OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 17 January 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 17 January 2017

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HEALTH AND SPORT COMMITTEE
1st Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Paul Edie (Care Inspectorate)
Niki Maclean (Scottish Public Services Ombudsman)
Jim Martin (Scottish Public Services Ombudsman)
Martin Moffat (Scottish Government)
Rose Marie Parr (Scottish Government)
Karen Reid (Care Inspectorate)
Shona Robison (Cabinet Secretary for Health and Sport)
John Stevenson (Scottish Public Services Ombudsman)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 17 January 2017

[The Convener opened the meeting in private at 09:32]

10:00

Meeting continued in public.

Subordinate Legislation

Regulation of Care (Prescribed Registers) (Scotland) Amendment Order 2016 (SSI 2016/413)

Caseins and Caseinates (Scotland) (No 2) Regulations 2016 (SSI 2016/422)

The Convener (Neil Findlay): Good morning, everyone, and welcome to the first meeting in 2017 of the Health and Sport Committee. I wish everyone a belated happy new year.

I ask everyone in the room to switch mobile phones either off or to silent mode. It is acceptable to use mobile devices for social media, but not for taking photographs, filming or recording.

As per the official agenda, we have already covered agenda items 1 to 4 in private. We move now to agenda item 5, which is subordinate legislation. We have two instruments that are subject to negative procedure to consider. The first is the Regulation of Care (Prescribed Registers) (Scotland) Amendment Order 2016 (SSI 2016/413). No motion to annul has been lodged and the Delegated Powers and Law Reform Committee has not made any comments on the order. As there are no comments from members, I ask the committee whether it agrees to make no recommendation on the order.

Members *indicated agreement.*

The Convener: The second instrument is the Caseins and Caseinates (Scotland) (No 2) Regulations 2016 (SSI 2016/422). No motion to annul has been lodged, but the Delegated Powers and Law Reform Committee has commented on the regulations and has drawn them to Parliament's attention on reporting ground (j). The regulations fail to comply with the requirements of section 28(2) of the Interpretation and Legislative Reform (Scotland) Act 2010, although that does not affect their validity. The regulations were laid on 15 December and came into force on 21 and 22 December. They therefore do not respect the requirement that at least 28 days should elapse between the laying of an instrument that is subject to negative procedure and its coming into force. However, as regards its interest in the Scottish Government's decision to proceed in that manner, the Delegated Powers and Law Reform Committee finds that failure to comply with section 28(2) to be acceptable in the circumstances.

Do members have any comments?

Members *indicated disagreement.*

The Convener: Does the committee agree to make no recommendation on the regulations?

Members *indicated agreement.*

Scottish Public Services Ombudsman

10:02

The Convener: Agenda item 6 is a session with the Scottish Public Services Ombudsman. With us we have the ombudsman, Jim Martin; Niki Maclean, who is the director of the SPSO; and John Stevenson, who is the head of complaints standards. I thank you for your attendance.

The ombudsman has agreed not to make an opening statement, so we will start with questions. I will begin. Can you briefly explain your role and experiences over the past year or so?

Jim Martin (Scottish Public Services Ombudsman): The Scottish Public Services Ombudsman is the last port of call for people who have unresolved complaints about public services in Scotland. We have a very wide remit: we deal with the national health service, Government, local government, prisons, Scottish Water—and so it goes on.

We deal differently with the health service from how we deal with the other public sector areas that are within our remit, because in relation to the health service we have the power to look at clinical judgment. That means that I have to take advice from professionals in all the disciplines in the cases that come to me. I do not have such a power in relation to local authorities, higher education, further education and schools, for example: I cannot look at academic judgment and that kind of thing. In health, I have a particular power.

As the committee will have seen from the papers that we have given you, over the past year we have had a significant increase in the number of health service complaints coming to us. It is maybe worth our while to say for people who are unfamiliar with the SPSO that people normally only come to the ombudsman once they have been through the complaints process for the public body concerned. If someone comes to us early, we call it a premature complaint and would normally signpost them to the appropriate place and have them take their complaint through the process there. Once a complaint has been through the process at local level—general practice, dental practice or health board level—if the complainant is still dissatisfied with the outcome, they can bring it to us. Last year, we had about a 9 per cent increase in the number of complaints that came to us. Since I became ombudsman in 2009, health complaints have increased by about 75 per cent. There are lots of reasons for that, which I am sure the committee will want to discuss.

