government)
John Paterson (Scottish Government)
Stacey Smith

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 19 November 2019

[The Convener opened the meeting at 09:30]

Subordinate Legislation

Public Services Reform (The Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020 [Draft]

Public Services Reform (The Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020: Statement of Principles [Draft]

The Convener (Lewis Macdonald): Good morning, and welcome to the 27th meeting in 2019 of the Health and Sport Committee. We have received apologies from Sandra White; Bob Doris has joined us in her place. I ask everyone in the room to ensure that their mobile phones are off or on silent. Please do not record or photograph proceedings, as we do that ourselves.

Agenda item 1 is subordinate legislation. We will consider two instruments that are subject to affirmative procedure. As usual with affirmative instruments, we will start with an evidence session with the Cabinet Secretary for Health and Sport and her officials, which is an opportunity for members to ask the cabinet secretary about the instruments. We will then move on to debate the instruments.

We are looking at the draft Public Services Reform (The Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020 and its statement of principles, which will be debated separately following the debate on the order.

I welcome to the committee the Cabinet Secretary for Health and Sport, Jeane Freeman, and the Scottish Public Services Ombudsman, Rosemary Agnew. Accompanying them are Stephen Lea-Ross, who is head of workforce planning in the Scottish Government, and John Paterson, who is a divisional solicitor in the Scottish Government. I understand that the cabinet secretary will begin with an opening statement.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you very much, convener. Good morning to you and to colleagues. I will be brief.

I thank the committee for inviting me to the meeting and to move the two motions that are required to introduce the role of the independent national whistleblowing officer for NHS Scotland. It is vital that we continue to review and strengthen the mechanisms that we have to support and promote whistleblowing in our national health service. It is important that our staff feel able to speak up when they believe that things are not right and that they have no qualms about doing so, but I am conscious that, currently, that is not always the case. That is why, among other measures, I am determined to ensure that we do everything practical to make raising concerns and dealing with them a part of day-to-day business.

I have been very clear that the true litmus test for our health service will be that formal whistleblowing mechanisms will not need to be used precisely because we respond appropriately and timeously to issues that have been raised. Nevertheless, for us to get to that place, it is only right that we put in place the strongest system of effective checks and balances.

In response to the committee's call for evidence, which has been very welcome, we have adopted a number of the committee's recommendations. That is why I hope that it fully welcomes and supports the legislation, which will allow the Scottish Public Services Ombudsman to take on the role of independent whistleblowing officer for NHS Scotland.

I ask the committee to recommend that the draft Public Services Reform (The Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020—I see that we are still in favour of very short titles—and the statement of principles be approved. That said, I will be very happy to take any questions, as I am sure my colleague Ms Agnew will be, too.

The Convener: Thank you very much, cabinet secretary.

I acknowledge the point that you made that many of the recommendations in the committee's report have been taken on board, including on the inclusion of a definition and the laying of the standards before Parliament. One issue that perhaps has not been entirely taken on board is the relationship between whistleblowing in the NHS and issues that may arise in social care and social work. I would be interested in the views of the cabinet secretary and the Scottish Public Services Ombudsman on how that relationship should be managed, given the nature of the structures that will be created under the order.

Jeane Freeman: I know that you and your colleagues understand that the Government and local authorities take a partnership approach to social care. Quite rightly, local authorities have

their own processes and procedures for complaints and whistleblowing. The common factor is our Scottish Public Services Ombudsman, whose role will be important in helping us to ensure that the broad principles and the overall approach that we want to take in the health service are reflected in how things are managed in social care. We will continue to discuss with our colleagues in the Convention of Scottish Local Authorities whether more can be done in that regard.

The key common denominator for us all is twofold. First, I am sure that our colleagues in COSLA and local authorities share our intention to ensure that staff feel able to speak up about their concerns, that those concerns are listened to and acted on and that no adverse redress is inflicted on staff as a consequence. Secondly, the shared common denominator is the Scottish Public Services Ombudsman—I hope that Ms Agnew does not mind me referring to her as such.

Rosemary Agnew (Scottish Public Services Ombudsman): There are two areas in which there will be some clarity and in which some clarity will be needed. On the ground, I completely agree that we need to ensure that clear guidelines are in place for both sides—health and care—and that we are available for advice on how to take matters forward. We will be entering into a memorandum of understanding with the Care Inspectorate, so we will be able to share information at a regulatory level. There is a strategic overview side to the issue but, in the early days, it is about how we make the system work practically on the ground. Although we have clear views on how we can offer guidance, some things will be learned through the testing.

Emma Harper (South Scotland) (SNP): I have been contacted by and have met some of the petitioners who have called for the creation of an independent whistleblower. They brought up the idea of an independent hotline for people to go to directly, and I am interested in whether such a hotline will be created. Would that result in any changes to the role of a whistleblowing champion? How will we assess matters as roles evolve?

Jeane Freeman: In relation to the additional request for the hotline, we continue to fund the whistleblowing alert and advice line. As we have discussed previously in the committee, the Government's view is that that service and the role of the Scottish Public Services Ombudsman—as our national whistleblowing champion, my colleague's office will provide advice and support if that is appropriate before people take up specific issues—are sufficient in offering people a route to go down if they want to raise concerns in that manner.

As we have developed the role of the whistleblowing champions, we have been conscious of the intention to create the national independent whistleblowing officer. I advise the committee that we are due to appoint the champions by the end of this year—before the Christmas recess. We received 136 applications, and we have shortlisted 45 candidates to go through the interview process. I am delighted and very grateful that Ms Agnew has taken part in every single interview, as our independent person. That has produced an additional level of understanding about how the two roles will match and complement each other, which will feed into the induction and training work that we do with the people in each board in Scotland who are appointed as whistleblowing champions who report to me. What has happened already has been informed by that experience and, as we go forward, we will continue to keep in mind both roles and how they interact.

Brian Whittle (South Scotland) (Con): Cabinet secretary, there is no doubt about the intention of the order.

You will be aware of the evidence that the Public Petitions Committee has taken over time, which has identified some worrying trends. Scottish Ambulance Service staff and union representatives have come to my surgeries several times to talk about the bullying and harassment of whistleblowers. I wrote to the Scottish Ambulance Service, but its answer was—frankly—head-in-the-sand stuff.

Guidelines are all well and good, and I do not think that anyone would object to the direction of travel that you are trying to take, but how will you ensure that the guidelines are followed and that people who want to raise issues will be able to do so in line with the guidelines and in a safe environment? Currently, that is not happening in the Ambulance Service.

Jeane Freeman: There is a mixed picture across the entire national health service—and I, too, have had representations from the Ambulance Service unions. However, staff across the health service have told me that they felt able and confident to raise issues—and that it was safe, as you put it, to do so—and that the issues were addressed. It is fair to say that there is a mixed picture. You and I both want all staff across our health service to feel encouraged to raise issues of concern, and to feel that if they do so, what they say will be heard and they will be safe from adverse redress.

You are right to say that guidance is important. Across our health service, there is significant room for improvement in basic complaints handling, for many people who raise issues or make complaints. It is all about whether individuals

understand that a complaint is an opportunity for improvement and learning or whether they adopt an overly defensive stance. That applies in whistleblowing cases, too.

Therefore, part of the work that the whistleblowing champions will undertake will be the continuous promotion of a change in culture in individual boards. The champions will liaise with unions, staff side and managers at every level. The work that we lead with human resources directors in health boards will complement those efforts, as will the work that is under way in the ministerial group that I chair, which, post-Sturrock, has brought together a range of organisations and bodies, including our royal colleges, our unions, the Royal College of Nursing and the General Medical Council, to identify different ways in which we can all contribute to promoting the positive, safe working culture that we are talking about.

It is not about doing just one thing; it will take all those layers of effort to begin to put together the pieces of the jigsaw that are needed if we are to promote that change in culture.

Rosemary Agnew: I will be responsible for ensuring that the standards and principles are implemented and monitored. Following feedback on the draft standards, we have emphasised an issue to do with the handling of complaints about whistleblowing concerns that have not been through the public body—the NHS organisation. We refer to such complaints as "premature" complaints. We have done that because it is clear that, although the ultimate aim is the culture change that means that we do not have to engage in whistleblowing because we have an NHS in which everyone feels confident to speak up, there will be a period of time during which we must support people to build that confidence.

09:45

One of the significant differences between whistleblowing complaints and other complaints that we look at concerns how we get involved at the first stage. We have made it very clear that people can come directly to us—they do not always have to go to their organisation first. That does not mean that, as the independent national whistleblowing officer, we necessarily investigate everything. If we did, that would undermine the idea of learning and of building a listening and trusting culture. However, it means that we can get involved at the outset in a very different way, I hope giving whistleblowers the confidence that they are not doing it all by themselves and that somebody is monitoring what is happening. I am trying to reassure you that we have picked up some of those issues in how we intend to implement monitoring and to use the standards as part of the greater jigsaw.

As was mentioned, I have been involved with the recruitment and interviewing of the whistleblowing champions, which has provided some insight into how relationships will work. Whistleblowing champions are not under my jurisdiction, for want of a better phrase, but it is vital that, in giving their assurance to boards and in championing how whistleblowing works on the ground, they have access to the advice and guidance that my organisation can give. I feel that, between us, we are putting together a fairly robust framework.

Brian Whittle: Convener, can I just—

The Convener: There will be an opportunity in the debate, but if you have a further question for the minister, you should ask it now.

Brian Whittle: Cabinet secretary, you raised the issue of culture, which is central to the whole whistleblowing issue. How are you proposing to change the culture at the top line of management? From the work that the Public Petitions Committee has done and the evidence that it has taken, it seems to me that that is where the greatest resistance is. If we cannot change the culture at the top lines of management, it will be very difficult to cascade anything through the rest of the organisation.

Jeane Freeman: That is a very fair point. We have significant work to do at the lower levels of management to provide support to individuals so that they can undertake the role that we are asking them to play in a way that they feel confident about. I know from the individual instances that come to me as a constituency MSP that we are not talking about the most senior staff in the organisation; we are talking about people who have been promoted into a leadership role. They will often have been very good at the role that they undertook before, and they will now be leading a team, but without any additional support on how to do that in addition to undertaking the actual work. That can often produce grievances that are not dealt with fairly or heard, which can then escalate and become something much more serious. I think that the issue arises at every level. Through our work on project lift, which members are familiar with, we need to ensure that we are offering learning and support at every level of supervision, management and leadership.

For the most senior level, all that will now be reflected in how we conduct the ministerially led annual reviews. As discussions among chief executives, HR directors and directors of estates across the NHS come together, with this issue forming part of those discussions, we should ensure that those senior staff understand all the pieces of the jigsaw that we are putting together, as I have described it, and the aim that we are putting them together for. We will then look at how

the monitoring work that is undertaken can feed into those ministerially led annual reviews, which always include a discussion with staff side representatives about how they feel management is delivering on the service to them as staff. In all that, we will have discussion, opportunities for learning and training, and then the chance at ministerial level to review how each board is doing on this, with data but also with discussion.

David Stewart (Highlands and Islands) (Lab): Good morning, cabinet secretary and panel. During the past 12 months, I have spent a lot of my time dealing with the culture of bullying in my local health board, NHS Highland. Brian Whittle spoke about a culture of bullying, and that is what I was certainly dealing with. Will the order help to prevent future situations such as we had in the Highlands from blowing up? I do not believe that the Highlands is the only place in Scotland where we have bullying. Will it also improve the situation for and support our current whistleblowers?

Jeane Freeman: In and of itself, simply having the order will not change the culture of an organisation. I have said repeatedly that I want us to get to a point where whistleblowing is the exception because the culture, policies, approaches and internal relationships in our organisations work in such a way that nobody needs to whistleblow. Instead, people can raise concerns that are heard and acted on, and they are treated with respect, with no negative consequence for them. Whistleblowing happens, I believe, when people feel strongly about an issue that they raise and they do not believe that they have been heard; alternatively, they believe that they have been intimidated into silence, so they look for another way. The order creates that route, but in and of itself it does not change the culture that has taken us to that place.

All the other elements that I have outlined—you and I have discussed them before, Mr Stewart, including in the committee—form what I described a moment or two ago as the jigsaw. I believe that, partly through what it sets up and partly through the way in which Ms Agnew's office can intervene at an earlier stage, as she said, and provide support and help, the order contributes to giving staff an assurance. They will have to test that assurance, and we will have to ensure that we earn their trust in their testing of it and assure them that we take the issues very seriously. We want to hear their concerns, investigate them and act on them—at Government level but also, most importantly, at board level.

Miles Briggs (Lothian) (Con): Good morning, panel. Cabinet secretary, the most recent revelations about the Queen Elizabeth university hospital have demonstrated the need for a fit-for-purpose whistleblowing system that protects whistleblowers. Before we approve the order, I want to ask why you think that whistleblowers are saying that it is not fit for purpose. We have heard that you do not want to take forward an independent whistleblower hotline. Why has the Scottish Government not adhered to the new Council of Europe standards on whistleblowing in the order?

Jeane Freeman: Rosemary, do you want to answer that?

Rosemary Agnew: I respectfully challenge the idea that the order is not fit for purpose. It is questionable whether what is in place today, without the order, is fit for purpose, given that we have had the incidents that have been described around the table. We are taking a crucial step on a journey to making a difference because, following extensive consultation, we have produced standards that are fundamentally rooted in the values of the NHS. They recognise all the issues that whistleblowers and those who scrutinise whistleblowing have raised. We are talking about something that takes us to the right place, I hope, for Scotland and Scotland's NHS. It is about embedding those principles and values and making them come alive in such a way that whistleblowing over a culture of bullying means that it is identified and addressed very quickly, or does not occur at all.

I cannot talk about the Council of Europe element, but I hope that I can give you some assurance about the way in which the standards have been produced and drafted. There has been extensive input not only from the NHS but from whistleblowers and other interested parties, and we have also talked to a lot of whistleblowing organisations about the approach that we are taking. I think that we are at the start of a positive journey. These standards will work for us.

I also know, through my network of ombudsmen, that it is not only people in Scotland who are watching what is going on. Many of my international colleagues are interested in what we are doing and see it as an innovative approach.

Miles Briggs: I appreciate what you are saying, but the whistleblowers we have met do not feel that that is the case. They feel that the Scottish Government has clipped the wings of the system before it has even been implemented. Am I correct in thinking that, if I am a whistleblower at NHS Lothian and I come to you with a concern, you will not investigate it and, instead, you will hand it back to my employer to investigate?

Rosemary Agnew: I do not think that it is quite that straightforward. It comes back to the point that we made about premature complaints—things that have not been investigated before being escalated.

We have two aims. First, we want to ensure that the whistleblower and anyone who is involved in the matter is protected in the way that they should be. Secondly, we want to ensure that organisations learn from what is brought to them. The best way of doing that is for them to address the issues themselves.

If things come directly to us, we have the option of making a decision at that point about how to proceed—that is in the order and is reflected in the principles and standards. There might be some cases in which we feel that it is in the public interest and in the interests of the whistleblower to get involved straight away. In other cases, based on conversations with the whistleblower, we might refer the matter back to the organisation. However, if we do that, we would not simply say to NHS Lothian, "Here you are—please investigate this"; rather, we would take a much more active role in monitoring the process and the outputs, so that we can ensure that what the whistleblower is seeking as an outcome is addressed head on. We would take different routes, depending on what is brought to us.

The fundamental point is that we want whistleblowers to feel supported and confident and to be able to trust the system. If we can engender that trust, we might not need the whistleblowing element at all, because the approach would simply become part of the normal way of doing business.

I recognise, of course, that, particularly in the early days, people who have had negative experiences will be looking for a bit of extra reassurance. I am not saying that we will investigate every instance, and I am not saying that we will investigate none of them. We will take a case-by-case approach to our decisions, based on discussions with the whistleblowers.

Jeane Freeman: We must not forget that linked to all of that is the role of the appointed whistleblowing champion. The champion will not only monitor a board's conduct in relation to its complaints procedure but work with the ombudsman to provide advice and support to any individual whistleblower or group of whistleblowers.

Alex Cole-Hamilton (Edinburgh Western) (LD): It is fair to say that the changes that the order brings in will stand or fall on the basis of confidence. My question in that regard follows on nicely from the question that Miles Briggs asked. How will the changes be communicated to the staff on the ground? How will staff know what merits a whistleblowing approach as opposed to an approach that involves normal grievance procedures? Those are the questions that I have been asked in my surgeries by people who have tried to blow the whistle and have been referred to the HR grievance process in their health board.

10:00

Rosemary Agnew: How we make the distinction between grievance and whistleblowing is a really good question.

We have included in the standards the idea of business as usual. Where whistleblowing has not kicked in, it would be business as usual. When someone raises a whistleblowing concern, we would first of all ensure that the NHS organisation sends it down the right route. If the concern relates to a grievance, it should go down the HR route, whereas if it involves whistleblowing, it will go down the whistleblowing route. There will be situations in which the correct route is a little difficult to establish, and that is where the whistleblowing champion and the SPSO will have an important role to play in offering advice.

In underpinning the implementation of the standards and principles, I am aware that the SPSO has a job to do to raise awareness specifically within boards. However, we also need to ensure that boards and others have in place their own local guidelines and principles that comply with the standards and guidance and meet whistleblowers' needs. We expect boards to run training and awareness sessions for their staff, and we will support and get involved with awareness-raising work as far as we can.

Jeane Freeman: I have one additional element to highlight. I know that the committee will be familiar with the idea of partnership working in the health service, and we have a national staff-side organisation that brings together trade unions and other organisations that represent staff. The staff-side organisation is aware of the issues, and there will be further discussions with representatives of individual boards who come together in the national body on what more they believe would be helpful for them, as individual staff reps, so that they are enabled to properly advise those whom they represent on how the system works.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): Good morning. The "Draft Explanatory Document" states at paragraph 1.5 that, under the order, one of the SPSO's roles will be

> "to investigate whether a relevant body or provider has handled a whistleblower's complaint properly in accordance with the SPSO's model complaint handling procedure for whistleblowing complaints and any action taken by or on behalf of the body or provider in respect of that complaint"

to see whether—I am paraphrasing here because of time constraints—it has been undertaken appropriately.

Will the SPSO interpret that provision flexibly or in a restricted fashion? I will explain what I mean by that, because it is quite important. When any investigation in an NHS board or wherever starts

to take place based on a whistleblower's complaint, it may cover a number of matters that the whistleblower did not complain about in the first place. In my experience, if additional facts that were not part of the core initial complaint emerge in the process of the SPSO's investigations, the organisation can at times be restricted in the view that it takes on such matters.

I very much hope that the new process will ensure that, if NHS boards and other organisations uncover additional information outside the terms of the initial whistleblowing complaint that gives cause for concern, that information will be looked at in a meaningful way. More importantly, I would hope that, when the matter goes to the SPSO's independent national whistleblowing officer, the organisation will take a view on any additional facts that may have emerged.

Taking a restricted view would mean that, if the complainant or whistleblower did not complain about certain matters in the first instance, although those matters will be looked at appropriately, the investigation might not take account of all the additional information that emerges during the process. As things stand, that does not happen in other areas of the SPSO's complaints-handling work. Can we get some reassurances on that in relation to the new whistleblowing protocols?

Rosemary Agnew: It is probably worth highlighting the difference between complaints about service and whistleblowing.

Generally, complaints about service are about something that has happened; fundamentally, whistleblowing is about someone witnessing something that is happening, and, by definition, the whistleblower might not have witnessed everything relating to a particular issue. I cannot say that, every time, we will go as far as looking at every single line that has been raised. However, with the focus on patient safety and on the treatment of those who are involved in a whistleblowing complaint, the new protocols will mean that we have to go as far as we can to ensure that the whole issue is looked at, including how the board looked at it.

I do not think that we would be looking for additional things. However, issues may emerge, and the nature of whistleblowing complaints means that we follow different lines and perhaps do things in a slightly different way from what we do with straight service complaints.

I do not know whether my answer has been clear enough. I am not saying that we will do that every time, but I take your point that service complaints and whistleblowing are, by nature, quite different and probably have different starting points. I think that, perhaps more so than some of the other complaint work that we do, whistleblowing complaints will be based on statements, views and interviews involving a lot of people.

Ultimately, we have to keep sight of why we are doing this. It is about patient safety, the treatment of individuals and building a culture change. By definition, we almost have to make sure that we look at everything thoroughly.

Bob Doris: I am not quite sure that there was an answer in there. I am not trying to be discourteous, but I make the point that, if there is a culture that has to be addressed, a defensive NHS board might have a very restrictive view of any complaint from a member of staff. Whether a complaint relates to things in the past or things that are going on, additional things will need to be investigated and checked out as matters unfold and more information comes into the public domain. We will need to make sure that the NHS board follows through on those aspects if they did not form part of the initial complaint. If any board does not follow through in that way, we will have to make sure that the SPSO follows through and ensures that NHS boards do the right thing. That is the reassurance that I am looking for.

Rosemary Agnew: I think that I can give you that reassurance.

Bob Doris: Okay; thank you.

The Convener: Does the cabinet secretary want to add to Rosemary Agnew's previous point?

Jeane Freeman: No.

The Convener: That is fine. That exhausts the questions. We move on to agenda item 2, which is the formal debate on motion S5M-19757.

I thank Rosemary Agnew and the other officials at the table. They will not take part in the debate. I invite the minister to move the motion. Members can then contribute and the minister will sum up.