For most public services in Scotland from which cases come to me, the uphold rate—the rate of cases that we investigate and find that something should have happened but did not happen—is currently running at about 50 per cent. For health, the figure is about 56 per cent. The worrying thing about that is that those cases have already been investigated at the local level and, by and large, the complaints have not been upheld and have then been brought to me. In that situation, we investigate; in more than half the cases, we have found fault.

A complaint is sometimes upheld at the local level but not to the full satisfaction of the complainant. If we find that the case has not been investigated properly, we look at it. If we find that it has been investigated properly and there is nothing more that we can do for the person, we tell them that and that closes the matter.

The proportion of health service cases that we see has increased over the period. Health service complaints is the fastest growing area of complaints that come to my office and is now the second-largest area, behind local government. If the rate continues to increase in that way, I anticipate that health might well be on a par with, or overtake, local government in two to three years.

The cases that we are seeing now are more complex than those that we saw in the early stages. More and more often we have to send away for advice, perhaps from two or three specialisms, when we consider a case.

This is beginning to sound like an opening statement, convener, so I am sorry about that. However, you will see in our submission that we have a problem with provision of clinical advice. The Parliamentary and Health Service Ombudsman, which deals with health service issues in England, has decided after 23 years that it feels that it can no longer give us access to its clinical advice. I will say more about that later if someone asks me the right question, but it means that we are having to create our own bank of clinical advisers. Over the past year, we have seen an increase in health service complaints and the uphold rate is still quite high. We are also having to rethink how we get advice to investigate cases.

Further, we have been working alongside the national health service to help it to put in place a new complaints handling procedure, which will go live in April. That will introduce the same standardised procedure in the national health service as exists in the rest of public services in Scotland. We have argued long and hard that if we are to have health and social care integration, we need to have one complaints procedure for everything. Therefore, the social work complaints

process will also be brought into line with the procedure from 1 April.

From 1 April, we should have a user-centred standardised complaints process, which will enable local authorities and health boards to work together to solve problems when they arise. It should also give the committee better information about the number and nature of complaints that come forward in the health service and in the integrated health and social care system. That will place the Scottish Parliament in a better position—certainly, better than any other Parliament in the United Kingdom and, I would argue, any other Parliament in Europe, in that we will be able to look across the whole of our public services to see what is happening with complaints. We will be able to see what areas are leading to complaints from the public, how complaints are being managed and how health boards, local government bodies, universities, housing associations, prisons and other bodies deal with them. I hope that, in the future, the committee will mine the raw information that it will have at its disposal to get underneath what bothers the public in provision of public services.

John Stevenson, who is the architect of most of that stuff, will happily answer questions on it, and Niki Maclean will do the stuff with the numbers. I just do the blarney at the front.

The Convener: Thank you for your non-opening statement.

You have said that 56 per cent of the health service cases that you looked at were upheld after having already gone through the NHS complaints system. Is that an indication that the NHS system is broken?

Jim Martin: In its 2014 report "Making It Better: Complaints and Feedback from Patients and Carers about NHS services in Scotland", the Scottish Health Council expressed a few concerns about the way in which the health complaints system was working, and it asked the health service to work with us on a better process for handling complaints that would give us a new national complaints-handling procedure. As for areas in which I think the health service is improving but could go further, I am not convinced that management of complaints is given the weight that it should be given—in particular, in health boards. Indeed, I am absolutely convinced that that is the case with regard to general practitioners.

In his report on Mid Staffordshire NHS Foundation Trust, Robert Francis highlighted his discussions with the chair of the trust, to whom he had put it that many of the issues that had led to the deaths of so many people had been flagged up in the complaints system but had been neglected by the chair, the chief executive and the board of the trust. Essentially, the chair said, "There'll always be complaints. We know that, and they don't really add anything." Francis's view was that if you take that approach you miss out on early warning and learning.

I think that the national health service is getting better at understanding that when complaints are brought they should not necessarily be looked at on the basis of potential reputational damage—when I came to office, one or two health boards definitely saw my office as a threat to their reputations.

Moreover, in my view, this is not a matter for lawyers. Over the past couple of years at least, we in Scotland have been moving away from lawyers saying, "For goodness' sake, don't say sorry or admit anything just in case that 0.4 per cent, or whatever, of complaints end up in court or litigation." The health service is getting better at such things and at knowing that it has to investigate complaints.

I hope that once the new processes and procedures are in place, and with the work that Niki Maclean is doing with health boards and others on learning from complaints, the uphold rate that I have been seeing—or which my successor will see, given that I am leaving office soon—will fall. I see a willingness on the part of the national health service to grasp and learn from the issue, but sometimes it looks to me as though the machinery of the national health service has been oiled with treacle, given how long it takes things to come through. In this case, it is moving relatively quickly on the complaints-handling procedures—although it is still slow—and I hope that from 1 April we will have a better system in place.