Jeane Freeman: I am happy simply to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Public Services Reform (The Scottish Public Services Ombudsman)(Healthcare Whistleblowing) Order 2020 [draft] be approved.—*[Jeane Freeman]*

Miles Briggs: In looking at what the committee has done to date on the issue, I think that this is a missed opportunity to create a fit-for-purpose whistleblowing system. There are real concerns that the legislation will not meet whistleblowers' needs. I do not want the legislation to be held up, so we will support the motion, because we need to improve the protection of whistleblowers. However, I hope that we can look again at the

issue and that further reforms will be brought forward as soon as possible.

Given what we are seeing across health boards from the Highlands to Glasgow and from Lothian to Tayside, it is important that we fix the matter and have a system that is fit for purpose. We will support the motion, but I think that we could have produced a much better system to protect Scotland's whistleblowers.

Brian Whittle: I am trying to look at the issue from the perspective of those from whom we heard evidence who, having attempted to whistleblow, have found themselves on the wrong end of harassment and bullying.

The aims and objectives in relation to whistleblowing and the fact that we have recognised that there is a problem are admirable. However, like Miles Briggs, I have not heard any evidence today that would allow me to say to any whistleblowers who might be watching that I feel more comfortable with the system. At the end of the day, this is about the implementation of the system and how people are recognised and protected in it. As yet, I have not heard those practical reassurances. Like Miles Briggs, I think that we should support the order in the hope that the legislation can be strengthened to give confidence to those on the front line who are looking to take part in the system.

Emma Harper: I have the draft standards in front of me. They say:

"An effective procedure for raising concerns ... is ... open ... focused on improvement ... objective, impartial and fair ... accessible ... supportive to people who raise a concern and all people involved in the procedure ... simple and timely ... and ... thorough, proportionate and consistent."

If the standards and principles are followed, we should have a process that supports whistleblowers. I look forward to continuing to monitor and review the processes that are in place. I will support the motion to approve the order.

Alex Cole-Hamilton: I share a lot of Miles Briggs's concerns. The changes will only be as strong as the confidence that they enjoy from the staff on the ground. I will reserve judgment on that. I will listen to the people who come to my casework surgeries. With those caveats, I am minded to support the motion to approve the order, for now.

The Convener: The cabinet secretary might wish to say something about a future review of the effectiveness of the system that is introduced.

Jeane Freeman: I will be very brief. I do not agree that this is a missed opportunity. Members are failing to see what we are doing as part of the wider suite of serious actions that we are taking. I am grateful to Ms Harper for reminding us of the detail of the draft standards and principles. In this case, as in everything, what counts is delivery, as well as words on paper. I do not think that there can be any doubt about our collective and shared intent to improve the culture in our health service across the piece.

I add a note of perspective: there are many examples across all our health boards of issues and concerns that staff raise being dealt with timeously and with respect. We are trying to ensure that that happens consistently across the piece, that organisations learn from such practice and that people who raise concerns are and feel protected.

Mr Cole-Hamilton is absolutely correct to say—I think that I have said this previously—that, at the end of the day, it is about the quality of relationships and the degree of trust that we can engender across our health service. All the areas of work contribute to that, and the order is part of that work. The work is enhanced considerably by having the Scottish Public Services Ombudsman, which is an independent and credible office, as our national whistleblowing officer. In addition to the other matters that we have discussed, that, in and of itself, gives the order additional force and credibility.

The Convener: Thank you very much, cabinet secretary.

Motion agreed to,

That the Health and Sport Committee recommends that the Public Services Reform (The Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020 [draft] be approved.

The Convener: I invite the cabinet secretary to move motion S5M-19770, which is the second motion in relation to healthcare whistleblowing.

Motion moved,

That the Health and Sport Committee recommends that the Public Services Reform (The Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020 - Statement of Principles be approved.—[*Jeane Freeman*]

Motion agreed to.

The Convener: I suspend the meeting briefly to allow for a changeover of officials supporting the cabinet secretary.

10:14

Meeting suspended.

10:15

On resuming—

Healthcare Environment (Health Hazards)

The Convener: The fourth item on the agenda is evidence on health hazards in the healthcare environment. I again welcome Jeane Freeman, the Cabinet Secretary for Health and Sport. She is accompanied by Christine McLaughlin, who is the chief finance officer of NHS Scotland and director of health finance; Fiona McQueen, who is the chief nursing officer; and Alan Morrison, who is capital accounting and policy manager in the Government's health finance and infrastructure division.

I invite the cabinet secretary to update the committee on the inquiry that she announced into the issues at Queen Elizabeth university hospital and the Royal hospital for children and young people.

Jeane Freeman: I am grateful for the opportunity to address the issues that I understand the committee wants to raise in the course of the discussion, including the inquiry, where we are with respect to the Royal hospital for children and young people in Edinburgh, and clinical waste.

As you know, the inquiry is a public inquiry with statutory powers. We are in the process of finalising who will lead the inquiry, with the support of the Lord Advocate and the Lord President. I hope to be able to announce the lead before the Christmas recess. Members are aware that the chair of a public inquiry has a significant role in respect of finalising the inquiry's remit: we will undertake that finalising work with him or her, and will be able to announce the inquiry's final remit and its start date shortly after telling the committee and Parliament who will lead the inquiry.

The Convener: Thank you very much.

An independent review is already under way on the Queen Elizabeth university hospital. Will that be incorporated into the wider inquiry or run alongside it?

Jeane Freeman: A number of additional issues need to be taken account of in finalising the start date for the public inquiry. Those relate primarily to the Health and Safety Executive's investigation, the report on which will go to the Lord Advocate and to the Crown Office and Procurator Fiscal Service, who will take a view on whether criminal proceedings or a fatal accident inquiry should be begun. I understand that the HSE's report is expected before the end of the year. Once we have that, we will find out what will happen thereafter and whether and how that work will interrelate with the public inquiry.

The independent review that I commissioned on the Queen Elizabeth university hospital campus is well under way. Our expectation is that the final report will be available and published in the early spring, although it is possible that the co-chairs will find that they are in a position to outline interim findings and recommendations before then. However, that will be entirely a matter for them as independent co-chairs.

That information, the work that they undertake, the evidence that they gather and the conclusions that they reach will feed into the public inquiry. Whoever leads the public inquiry will then take a view, against the inquiry's remit, on whether to take evidence in addition to what has been provided by the independent review.

I hope that that is clear.

The Convener: That was very helpful.

David Stewart: I have a brief question for the cabinet secretary, which my colleague Anas Sarwar has asked me to ask her directly. You will be well aware from the points that Anas Sarwar raised at First Minister's question time last week of the tragic death of Milly Main and its alleged link to water contamination. The key question is this: will the issue of water contamination be fully examined by the independent review group and/or the full public inquiry? I take your earlier point that the chair of the public inquiry will have a role in aspects of the remit, but is it your understanding that water contamination will be discussed fully in either or both?

Jeane Freeman: My understanding is that evidence on that has been taken in the current independent review, so the issue is part of what it is considering, among other matters. The review has been asked to look at the design, construction and maintenance of the campus and their impact on effective infection prevention and control.

I expect the public inquiry to also take the matter into account. It will be for whoever leads the public inquiry to determine whether they are satisfied that what the independent review hands over is sufficient, or they want to take more evidence. However, it is clear that that issue will be part of both pieces of work.

David Stewart: I understand that the new chair's role is independent, but could the Scottish Government recommend to them that water contamination be looked at in the full public inquiry? Could you take a proactive approach to that?

Jeane Freeman: We will do that when we have confirmation of who will lead the public inquiry. From memory, I think that I indicated in the

statement that I made to Parliament, in which I announced the public inquiry, the work that I expect it to consider. That work includes effective infection prevention and control. We will have a draft remit to discuss with the independent lead in the public inquiry, on which they can comment and make additions to. We will include water contamination in the draft remit because it and other matters are central in what needs to be considered, and in deciding what more needs to be done to ensure that mistakes are not repeated.

Brian Whittle: Good morning. How many current capital projects that are under way or planned will be impacted by the review?

Jeane Freeman: Do you mean the public inquiry?

Brian Whittle: Yes—I am sorry.

Jeane Freeman: That question is quite difficult to answer, because we cannot know at this point how long the public inquiry will take. A number of capital projects are coming on stream—for example, the elective centres that are being planned, the Baird family hospital and ANCHOR—Aberdeen north centre for haematology, oncology and radiotherapy—and others that you will be aware of. We will ensure that the recommendations that have already been made by Health Protection Scotland and Health Facilities Scotland, the recommendations and points in the reports on the sick kids hospital in Lothian that I commissioned, with which the committee is familiar, and any recommendations from the independent review of the Queen Elizabeth university hospital, are all fed into that work so that we do not halt what we are doing while the reviews progress.

Brian Whittle: We already know about some of the failures. Are you taking action to prevent the same mistakes from being made in the capital projects that you mentioned? Are you implementing measures to eradicate the problems?

Jeane Freeman: Yes, we are. For example, there has already been retrospective reviewing to ensure that the new hospitals in Dumfries and Orkney, both of which opened fairly recently, are fully compliant. We asked Health Protection Scotland to undertake that work, which it has done.

We know about the ventilation issues and other matters; that knowledge will proactively be fed into what comes before us for approval in respect of infrastructure builds that are in planning, including the elective centres.

You will recall from the programme for government our intention to establish a national centre of expertise that will have a clear role in all such issues. It will centralise expertise in contract negotiation, contract compliance, microbiology and other matters. The centre will also, to a degree, have a compliance function, and will take inside it the relevant parts of Health Protection Scotland and Health Facilities Scotland. Work is well under way on scoping for establishment of that national centre. We will, of course, advise Parliament of our progress on that.

In all that work, we are attempting to take account of all the lessons that have been learned so far, and to ensure that they are applied to projects that are in the pipeline while we wait for the final recommendations of the independent review, and for the public inquiry to get under way.

Brian Whittle: What is the expected timeframe for the inquiry to report, and what is the estimated cost?

Jeane Freeman: At this stage, it is not possible for me to give an expected timeframe for the public inquiry. That is, in part, because it is a public inquiry: it is independent of me, so I do not control it. It needs to be led by whoever is appointed to lead it, based on the view that they take about the evidence that is already available to them and the written and oral evidence that they will want to have in order to fulfil their remit. As you touched on in the earlier evidence session, other avenues of inquiry might emerge as the public inquiry begins. It is therefore not possible for me to say how long the inquiry will take; there is always a discussion to be had about that.

A recommendation from previous inquiries is that the discussion should aim to limit the time for public inquiries, but there is a balance to be struck. We need to ensure that a public inquiry fully meets its remit and is seen to do so, and that it takes evidence from those who want to give it and so on, while not leaving it entirely open ended. Once the decision is made about who will lead the public inquiry, I will have that discussion with that person. However, at the end of the day, that lead person will be independent.

Those points about time also relate to cost: until we have an idea of the former, we cannot have a significant idea of the latter, although the costs of previous public inquiries can guide us in estimating the cost.

Emma Harper: The cabinet secretary has touched on a lot of the points that I wanted to raise about ventilation and water. Earlier this year, you specifically asked Healthcare Improvement Scotland to carry out an unannounced inspection of the Queen Elizabeth university hospital. The report on that highlighted a number of specific areas in which the hospital could do better. It said that the hospital should develop a strategy that provides assurance that cleaning of high-activity

areas is carried out to an appropriate standard; that there should be improvements in the estates and facilities with regard to cleaning, environmental damage and water management; and that the hospital should strengthen the governance around infection prevention and control. Can you update us on QEUH's progress on implementing the report's recommendations?

10:30

Jeane Freeman: Our chief nursing officer will give a significant part of the answer, then I will come in.

Fiona McQueen (Scottish Government): As the committee will know, when HIS publishes a report, the board in question has an opportunity to consider alongside it an action plan for taking all the recommendations forward. NHS Greater Glasgow and Clyde fully accepted HIS's recommendations; some actions were completed before publication of the report.

There are a couple of aspects to highlight. Boards are looking at the more recent report, "A Blueprint for Good Governance", to ensure that they have in place effective systems of governance, including clinical governance, which relates to the situation that Emma Harper raised. It was recognised that the recommended actions would need to be implemented in order for the board to move forward. The issues that the report highlighted, including improved access to enable cleaning in some areas, and the on-going relationship between estates and clinicians to enable access in order to maintain ventilation systems and ensure that vents are cleaned, were summarised in the action plan.

Six months on, NHS Greater Glasgow and Clyde will provide an update or summary to Healthcare Improvement Scotland, which can at any time review the progress of a board and take a view on whether it will carry out an inspection to see what further progress has been made. An action plan was submitted, and was accepted by HIS. There is on-going monitoring, and it will be for HIS to go back at a time of its choosing.

The Convener: Does the cabinet secretary want to add anything?

Jeane Freeman: No—that response was sufficient.

Emma Harper: I am familiar with hand hygiene audits. When I worked as a clinical educator, we spent a lot of time focusing on hand hygiene, which included the processes and protocols for washing hands and keeping the critical areas clean. I assume that any plan would involve education and tracking of education to ensure that all healthcare workers—nurses, doctors and allied health professionals—are part of a process to integrate hygiene education. That would ensure that simple actions such as hand washing are supported and promoted, and that people are doing those things properly.

Jeane Freeman: Yes—that is part of the plan. As you will know, hand hygiene audits pick up areas where not every aspect of good hand hygiene has been followed. There is then an intervention to ensure that staff are retrained, or that their training is refreshed, so that they remember every element that they need to undertake. That covers staff across areas such as you described. There is a constant process of auditing what is happening and looking to refresh training and education to ensure that people continue to treat those important areas of work with the same focus that they apply when they first start work.

Alex Cole-Hamilton: The Royal hospital for children and young people in Edinburgh currently lies empty and is still costing the taxpayer £1.4 million a month. In the light of the revelation from NHS Lothian that the wrong ventilation equipment was used at the RHCYP, would the cabinet secretary now reconsider her response to the committee's request for a review of equipment in all high-risk clinical areas? That should apply not only to recently built facilities. Given that we have set a standard that air ventilation in critical care should meet, should we not review all settings in which critical care is provided?

Jeane Freeman: We asked Health Facilities Scotland to review the most recent builds to ensure that they were compliant, as we would expect them to be—I discussed that at the outset of the meeting.

If you think about the entirety of our NHS estate, you can understand that undertaking the complete inspection that you are suggesting would be a significant piece of work that could result in our not having the resources that we need in order to ensure that the hospital in Lothian meets the timetable for completion that I have set out. It is important that that timetable is met and that the hospital is up to standard in all of those areas. There will be a piece of work that considers what are the additional critically important areas that we want to ensure are meeting the standards, and we will work through them in order of priority.

I do not believe that I said that a review would not be done. The point that I am making is that the exercise, in its entirety, is a significant one. We have considered the most recent builds, and, as I said to Mr Whittle, we are looking ahead to the builds that are in the pipeline. Following that, we will consider what more needs to be done at other sites, starting with the most critically important areas in terms of impact on patient safety.

Alex Cole-Hamilton: Nobody expects you to undertake a review of the entirety of the critical care estate and to conduct remedial work before Christmas—or any time soon, for that matter. However, are you undertaking to ensure that, following consideration of new builds and those that are in the pipeline, there will be a review of all critical care settings in the Scottish healthcare estate, and that there will be subsequent remedial work, even if that takes several years to complete?

Jeane Freeman: Remedial work will be done if it is required, and we need to be clear about whether that is the case. Yes, we will work proactively with boards in terms of their schedules of maintenance and inspection. That will go alongside work that Health Facilities Scotland and others undertake, so that we can systematically ensure that all those critical care areas are at the standard that is required.

Alex Cole-Hamilton: On the sequence of events that led to abandonment of the decamp from the old sick kids hospital to the new site at Little France, we know that that happened roughly 100 hours before the decamp was meant to commence. However, we also know that the flaw was built into the environmental matrix when the tender was first issued—that information comes from the KPMG report that was commissioned by the Government—and that several opportunities to identify the problem were missed. How was the problem finally identified? Who identified it and why did they not do so sooner?

Jeane Freeman: As always, Mr Cole-Hamilton, you and I slightly disagree on language. I would not say that there had been an "abandonment of the decamp". I halted the move in the interests of patient safety.

We now know that the issue around ventilation and critical care stemmed from a failure in the initial environmental matrix and from a number of what were described in the KPMG report as "missed opportunities" to correct that. That environmental matrix became the thread that runs through the construction, and the flaw was not picked up.

The flaw was identified in the final check by the independent assessor of the ventilation in the critical care areas. That final check, which took place a matter of days before the staff and patients were due to move to the new site, found that in the areas where the air change should take place 10 times per hour, it was not happening as frequently as that. Consequently, we decided that that was not the right situation for us to move patients and staff into. That is why I undertook to halt the move. The fact that the flaw was identified so late is why I commissioned the additional work to check all the other critical areas of the site and ensure that they are compliant. As you know from the two NHS National Services Scotland reports, there is more work to be done, but that work will be done in parallel with the work that is undertaken on critical care.

Alex Cole-Hamilton: I have a final question concerning the independent assessment that led to the revelation of the flaw with regard to the air change in the critical care setting. Is there an argument that that independent assessment regime should be undertaken throughout the build, rather than at the very last stage, or does it already happen but was just missed?

Jeane Freeman: Independent assessment happens throughout the build at a number of key points. Of course, one thing that the public inquiry needs to look at is what more we can do. Is the nature of independent assessment sufficient for our purposes? Does it give assurance or should we require more from independent assessment? What more needs to be done, if anything, about the frequency of independent assessment, about where the report then goes and about the requirement on the recipient of that report to act? There are a number of things that the public inquiry needs to get beneath, including, as I have said, the nature of independent assessment and what is actually involved.

David Torrance (Kirkcaldy) (SNP): What role did Health Facilities Scotland have in ensuring that the Royal hospital for children and young people complied with relevant guidance to do with the ventilation system? I ask that from an engineering point of view, because, as a design engineer, I know that it is a specialised area. Was the skill set there for that design, or did people just find out that it did not work when they turned the system on?

Jeane Freeman: That is what we are attempting to address by the creation of the national centre of expertise—my colleagues might wish to come in on this. The way that major infrastructure build is conducted in the health service means that boards have a significant responsibility in that area. Where they believe that it is needed, they contract to bring in additional expertise, which is not automatically in Health Facilities Scotland, at the design, construction and assessment stages. The general view is that for any board to be responsible for such a major piece of infrastructure as the sick kids hospital in Lothian will be a once-in-a-lifetime exercise, so where there is not the necessary expertise within the board, the board must rely on contracting in additional expertise. In moving to the national centre of expertise, our intention is to remove that obligation and responsibility from boards.

Boards will, of course, still have a significant responsibility to identify the local need for a service and what should be in it—by engaging

clinicians in designing what the inside of a building looks like, and considering where the different elements of the service should be and what the flow is—and to future proof that, but a country of this size needs to have, in a central place, the expertise that is required across contract negotiation, design, compliance, build, maintenance, microbiology and other areas. We already have some of that in Health Facilities Scotland and Health Protection Scotland, but we need to add to that. That will then become the central place where that work is undertaken, although it will be undertaken alongside the work of boards. We will shift away from it being entirely the boards' responsibility to it being a national responsibility, alongside the work of individual boards.

David Torrance: When work goes out to tender, what responsibility does a contractor have to check that its building conforms to the national standards that exist for all ventilation systems?

Jeane Freeman: I do not know—perhaps Alan Morrison or Christine McLaughlin can explain.

10:45

Alan Morrison (Scottish Government): It will be done in conjunction with the boards and the technical advisors, as they are going through the specification for the hospital. The onus will be on them, in conjunction with the boards, to identify what is required. Healthcare-specific guidance applies, as well as building standards and more general guidance. It is through that combination that boards and advisors will arrive at their conclusions.

Emma Harper: I know that decisions to halt the moving of patients are not taken lightly, and that patient safety is a huge concern. There are immunosuppressed patients and bone marrow transplant patients—anybody is potentially at risk. There are superbugs such as vancomycin-resistant Enterococcus, carbapenem-resistant bugs and MRSA. Such decisions are not taken lightly.

We obviously need to ensure that patient safety is the number 1 or top priority. I would be interested to hear about the focus on protecting the patients who would be at risk if they were moved when the hospital was not ready.

Jeane Freeman: You are absolutely right: patient safety has to be the number 1 priority in our health service, recognising that there will always be limitations to how much we can protect against infection. As you say, new strains of bugs emerge all the time. The key is to ensure that the expertise in microbiology and elsewhere is built into how we design and build. It should be constantly reviewed and built into how we undertake infection prevention and control measures, so that we identify infection when it happens, take steps to address it and take steps to prevent its spread and control it. You have touched on some of that, but there are other steps that need to be taken by way of mitigation—ventilation and other measures to prevent the spread of infection and to treat infection where it arises.

I am not sure whether that fully answers your question, but the CNO might wish to say a bit more about what we do in that regard.

Fiona McQueen: The cabinet secretary has spoken about the building—the use of ventilation, single rooms and positive pressure rooms. A number of factors can be put into the built environment. You have already mentioned the standard infection prevention control measures, Ms Harper, which not just clinicians but all staff take, including our estates team, who have a particular approach when carrying out any maintenance or construction within the hospital.