The Convener: In my experience of representing constituents—practitioners and patients—I have felt, with regard to the attitudes that prevail among very senior managers in the NHS, that there often appears to be a culture of closing things down and denial rather than of acceptance that there are problems. There is also the ability at the very senior level of the health service to claim that white is black and black is white. Do you think that that culture existed in the past? If so, is it still there, or do you sense that there is an opportunity for real change and that the health service is grasping it to ensure that it learns from mistakes and complaints, and that it is open about them?

10:15

Jim Martin: It is wrong to suggest that all health boards are the same: their cultures are different. If you had asked me about that in 2009-10—I will

not name names, if members do not mind; I will say why later—I would have said that a couple of health boards would nearly fit that description and that their first port of call would have been to say no, or to say that there is nothing to see here, so please move on.

This is paradoxical and will sound really silly, but the national health service has been unprofessional in some cases in the past in not being good at closing things down. Five years ago, I would have said that consultants in hospitals, for example, had far more power over what happened to complaints than they ever should have had, and that investigations, particularly of the work of consultants, in many health boards were not up to scratch. On the other hand, in some cases in which it would have been in the best interests of everyone—including the family—to close something down, the health service would attempt to go the extra mile and would drag a process out without coming to a conclusion, which would lead, for example, to a family coming to me to say that the board had been investigating the case for over a year. However, when I looked at the detail, I could see that it had not; it had investigated the case and had reached the point at which it could take a decision, but had instead tried to help the family by getting more information, thereby not providing closure.

The handling of complaints has been a curate's egg across the board, with the health boards. However, I think that that culture is changing, and the Scottish health council deserves a lot of credit for putting its foot on the ball—as we used to say where I come from—in 2014 and asking, "Hold on a minute. What are we actually doing here?" That has enabled boards to look at what their complaints process should be, how they should investigate complaints, and what the status of the people who handle complaints should be.

Post the Francis report, NHS Education for Scotland and the boards got together and asked us to help them with master classes so that non-executives in health boards could understand the central role that complaints play in governance in the national health service. Over the past two years, there has been pressure from the boards down and a move towards improving procedures, which I think will lead to a change in culture.

However, I agree with the convener that there is still a bit to go in many health boards. In the convener's area, for example, we recently had to say to Lothian NHS Board that we were not happy with how it was managing the complaints process generally. If members look at that board's minutes, they will see that it is now grappling with how it can improve that. Five years ago, there might have been a fight, but now—I give some credit to the chair of the board for this—the board will say, "We really need to get this fixed in the interests of patients and their families."

Donald Cameron (Highlands and Islands) (Con): I have two questions. First, what are the reasons behind what appears to be a very significant rise in health-related complaints over not just the past year, but the past five years? You mention that in your letter. Secondly, it seems that the number of clinical and hospital complaints regularly far outstrips other complaints. That is mentioned on the second page of your letter. What are your observations on that, please? Will you explore that for the committee?

Niki Maclean (Scottish Public Services Ombudsman): I am happy to deal with that question.

The rising volume of complaints that the SPSO sees very much mirrors the increase in complaints that are recorded in health boards. We have to be careful not to presume that an increase in complaints is in itself necessarily a bad thing; it can, for example, mean that there is increasing confidence in a complaints system. My colleague John Stevenson might want to say a bit more about that and the role of the complaints standards authority in the SPSO. The SPSO certainly sees a reflection of what is happening in NHS boards.

Donald Cameron is absolutely right in his second question. We see a relatively low number of complaints about, for example, general practitioner services, relative to the number of people who access the services. That is partly about access to complaints processes: small practices might not receive high volumes of complaints. Processing of complaints within health boards is more established. There is, potentially, underreporting of complaints in areas including the GP sector.

Jim Martin: You have to remember a number of things. The Patient Rights (Scotland) Act 2011 came in. We can argue about how much was in that act and what it changed, but it raised awareness that people have rights.

In 2011, Parliament gave my office the right to publish decisions—we were the first in the UK to do that. We now see newspapers reporting that decisions have been upheld and so on. I am particularly pleased that we can see that in local newspapers because it encourages people to come forward, which is important.

As John Stevenson will tell you, when we start to look underneath the numbers, it becomes difficult. I always ask committees to remember that I see only the tip of the iceberg. The cases that come to us are but a small portion of the total number of complaints, so you have to be careful about reading across from what we are seeing.