You have also talked about the emergent threats. Yes—people whose immune system is not working as well as it could be, because of their illness, are always more susceptible to infection. Unfortunately, there will be times when, despite the best efforts, people will have an infection.

Our job is to minimise that, and that is why we consider on-going monitoring. Every month, boards monitor Clostridium difficile and E coli. Increasingly, Health Protection Scotland is coming up with advice about what organisms we should monitor and whether that should be done by water testing. When a very unusual organism comes into the laboratory, that triggers particular actions to be taken.

There is constant new knowledge, new practice and changes to practice. At the Queen Elizabeth, we are learning about what the alert organisms should be and how many of them are in the background. They have always been there, whether in soil or in water, and those of us with healthy and robust immune systems have nothing to fear and can deal with them quite comfortably. Unfortunately, for some of our patients, that is not the case, which is why the increased monitoring and the triggering of observation are increasingly important.

Emma Harper: My point was that it is a complex issue, and multiple approaches—in the built environment, and to do with air quality, water management, hand washing and so on—need to be put in place to protect patients and staff from cross-contamination. The challenge of resistant organisms, and antibiotics that no longer work on those organisms, is almost a moving feast.

Brian Whittle: I want to continue David Torrance's line of questioning. The cabinet secretary rightly highlighted that use of the Edinburgh sick kids hospital was halted because of a failure to comply with safety standards, and that the delivery of public services is paramount, especially when public funding is involved. I am interested in the failure to comply with safety standards, because there is liability there in some way. I apologise if I have picked you up wrongly, cabinet secretary, but I think that you said that there were gaps in expertise in the specification element of procurement. It would be worrying if the project went ahead with such gaps. Will procurement, right back to the very start of the project, form part of the public inquiry?

Jeane Freeman: I do not think that I said that there were "gaps in expertise", and if I did, that was not my intention. What I was saying was that for an individual board to be entirely responsible for a project is something that will happen once in its lifetime, if at all, which means that it does not build up expertise over a number of projects. That is part of the rationale for the national centre. What boards have been doing is commissioning in expertise in areas that are not, as a matter of course, part of their day-to-day business. I hope that that clarifies the matter.

Liabilities and so on are undoubtedly questions that need to be looked at, and the public inquiry is the right place to do that. That partly picks up on Mr Torrance's point about the various obligations of all the parties who would be involved. In this instance—the hospital in Lothian—that would be the board through to the contractors, the single-purpose vehicle and others. The public inquiry will be the place to unpick various contractual and other accountabilities and liabilities, and it will be down to the expertise of the individual who leads the inquiry to reach a view on all of those.

David Stewart: I will touch again on the NSS report and a couple of points that I do not think have been raised so far. The NSS said that there were major deviations from the guidance in relation to electrical systems and, particularly worryingly, in relation to fire systems. It said:

"Action is recommended to include remotely resettable fire and smoke dampers within the ventilation system".

We have touched on the fact that, by definition, hospitals contain a lot of vulnerable patients, but the fact that there were faults in the fire system is extremely worrying. To add to Brian Whittle's point, was that non-adherence down to Multiplex or was it, again, due to mistakes in the tender document?

Jeane Freeman: The proper way for the answer to that last question to be found is through the public inquiry, so I will leave it at that.

On what the NSS report said in respect of fire dampers, we need to remember that the board received a fire certificate for the site, and that NSS said that there was the opportunity for improvement steps to be taken by adding additional fire dampers. That work is being undertaken in parallel with the work on ventilation and so on.

David Stewart: I take that point, but I would throw back at you the fact that two wrongs do not make a right. NSS said that there were "major deviations from guidance". It could not be much clearer than that.

Why were those issues not identified before the building was handed over to NHS Lothian?

Jeane Freeman: I must make it clear that I am not defending the situation that arose. I am not saying that it was all fine. If I had thought that it was all fine, I would not have commissioned NSS to undertake two major pieces of work. I wanted to be assured that everything was fine. It is self-evident from NSS's reports that more work requires to be done. If that work was not needed, we would not be spending the money doing it. In addition to ensuring that the ventilation system in critical care is fit for purpose, all those other areas of work will be undertaken, because it is my view that it is important that they are undertaken.

It is not clear to me whether, as with the ventilation system, the issues that were identified by NSS sprung from earlier documents that were comparable with the environmental matrix. The public inquiry will carry out investigative work to come to a conclusion on such matters. There are specific issues that the public inquiry needs to get behind. In a previous discussion, I said that although the KPMG report helpfully set out everything that had happened, it did not answer—it was not asked to—the "How come?" questions: "How come opportunities were missed?" and "How come we got to where we got to?" The public inquiry's job is to get underneath and behind that while we focus on undertaking the work that the two NSS reports clearly identified need to be done to meet the timetable that I set out in Parliament.

David Stewart: My final question might be one for your lawyer to answer, rather than you. Who will fund the remedial works in question? Will it be the contractor or will it be NHS Lothian, on the basis that it accepted the handover of the building? Is there is a general legal principle in this area? I know that you will probably say that that will be up to the inquiry, but it is important that we get some understanding of who will be responsible for paying for the remedial work, the costs of which will probably be quite substantial.

Jeane Freeman: In addressing that question—which, clearly, I did some time ago—I took the

view that the Scottish Government would fund the remedial works to ensure that they would be undertaken, that the timeline would be met and that we would be able to move, as quickly as possible, children, families and staff into the new site, which, overall, represents a significant improvement on the existing site from the point of view of patient care, quality and so on. I want to get people in there as quickly but as safely as possible. Therefore, my focus was to say that we would pay for the remedial works.

Whether there will be any redress against any party is for the public inquiry to determine. It would be wrong of me to express an opinion in advance of that, given that I have no contractual or legal background to base an opinion on. I do not want to compromise the public inquiry, which needs to do its job. While it gets on and does its job, my focus will be on making sure that the work gets done.

Miles Briggs: I want to ask about hospital waste and the problems that there have been with that. How many tonnes of medical waste are currently being stored in Scotland?

Jeane Freeman: I think that the figure is 500 tonnes.

Miles Briggs: What work is being done to monitor and inspect where that waste is being stored to ensure that our environment and communities are protected?

Jeane Freeman: The Scottish Environment Protection Agency undertakes that work, and it does so with some rigour, to ensure that those who, under the contingency arrangements, are currently responsible for the collection, storage and disposal of both streams of waste are meeting the required standards and regulations. SEPA is, if you like, the regulator of that.

11:00

Miles Briggs: On the future of the system and where we are going to get a fit-for-purpose waste disposal system for NHS Scotland, how much have the arrangements cost NHS Scotland and health boards to date in addition to what they budgeted for?

Will you outline what is being done to address the issue of hazardous waste going to Wales?

Jeane Freeman: We do not have the final cost of contingency arrangements, because we are still in the contingency period. On more than one occasion in Parliament, I have said that when we move from the contingency arrangements to the final arrangements with the new contractor, I will be able to advise Parliament of the additional cost of contingency above the planned cost for the original contract. I will do so at that point.

On the transportation of waste to England and Wales, my understanding is that no bidder for the new national contract offered an option that would take that waste in Scotland, so it had to go outside. However, the new contractor, Tradebe UK, is looking to build—and, I believe, now has planning permission for—a site at Bellshill, which will be its transfer station and area for processing waste, and where it will be able to dispose of a significant proportion of the waste collected.

Miles Briggs: Can you guarantee that no hazardous waste has been burned in a non-hazardous waste incinerator in Scotland?

Jeane Freeman: If that had been the case, SEPA would have alerted me to it, and I have had no such alerts.

Miles Briggs: Has SEPA relaxed any licensing around that?

Jeane Freeman: No, not that I am aware of.

The Convener: Thank you very much for your time this morning, cabinet secretary. It would be helpful for the committee if, at an appropriate time, you were to bring us up to date on some of the matters that Miles Briggs raised on the new contract, recognising that you do not yet have all that information to hand. I thank you and your colleagues for your attendance.

We will have a short suspension. I remind members that you will be moving seats during the suspension, so please gather up your goods.

11:02

Meeting suspended.

11:12

On resuming—

Primary Care Inquiry

The Convener: I welcome all those joining us who were participants in the public panel sessions in Inverurie, Cambuslang and Dunfermline. I remind everyone at the table and in the public gallery that their mobile phones must be on silent and that they must not record or film proceedings.

Colleagues will remember the phase 1 panels—I think that all of us took part in one or other of the panels and met some of the people who are here today. The panels identified several key themes that have since informed our work on the inquiry into primary care. Themes that came from the participants in the public panels included a focus on technology, a patient-centred approach, workforce planning, a focus on prevention and a community-wide approach to wellbeing, and we carried those themes forward in our evidence sessions.

In phase 2 of our inquiry, as many of you know, we heard from a variety of healthcare professionals—not just general practitioners but occupational and other therapists, pharmacists, dentists, those from the third sector and technology professionals. Most recently, we heard from the Cabinet Secretary for Health and Sport, whom you will have seen giving evidence again this morning.

As a committee, we felt that, before we concluded our inquiry and got down to the business of writing and agreeing a report on it, it was important that we went back to you—the people who informed the very beginning of it—to hear from you and have a discussion.

Rather than introducing everyone myself, I ask you all to briefly say who you are. I will start. I am the convener of the committee.

Martin Misovic: I stay in Inverurie, and I joined the Inverurie panel.

George Adam: I am Paisley's member of the Scottish Parliament.

Craig Henderson: I live in Glasgow and have come here to participate in the discussion.

Emma Harper: I am an MSP for the South Scotland region.

Adedokun Adenipekun: I was at the public panel sessions in Inverurie.

11:15

David Stewart: I am an MSP for the Highlands and Islands region.

Stacey Smith: I live in Edinburgh, and I attended the Dunfermline panel.

David Torrance: I am the MSP for the Kirkcaldy constituency.

Iain Laing: I attended the Dunfermline panel.

Alex Cole-Hamilton: I am the MSP for Edinburgh Western.

George Burton: I live in Edinburgh and I attended the Dunfermline panel.

Brian Whittle: I am a South Scotland MSP.

Hugh Dunn: I attended the Cowdenbeath panel.

The Convener: Thank you all for your introductions.

We agreed that we will start by inviting you to ask us some questions. Stacey Smith will kick off.

Stacey Smith: Thank you for the opportunity to take part in the panel. It was a fantastically empowering experience to be on that side of things both as users of healthcare and as people who live in Scotland and are, therefore, the reason why the Parliament and, therefore, the Government exist.

The issue of prevention and early intervention—sometimes, we talk about early detection, too—came up quite strongly in our panel and, I believe, in other panels. What appetite is there for prevention? We know that there was a lot of talk about improving education in order to handle some problems through prevention. We also know that, if we are bold and start to invest in prevention, we can take some of the burden off secondary health care, because prevention is inextricably linked to that.

Brian Whittle: This is my favourite topic. Are we all sitting comfortably?

The Convener: I would like a brief answer, Brian.

Brian Whittle: There is a general recognition that we need to move towards a more preventative agenda, because of the impact that that will have on the overall health of the nation. I agree that we need to be bolder. Taking that step will require some funding to be shifted from one area to another, and it will take somebody very brave to do that—I am your very man.

We discovered that the issue encompasses much more than health. You mentioned education, which I think is a huge part of this agenda. Everyone agrees that we need to take a preventative approach but, so far, no major steps have been taken towards it. Hopefully, our inquiry will pull together notions about what can be done practically in that regard.

The issue of prevention is at the front of your mind, and it is also at the front of this Parliament's mind. However, people need to take a leap on prevention, so you need to shove us a bit harder.

Stacey Smith: Absolutely. I think that there was a slight nervousness among panel members that there would be a strong response that the issue is all about education. As some of the other panels agreed, the approach must be multifaceted. Simply putting adverts on social media to say that people should eat more fruit and do more exercise is just not good enough. We want reassurances that people understand that the approach must be multifaceted and must involve more than simply putting out a strong message. Sending that message is just one part of what needs to be done. Tackling social inequality and other things that underpin how much someone will engage with that message is more fundamental.

Brian Whittle: Absolutely.

Emma Harper: Thanks for your question, Stacey. I think that we are making progress in this regard. Social prescribing is happening across the NHS and integration joint boards.

I agree with Brian Whittle that we need to get in aboot the weans and ensure that they are educated, so that they understand what we mean when we talk about prevention. Professor Richard Davison told us that, when we provide education for young folk, we should perhaps talk about lifestyle choices rather than using language such as social prescribing.

Work is being undertaken across NHS boards where type 2 diabetes patients are in remission and are losing weight and not taking their meds any more. Dealing with that takes concerted effort and engagement by multidisciplinary teams, including third sector organisations. I am keen to promote and improve that approach and to do whatever we can to shift money from acute services into preventative services.

The Convener: A number of committee members are keen to respond to the very first question. I suspect that there will be opportunities to respond to questions as we go forward. I thank Stacey Smith for getting us going.

Ade Adenipekun has the next question.

Adedokun Adenipekun: My particular area of interest is social prescription, which has just been mentioned. In the panel sessions in Inverurie, I noticed that, in the Health and Sport Committee's to-do list, social prescribing is separated from the future of primary healthcare. It occurred to me that the concept of social prescribing is not new and has been around for decades, but not many people are aware of it. It is gaining relevance because of the special challenges in this day and age, when we have an increase in obesity and a lot of loneliness. Especially in Scotland, we also have a lot of mental health issues. It seems to me that social prescribing cuts across many portfolios such as health, sport, social housing, finance and education. Will the concept of social prescribing be driven solely through the NHS or will a separate structure be put in place to drive the implementation?

The Convener: You are right that the committee has picked that out for a special look, but we see it in a wider context.

Alex Cole-Hamilton: It is a great question. The concept of social prescribing enjoys cross-party buy-in. The problem that we encounter is that some communities—they are often the communities that would benefit the most from social prescribing—lack the facilities for GPs to prescribe into. For example, we have seen leisure centre closures and we are not training and churning out professional youth workers in the way that we used to. Particularly for young people, the opportunities to engage in structured activities that GPs or others could prescribe into just do not exist any more.

That speaks very much to the earlier question about prevention, to which social prescribing is key. Therein lies a tension. Politicians struggle to see beyond the date of their next election or re-election, so they like to see results immediately, and the big things that grab headlines are cancer waiting times or mental health waiting times. There is a lot of focus on reducing acute care waiting times, rather than investing in something that may lead to an invisible benefit. We cannot measure the number of people who we have kept well, but we can see the number of people who need acute care. Those issues are all wrapped up together. We have the political will, but sometimes the rhetoric is not matched by reality.

Adedokun Adenipekun: As a follow-up, I say that I have realised that the level of awareness among the population is not so high. To be honest, I did not know about social prescribing until I participated in the panel discussion. However, there are stakeholders in the third sector and other areas who share the passion for social prescribing. Are there plans to educate the populace and to encourage participation of the third sector and the other sectors that we have talked about?

David Stewart: That is a very good point. First, I will respond to your question about social prescribing. Alex Cole-Hamilton is quite right: the problem is that many of the people who would benefit from social prescribing come from hard-to-reach groups. One of the GPs from Glasgow who gave evidence a few weeks ago said that the

typical patient who would benefit is hard to reach and one that he rarely sees.

It is easy for us all to talk a good game about active travel—walking and cycling—but there are huge safety issues involved in doing that in many disadvantaged areas, and that approach will not work. Alex Cole-Hamilton mentioned that we are all busy with the election. I can recommend elections as a good way to increase people's step count and their ability to get fit.

We know that difficult-to-reach groups are those in disadvantaged communities and include men over 55. I certainly commend the work that our football clubs are doing, which a number of committee members, including David Torrance, have mentioned in the past. My football club in Inverness has done a really good job of getting men to come along for weight and blood pressure checks and to play walking football. That is very helpful. I was at one event recently with the Presiding Officer when he did a tour. Many of the participants have early dementia. Having an annual MOT is vital. Well men and well women clinics are vital.

Emma Harper talked about diabetes earlier, which is an issue that a number of us have a big interest in. I think that 10 per cent of NHS expenditure is on avoidable complications arising from diabetes. That is a classic preventable condition. I am extremely keen that we focus on high-risk screening, which can pick up conditions in the over-45s, those with family history of the condition and those who are overweight, to detect all the undiagnosed people with diabetes, which is the main cause of blindness in those of working age.

The Convener: I know that other colleagues want to come in. I have a third question on this general area, and then I will give everyone a chance to chip in.

Iain Laing: I am interested in the health and welfare of people. From school age onwards, people should get the right physical development. Also, green spaces that are available for exercises such as walking and running seem to be diminishing slightly, because they are being built on, which is not a good thing.

The other issue that I am thinking about is the advertisement of different health clubs by the third sector, for example. There is a magazine that shows what is available in Edinburgh for elderly people, including bowling, walking and badminton.

George Adam: I am quite interested in the idea of that brochure on the various clubs that are available in Edinburgh. I will tie that into the issue that we were talking about of trying to get to the most difficult-to-reach people, who GPs do not generally get to see. In my constituency, we have been working with St Mirren Football Club. It is based in Ferguslie Park, which is an area of deprivation. We are working with the football club, the local university and the college to try to get everything in one place. Unlike Edinburgh, Ferguslie Park has big areas to build on, where we could create a centre for sport. I do not mean that it should be for elite sportspeople; it should be for the likes of you and me to go along to keep our weight down and make sure that we can have a fit and active lifestyle.

I know that all football clubs have community trusts, and it is those bodies that would be progressing such projects. St Mirren Football Club Community Trust has the football fans in training—FFIT—programme, which I think originates from the Scottish Professional Football League Trust. I think that we should take that idea to the next level. We need to take responsibility. Some of the football teams need to take responsibility, because football is still our national support, although we might not be very good at it.

St Mirren and many of other clubs do a lot of community work. The chairman of St Mirren once asked the chief executive of Renfrewshire Council when he was going to second some social workers to work with St Mirren. Everybody thought that that was a joke, but it was not. Indeed, a social worker working with someone with a St Mirren or football perspective would probably get more credibility than someone coming from a local authority. There are all sorts of different ways and mindsets that we can have to progress that. For me, the exciting bit of that is changing people's lives.

11:30

Craig Henderson: I go to Cumbernauld every week. Last weekend, when I was out with my father for a walk in the shopping centre, I noticed that one of the shops has been turned into a child community care cafe—although it is still being worked on. Children can go there for four hours while the mother, the father or the seniors go to the other shops. It is a good thing, and people should use it, because so many children are left stuck in the house all day.

The Convener: We heard evidence of a shopping centre having a pop-up shop in which people could play table tennis. That seemed to be a good thing for encouraging people to get fit.

David Torrance: The key to social prescribing and activities for the whole population is how we advertise them so that people know that such activities are out there. My constituency is rich in third sector organisations and voluntary groups, but I meet many constituents who do not know about the men's shed in Kirkcaldy or that

Alzheimer Scotland holds special events for people with dementia. Those events take place every week in the centre of the bus station. How do we advertise such events and let the general population know that they can go along and help themselves? The key issue is empowering people to get up and go to such events.

Iain Laing: Yes—there should be advertising.

I reiterate what Stacey Smith said about it being a privilege to be here. Sitting next to a champion walking footballer is quite enhancing. [*Laughter*.]

The Convener: David Torrance will want you to come back next week.

George Adam: He doesn't like to talk about it.

Ian Laing: It is nice that we have heard about green spaces, and I have read that, overall, it is going forward and we are getting better at everything that we are doing, but it seems to be taking a long time, which I do not think a lot of us have.

Brian Whittle: Iain Laing mentioned green spaces, which brings town planning into the equation. It is not just about health; it is about how we work on the health agenda across all portfolios. That was an interesting point that came out of the sessions that we held outwith the Parliament.

I will pick up on George Adam's point about hard-to-reach groups and being in a non-clinical environment. We should not be so fixed on bricks and mortar, because certain elements of the population are more comfortable in a non-clinical environment. The work that the SPFL Trust is doing is key, as is bringing the services to a non-clinical environment. In my view, we need a proper audit of the third sector to see what is available out there. It is not enough to just make things available. Some people do not have the mindset to be able to wander along themselves and take part, so there has to be a way of creating a link to allow people to get involved. The issue is multifaceted. Quite frankly, we know all the answers, but we need to be brave enough to put the plan in place.

Iain Laing: Another point is the amount of space that is needed for physical activity. A lot of schools have sports facilities such as gymnasiums that could be used at night when the school is closed, but they do not seem to be used.

The Convener: That is a fair point.

Emma Harper: On the point about who will deliver social prescribing, I think that multi-agency support will be necessary, involving the NHS and local authorities. I absolutely agree that the third sector also needs to be involved. Yesterday, I met Third Sector Dumfries and Galloway, which pointed out that one third of the UK's men's sheds are in Scotland, so Scotland is very good at providing those. The organisation is creating a new database, because the current one, which is called ALISS—a local information system for Scotland—and on which we have heard evidence, does not work or is not up to date. We need to ensure that people are aware of what is out there locally, and that requires the sharing of information by social media, newsletters, leaflets and so on.

We have changed our language around physical and mental health. We now refer to health and wellbeing, because you cannot have physical health without mental health and vice versa. We are seeing an evolution in the way in which people are addressing physical and mental health issues together as wellbeing, and including sport in that. However, we have more work to do.