Ivan McKee (Glasgow Provan) (SNP): This is fascinating. I want to touch on a number of issues around the process. I was going to ask about how many complaints were hidden, but you have answered that—I get the feeling that you do not really know.

The 56 per cent of health complaints that are upheld first go through a process within the health boards and then they come to you. Do you have data about what is happening in the health boards, how many complaints they see and the metrics around how many they deal with, how many they do not deal with and how many come to you?

John Stevenson (Scottish Public Services Ombudsman): We have data from the Information Services Division of the NHS that shows how many complaints are received and recorded in a year. It is fair to say that there was a rise year on year until the past year, when there was a slight decrease.

One of the issues that the Scottish health council's report "Listening and Learning: how feedback, comments, concerns and complaints can improve NHS services in Scotland" looked at was the consistent use of performance information and information about complaints handling. The report's main recommendation led to the development of the new procedure that Jim Martin spoke about, and another recommendation was that the datasets that are being captured and recorded by the ISD should be looked at afresh to bring them up to date with the information that is being recorded across the wider public sector and to make sure that that is done in line with the new complaints procedure.

Moving forward, we will have a more detailed and better understanding of the complaints that are being recorded by boards and primary care providers, what they are about and what the learning from them is. In my work with professionals from the NHS and in looking at performance reporting, I was encouraged that those professionals identified learning and improvement from complaints as a key indicator. You will find that the new complaints procedure that will come into place from April highlights that, in performance reporting, the number one issue to report against is learning from and recording complaints. It is fair to say that, moving forward, we will have a far better understanding of the number of complaints that are being received, what they are about and what the outcomes are.

Ivan McKee mentioned hidden complaints. In the NHS and across the public sector, there has been a concern about complaints not being recorded as complaints. In the past, when someone expressed real dissatisfaction with a service that has been provided, there was a tendency to resolve the issue professionally without recording the fact that it had been raised. If such issues are not recorded, we lose the opportunity to learn. There has been a change in the NHS, and that might partly explain some of the rise in the number of complaints. However, there has also been a change across the wider public sector towards rigidly applying the definition of a complaint—that is, an expression of dissatisfaction—and recording complaints so that the organisation can learn.

Ivan McKee: At this stage, you do not have any data on how many complaints have been made to health boards, how many of those are dealt with satisfactorily and how many come to you.

John Stevenson: We have raw numbers. We know that, in 2015-16, about 21,000 complaints were made. We can also tell you how many complaints came to SPSO.

Ivan McKee: It was about 1,500.

John Stevenson: Yes.

Ivan McKee: That means that 90-odd per cent of complaints are dealt with at the health board level.

John Stevenson: Yes. As Jim Martin said, what comes to the SPSO is the tip of the iceberg.

Jim Martin: It may be worth considering that number for a minute. I have concerns about how robust the numbers are. The number of health complaints was about 21,000, and the number of local government complaints was 62,000 over the same period. I do not know how that feels to you, but it suggests that, each day, we see 60 complaints about health and 180 complaints about local government.

I hope that, once we get everybody on to the same system, we can begin to look at the numbers a bit more scientifically. You will then have better data with which to begin to advocate policy changes.

Ivan McKee: You said that about 56 per cent of complaints are upheld. I assume that that is spread across health boards. I do not want to use the word "sanction", but is there any league-table measure or way of kicking the health board to say, "Your percentage is too high. You're not dealing with this stuff upstream well enough and you're letting too much of it come downstream to us," or is it accepted that complaints will be upheld and that that is just the way things are?

Jim Martin: I have intervened in a couple of health boards, one of which, as I mentioned, is NHS Lothian. We look at three things. The first is the rate of upholds—the issues that they and we have looked at and on which we have come to a conclusion. The second is the volume of complaints and whether, in relative terms, given

the size of the health board, it is what we would expect to see. The third is the level of premature complaints—when people come to us who should really have gone to the health board in the first instance. We then do a wee algorithm and come up with a figure. If, over a period, I uphold 70 per cent of complaints against a health board, I will have an informal chat with the board. If the number does not come down, I will have a formal chat with the officials. If the number still does not come down, I will have a very formal chat with the board.

Ivan McKee: That is good. My background is in consultancy and manufacturing. That stuff is done to death in that field: continuous improvement is a way of life, because if you do not do it, you do not survive. This discussion is like a throwback to where we were in that environment 30 years ago.