The Convener: Does George Burton want to come back in?

George Burton: Thank you, convener, for saving the best until last today. I echo Iain Laing's point about how grateful we are to have this opportunity to speak to the committee—thank you for that.

On the social prescribing front, I want to highlight a couple of brilliant projects that are underutilised in Scotland. One is parkrun practices. Many of you may be aware of the concept of parkruns, which are free 5k runs, walks or jogs. They are a way for people to take part in physical activity and get their 30 minutes in on a weekend. There is a local session in Edinburgh that on average has approximately 500 people turning up every weekend—at its peak, between 700 and 800 people go along. However, there are only seven parkrun practices—GP practices that actively refer people to the parkrun UK scheme—in Edinburgh. That is disappointing, as there are 1,372 such practices across the United Kingdom. Parkrun is a huge phenomenon, and it is simple and free. We could do a lot of strategic work on how we raise awareness of that type of initiative.

Other charities are involved in wellbeing issues. For example, we could think about how GPs use talking helplines such as the one that is run by the Samaritans. We might also think about where the first point of contact is for people who come into our health system, and where triage takes place to ensure that people are put in contact with the wonderful and free resources that already exist in Scotland.

Adedokun Adenipekun: I know that there is a lot going on in general, but are people happy to pay for the services that they get through social prescribing? I know that medical prescriptions are free in Scotland. Will social prescribing be free in the future? Is there a cost barrier?

The Convener: We took evidence on that, and there were different views. You are right that, at

the moment, for most of the physical activities that we might have in mind, there is a charge for people to take part. Even if the charge is modest, it will still be significant for people of limited means. We will focus in our inquiry on how to address that issue.

Craig Henderson: I am glad to note that, in the past few years, in places such as Glasgow, people have been going out of their way to help homeless people to access services. There are notices in places such as hostels that give people information on where to go. There are still a lot of people on the streets, but I am glad that some homeless people are getting themselves sorted out. That is nice to see, and it is important that the progress continues and that people get help.

When I was living rough, it was the most horrific thing that ever happened to me in life. It was terrifying. Just living like that is not a life. Some people out there are not registered for social security and so on. They do not want to be part of it—they just want to live the life that they pick, and they do not realise that they have neglected their health so much.

The Convener: Absolutely. Are there any other points on that general area? Stacey Smith asked the first couple of questions. Before we move on to talk about information technology and other topics, are there any other comments on social prescribing or physical activity?

If there are no further comments and everyone is happy with that, we will move on to IT, with a question from Hugh Dunn.

Hugh Dunn: I would like to speak about information technology. Everybody agrees that it is essential to have a national IT network with a central database containing all the complete records of every individual patient, to which every medical professional has unrestricted access. If such a network is so essential, why do we not have one?

There seem to be two major problems. One concerns the installation. I understand from a doctor friend that it has been tried before—the installation was attempted in one gigantic operation, and it just did not work. I suggest that the installation process be divided up into three easier stages. First, each GP practice, MDT centre, hospital and community practice would install an individual system in its premises. It would be necessary for them to use the same model and be compatible, and only the Government could lay down the law and, to put it bluntly, say that it must happen. Secondly, once each premise in a city had its individual system, they could be linked up and networked. Thirdly, once the city-wide networks were in place, all the city networks could be linked into a national grid. Rather than do one gigantic operation, it could be done in three easy stages.

The Convener: Thank you for that. That is another area that the committee has looked at long and hard. I see that Brian Whittle is itching to come in on the issue.

Brian Whittle: I again ask: are we sitting comfortably?

The Convener: I again ask you to be brief.

Brian Whittle: Before I came into the Parliament, I developed communication and collaboration platforms for healthcare. The reality is that the problem is not with the technology, because the appropriate technology has existed for a long time. It is a change management problem about how to instigate delivery of the programme. The technology is available, but the bit that is missing is how to train our front-line staff to use it. The issue that has come out quite strongly in the evidence is how to give our NHS staff the ability and time to learn how to use the new technology.

My only addendum to the earlier points is that I disagree that access should be available to every healthcare professional. There should be layered access, and it should be up to the individual, who should own their data, who gets access. The premise is correct with regard to delivery, but the biggest problem is one of change management to engage the whole system in the technology.

David Stewart: I will build on Brian Whittle's point and raise the issue of wearable health technology. To use the example of diabetes again, many people rave about the importance of FreeStyle Libre. For those who do not follow the issue, it is a form of continuous glucose monitoring—people might have noticed that Theresa May uses it. However, I want to flag up the problems with access, with regard to geography and disadvantaged areas. There is a cost and there are strict criteria.

There is no doubt that technology has moved dramatically in diabetes. There was a problem with the supply of pumps across Scotland which, I say in fairness, changed when Nicola Sturgeon was the health secretary and set targets for each area. Even in the past five or six years, there have been big developments. Technology can change for the better, but Scotland still has the fundamental problem of health inequality and geographic inequality, to which I do not have an easy answer. The technology is there and it can improve people's quality of life and their safety.

Iain Laing: I do not know whether it is just me getting older, but I find that the use of such technologies is getting more complicated. The idea should be to make technology simpler so that

more people can use it, but it seems to be getting way out of line and more complicated, which we do not need.

The Convener: That point goes back to Hugh Dunn's initial question. Part of the problem that has arisen is that individual GPs and health boards set up their own systems. In principle, we might think that a bottom-up approach is good, but it has meant that a lot of those systems do not talk to one another. The complexity that Iain Laing has referred to is obviously part of that. The key thing is to ensure that we have compatible technologies. I think that George Burton has a question in that area.

11:45

George Burton: I want to build on the idea of compatibility and interoperability in terms of how some of the systems speak to each other. I work in banking and we had quite a radical overhaul because of European legislation and directives so that there is now a system called open banking in the UK. Some of you might be aware of that. Basically, it is a decentralised platform that uses application programme interfaces, which means that I own and keep all my data and have control over whom I share it with. However, I can share it with multiple banks or financial institutions, which can use it in smart ways to provide collaborative services.

For example, I can give my data to bank A to store, but I can always add in data from bank B and they can pull all that together and do smart, innovative things in managing it. For example, they can say, "I know that your salary comes out of one account and that you spend a lot of money in another account. Let's pull it all together and work out how much you've got at the end of the month."

I question how, in health, we are building on the work of such providers and drawing on and bringing in best practice from the private sector. For example, I use wearables and I note that others on the panel have wearables on or are using them. The question is how we draw in information, whether we share it with our GP and whether they pull it in and use it in a smart and effective way.

I will describe briefly a kind of service journey involving registering with my GP and booking an appointment. Speaking from a personal perspective, when I moved to Scotland, I found that service journey challenging, to say the least, and certainly different from my experience down south. The first thing that I do is go on the internet and look up my nearest GP, but even finding out something as simple as that is sometimes a challenge. However, I then realise that there is no obvious way to sign up on the GP practice's website. I cannot enter my details or say, "I know my national insurance number and NHS number. Please take all my details. I give you permission to take them from my previous GP practice."

Consequently, I walk along to my local GP practice at the times that it prescribes, which are times when I should be at work, and say "Please can I register?" The practice then sends me away with a set of forms that tell me that I now need to provide all this information. However, I do not have half of it, so I go back and we have a dialogue about why I do not have it.

I then wait a little while and I get a letter in the post. I live only a few doors away from my GP practice, so why on earth it posts me such things and does not email me, I do not know. From my perspective, that is quite amusing. If any other organisation did that, I would refuse to take on their services. I do not know why we think that that is acceptable in the NHS or in GP practices.

The whole process takes about a month and I get incredibly frustrated because it could have been done very simply. I compare that to something as basic as joining my local gym. For that, I sign up online and say what service I want. I put my details in and am given a code and personal identification number to access the building. I am asked what classes I would like and am given a list of classes that the gym has noted that I am particularly interested in—for example, for leg strengthening or cardiovascular work—as well as a list of the trainers.

Why am I not doing the same sort of thing with my GP? I could go along to the GP and say "I'm struggling with my mental health at the moment. What appointments have you got available on this date with a mental health first aid practitioner?" That would let me self-refer to the right channel. Why are we not using smart triage systems? For example, why are we not using apps like Babylon, which is widely used in many areas? It could be used on two fronts in the GP model. If the GP already has all my data because I am sharing it through wearables and I tell them about certain symptoms, they could say, "Oh, yes—you've been here before, so we already know you've got cardiovascular issues. Now that you're presenting with these symptoms as well, we can refer you to the right place."

I question whether we are taking the right approach on all those matters, whether we are ambitious enough and whether there is the willingness at the front end to implement some of those systems. Ultimately, once we do that, it leads to better outcomes for patients and simpler systems for GPs and others at the coal face. It is a win-win process for everyone.

I wonder whether the committee has any thoughts as to why that message might not have got across and where some of the challenges are. Is the challenge around funding or willingness?

The Convener: You asked a lot of questions there, and you will know that we have put many of them to the Government and others.

George Adam: I was going to say the same thing, convener. George Burton is right to ask those questions, and we have asked many of them in the sessions that we have had during the inquiry.

We all think that the solution is simple. Hugh Dunn asked the question and proposed a solution. We think that what needs to be done is not exactly rocket science. However, the problem that we face and which George Burton brought up involves the ownership of data. Currently, it is the GPs who own your health data—it ends up in their offices. They will not let go of that data for a number of reasons.

The other problem is that, when you walk into your dentist or pharmacist, they ask you the same questions every time, because they do not have access to your medical records. All they need is basic access to information such as what medication you are on, but you end up getting really annoyed every time you go to your appointment—at least I do, because I spend five, 10 or 15 minutes before I go in each time filling in a form on a tablet to tell them that I am on no medication. My wife, however, who has three long-term conditions, has enough medication to fill in the form three or four times over, so the process is quite difficult for her, too.

We are all aware of the problems, as we have all done what I have described. However, there is a problem with the GPs. Either they lack the trust to let go of that information because they do not know what will happen with it, or they will not let it go because holding on to it is what they have always done. We must bear it in mind that, right from the beginning of the NHS, the vast majority of GPs have operated under a subcontractor model, because there would not have been GPs if we had not gone down that route in the 1940s. That contributes to another reason why they will not let go of the information: it is their main source of income. It is a power thing, because they have control of that data.

I can understand why individual GPs might be a bit complacent because of that. However, as a member of the public and someone who has a wife who has long-term conditions, I would love to live in a world in which your dentist or pharmacist has access to your information—not all of it, but enough for them to be able to help you. Of course, that would also help GPs, because enabling the pharmacist, dentist or optician to deal with various things would mean that GPs would no longer have to sit there from 9 o'clock until 5 o'clock, Monday to Friday—I will not say seven days a week because, unlike some of us, they do not do Saturday and Sunday surgeries. We need to use those professionals a lot better and give them access to that information. That is one of the simplest and most achievable things that has come out of the inquiry. The problem is the will of the clinicians to do what we are talking about.

The Convener: Hugh Dunn and George Burton have given clear proposals for what needs to happen differently. They have suggested that there must be a joined-up and user-friendly system for entering information across the NHS. Do other panel members agree?

Stacey Smith: Absolutely. That was a key theme that came out in our panel. I take George Adam's point that we need buy-in from GPs, but I think that a lot of them would say that they want to change the model because it is inefficient and involves a lot of waste. A lot of the witness panels expressed the view that there needs to be more workforce planning and that efficiencies in that regard are underpinned by adequate information technology platforms that operate more efficiently.

With regard to GPs' willingness to do what needs to be done, if they practise in our country, we have the ability to legislate and drive some of that expectation rather than be led by the people who practise.

There are a couple of issues there. It sounds like the committee has an appetite to push the Government further in that regard, which is reassuring.

The Convener: Correct me if I am wrong, but you are saying that, if GPs are reluctant to go down the road that we have described, we should require them to.

Stacey Smith: Yes. Reluctance usually comes from a valid concern, so we need to understand that problem and reframe it. GPs want to be more efficient, to reduce waste and to improve their workforce planning, so we need to say that, if we do X, it will underpin A, B and C, which are the things that we all want to achieve.

The Convener: That is very clear—thank you.

Emma Harper: There are complexities around sharing information because some folk might not want to disclose, for example, HIV status or hepatitis status. Yesterday, I heard about a case in which a woman was challenging the health board for not disclosing that her dad had had Huntington's disease. She had got pregnant and said that she might have considered terminating the pregnancy if she had known, because there is

now a 50 per cent chance that her daughter will develop the disease.

There are issues around protecting and sharing data, and making sure that people do not disclose information about someone that they might not choose to disclose. In rural areas, everybody kens your business, so we have to be careful about levels of access to data, and not allow everyone access to everything.

Adedokun Adenipekun: There might be some specific cases in which people do not want to share data, but a large percentage of the population want to share—although nobody has actually gone out to ask them. People have the opportunity to say yes or no to being an organ donor on their driver's licence, but nobody has gone out to ask whether people want to share medical data. There is just a general assumption that people do not want to share. Asking people whether they want to share their data might be a good place to start.

The Convener: Absolutely. That takes us back to the question who owns the data. If the person owns their data, they can decide whom they share it with.

George Burton: I will pick up on the point that GPs are reluctant to go down that route, but are slowly realising that people want to choose their channels of communication with their healthcare provider. There are initiatives and applications out there that are putting GPs out of business: in south-west London, Babylon's GP at Hand app has literally put GP practices out of business. GPs are becoming increasingly aware of such things.

At a simple level, it is about whether people can Skype someone to share their problem with, or have a videoconference with a health professional to discuss their symptoms and how they are finding things. One could not imagine people not doing so in any other professional practice—you would not go into a financial institution, professional services company or other private organisation every time, saying that you will not pick up the phone.

We have had excuse after excuse from GPs, but it is as simple as having a Skype account and asking individuals whether they are happy to have their appointments using Skype. I struggle to see why we are not moving more aggressively on that front.

The Convener: Putting GPs out of business is probably not a widely held objective, but making GPs more accountable and accessible might be.

Brian Whittle: I agree that that might not be the message that we want to send out from here. Perhaps we should be talking about aiding GPs to deliver their services.

We are talking about access to personal information. The flipside of that is who can input an individual's health information. For example, a third sector organisation that is delivering a healthcare initiative might have no access to a person's data, but could input data that their GP could see. In my area, for instance, Ayrshire Cancer Support can deliver mental health therapy for people who have been diagnosed with cancer. That organisation's ability to input data is just as important as who has access to it, in an holistic approach to health.

Emma Harper: I have issues with online GPs because they cannot do sets of vital signs. If you dial into a GP you might get a prescription for an antibiotic, but how do they know that the patient does not have a viral infection? Antibiotics do not work for viruses.

Perhaps we need to integrate wearable technology so that a person can say what their temperature, heart rate, oxygen saturation and blood pressure are, which would help an online GP to make informed decisions. It seems that there are concerns that the worried well are dialling in and paying £50 for an online consultation, when maybe more is needed than just handing over a prescription. We need to consider all the issues that come out when we talk about that kind of access.

12:00

Iain Laing: I am thinking about the number of systems that exist for putting vital-signs information into a computer, and having such information widely taken in in that way. We do not know whether any local telephone or computer has viruses on it—people using their phone to put information into a central computer would just be asking for trouble.

The Convener: Online security is obviously important.

David Stewart: Following on from Emma Harper's comments, I will make a quick observation. The other day, I was reading in the *BMJ* about widespread use of DNA tests, which many people—quite rightly—access for simplicity because they think that that would be useful for their medical records. However, the Royal College of General Practitioners in England has said that a DNA test's recommendations are not necessarily to be followed up, because there is dubiety about the accuracy of the tests. That might be an issue for another day. I would have thought that a DNA test would be important raw material for medical records, but it appears to be the case that that there are questions about that.

The Convener: That is a useful word of caution.

Martin Misovic: First, I thank colleagues for creating this opportunity, which is brilliant. The points that are being made are very important and could create much better primary care.

Education at the very beginning would help; for example, introducing to primary and secondary schools self-care and—possibly—parts of the triage system, so that kids and young people understand and know where to turn if they need help.

Brian Whittle: I agree. Everything that we have talked about leads us towards being more aware of ourselves, more able to look after ourselves and able to make better choices for ourselves.

I would go in earlier than Martin Misovic suggests: pre-school is where most of the building blocks for the rest of a person's life are set, so I would start at the pre-school stage.

It is not necessarily about education in the sense of traditional education; it is about giving kids the opportunity to play, and to take part in growing their own food. That kind of educational approach is very important, and it should develop all the way through the education system. In relation to the whole of wellbeing, we are driving towards inextricable relationships between physical activity, nutrition and each other. That is the end game that we are looking towards. I agree very much with Martin Misovic.

The Convener: Quite a lot of the discussion that we have had around patients owning data also implies patients owning some level of control over their own medical treatment, which perhaps also relates to Martin Misovic's point.

Martin Misovic: Yes.

Craig Henderson: Kids go to primary school and enjoy it; I enjoyed it and managed to get my head into books and find it interesting. However, when I went to high school, I was sort of saying to myself, "What a big building, and look at all these people." Unfortunately, I was bullied in my first and second years in high school and, because of that, I was unable to use common sense and study hard in class because I was worried about moving from classroom to classroom. I say to this day that some teachers must have noticed that I was being bullied. I was picked on for fights after school: it was horrible and frightening.

What about kids today who that is happening to? That gets to me. Psychologists might notice that a person has autism or Asperger's, but not enough time is given to such people. They are just left to stand by, and they have to catch up. The family do not want a bad name.

The Convener: Thank you very much. Last year, on visits during the year of young people it was striking to the committee how widespread concern about mental health and wellbeing is among young people from quite an early age. Your point is therefore well made.

I go back to Martin Misovic's question. We should not see engagement with young people simply in terms of what is good for their physical health; engagement to support people's mental health and wellbeing is also important.

Does Craig Henderson have a question about joining up services?

Craig Henderson: No.

The Convener: Okay. You have all had the opportunity to ask us questions. I want to ask you about the engagement process. How have you found the engagement with the committee and Parliament to be? How do you feel about the process—in particular, how we have tried to take your views on board?

Hugh Dunn: I have found the whole process to be very enjoyable. It has been a joy to come and take part in the work of the Parliament, and it has been exciting to see how the committees and the debating chamber work. It is satisfying to know that so many people work so hard to improve our health service.

The Convener: Very good. You have been spotted more than once in the gallery and at some of our other meetings. We clearly got that message.

George Burton: A lot of work has gone into supporting us to get to where we are now in our understanding and collective thinking, and to get diversity in terms of geography and other demographic characteristics.

I question the effectiveness of choosing individuals who have not had direct contact with the primary care sector. Does the committee have thoughts on whether there is anything to be said for speaking with people who have had recent interaction or more in-depth interaction with the sector? For example, a person who has gone to their GP and filled in a survey could, on the back of that, potentially be supported through such a route, or there might be scope for selecting people to do such things after they have come through a particular interaction. I am conscious that I found out about getting involved in the process purely because of a letter through the door. Members might find people who have had direct experience of the primary care sector to be more insightful.

Stacey Smith: We had a good cross-section of people on our panel, because almost everybody links to primary healthcare. The clue is in the word "primary". That certainly came out on our panel. There were lots of different experiences and social and geographical backgrounds, despite the fact

that we were huddled together in Dunfermline. That was excellent.

I have found the process to be really engaging and empowering, because being involved in it has made it feel as if the Scottish Parliament is a Parliament for me. People are passionate about different subjects: I am passionate about primary healthcare, so having the opportunity to glean more insights has been fantastic. I thank the committee.

The Convener: That is excellent. Thank you very much. I say a special thank you to Stacey Smith, who is the only woman among our participants today—although it is worth saying that half of those who took part in the panels were women. There was a successful diversity mix at that stage, which we are keen to encourage for the future.

Adedokun Adenipekun: I would echo the words of Hugh Dunn and Stacey Smith. It has been a privilege for me to participate in the panel session. It has been a wonderful experience—it has been informative and educative, and the collaborative approach that has been taken has been very good for solving problems. I have really enjoyed it and am proud to have been part of it.

The fact that some of the things that we have discussed have been brought to the table for possible implementation makes me feel very good about the whole process. Thank you very much.

The Convener: Thank you for that.

Martin Misovic: I thank the committee very much again. I have seen a lot of hard work being done by people in this building and in this room. It has been great.

The Convener: That is grand. Does anyone else have anything to add?

Iain Laing: I offer my thanks, too, because I have learned so much. When I first came in, the first question that I asked was, "What is primary care?" I had never heard of it before. That was answered by, I think, Anne Jepson. The path that I have been led along since then has been totally revealing. I have learned a huge amount, which has involved me going deeper into various aspects. I thank the committee.

The Convener: Thank you. In a sense, that is partly the point of this.

George Burton made a very valid point when he suggested that perhaps we should have started with people who have had direct engagement with primary care. That will certainly be looked at, but we were keen to be entirely random. It would have been very easy for us to have consulted patient representative groups, of which there are many. Although they do a fantastic job on behalf of the patients whom they represent, we were keen to get an even wider picture: the testimony that we have heard from participants today demonstrates how diverse are the experiences of people at the table.

On behalf of committee members and Parliament, I thank the panel very much for taking part as you have—for making such frank and helpful contributions at every stage of the process and for being with us this morning.

I thank everyone for their attendance.

Meeting closed at 12:12.

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