You are saying all the right stuff about where the system needs to go in terms of process improvements. I am interested in how many complaints result in the implementation of process improvements. Language is important, too. We tend to talk about "opportunities for improvement" or "improvement suggestions" and so on. Does the process allow people to say whether the system could be better and to suggest how to improve it, or does it just allow people to make a complaint? The complaints process looks at whether somebody did something wrong, rather than at whether there is a process that we could fix.

Niki Maclean: On process improvement, it is important to remember that the ombudsman was initially established to consider individual redress—that is at the heart of the ombudsman service's work. Fundamentally, our first priority is to try to put things right for that individual and their family. That said, 60 per cent of the recommendations that we make through our casework are improvement related. Increasingly, that area is where we should focus our attention, so that we make sure that people get as much value for money and as much improvement as they possibly can from our recommendations.

Obviously, it is very much up to health boards how they use the recommendations to drive wider improvement. However, some of the work of our learning and improvement unit is very much about encouraging and supporting health boards to ensure that they get maximum benefit from our recommendations.

We do not have systemic powers to follow complaints and investigate more widely. We are seeking more powers so that we can share the information that we hold on learning. That would be of real benefit.

John Stevenson: In my experience of working with NHS professionals over the past year, they aspire to have an NHS that is an open and learning organisation and which values all forms of feedback.

You asked whether there are other processes. Within the 2011 act is a requirement to record all forms of feedback, including comments, concerns and complaints. You are right that complaints have a certain connotation, but I know that boards and primary care providers are also recording concerns, comments and other feedback and are using that information to improve services.

Ivan McKee: Thank you.

10:30

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning and thank you for coming to see us. I am very grateful for the existence of your office. I have referred a number of constituents to you when they have reached the end of the line with complaints, particularly about NHS Lothian and health-related issues.

I would like to pick up on Ivan McKee's last question, which was about the application of learning. Yesterday, a constituent—Dr Patrick Statham, a neurosurgeon at the Western general hospital in Edinburgh—came to see me. He is very concerned about the level of cancellations in his ward as a result of the unavailability of beds because of the lack of ring fencing in the neurology department. He said that his morale and that of his fellow surgeons is plummeting, because they keep having to turn people away. That is clearly a systemic problem, which will undoubtedly lead to complaints to your office. It is clear that there is a mix of system-related complaints and complaints about individual practice or care.

In terms of the application of learning and the recommendations that you make, can you explore how much you look to other health bodies that have solved such problems in the past? I say that because Patrick pointed to St Thomas' hospital in London, which had exactly the same problem with its neurosurgery department. It brought in a management consultant, KPMG, to look at how it could better deploy the beds. KPMG came up with the simple idea of ring fencing beds for neurosurgery. That did not really impact on the rest of the hospital, but it meant that people got seen for elective surgery. Can you give us your reflections on learning from other places? These problems are clearly not unique to Scotland.

Niki Maclean: First, I think that it is fair to say that the complaints that we see are not about systemic issues. Secondly—and I know that this also does not address your question—we do not see a high volume of complaints about neurology.

Our recommendations stem from the use of clinical advisers who are in practice. They refer to relevant guidelines from the Scottish Intercollegiate Guidelines Network, the National Institute for Health and Care Excellence and other areas of good practice. We assess the reasonableness of the actions of clinicians and medical experts against national guidance. That is where we take our advice from.

Jim Martin: I would add a little to that. We were at the Local Government and Communities Committee the other day to discuss my annual report, and I used the opportunity to suggest ways in which the powers of the ombudsman might be augmented to enable better sharing of information, so that issues can be picked up.

We see things that occur frequently. For example, a few years ago, we were concerned that, at one hospital—it was in Fife, I think—a number of radiography cases had come through with the same flaw. Technically, I could look at each of those cases on its own, come to a decision on each case on its own and, presumably, make recommendations about each case on its own, but clearly there was a systemic issue.

Enabling my successor to share information with regulators—which the Scottish Public Services Ombudsman Act 2002 precludes us from doing—would enable us to take a more joined-up approach across Scotland. Where the ombudsman saw issues arising, those could then be tackled. If we were to operate simply to the letter of the 2002 act, we would not be allowed to do that. That is something that various committees of the Parliament might want to think about when—as I hope—the Local Government and Communities Committee takes forward our suggestions about information sharing.

Alex Cole-Hamilton: Thank you. My second question is about the split of complaints that you handle in real time—they are live situations that are still happening to people—versus complaints that are made after the fact.

Before the meeting began, I was talking to the convener about the fact that, on a number of occasions, I and a number of parliamentary colleagues have had to raise individual cases on the floor of the chamber and embarrass ministers and the First Minister in order to get action. That action is then taken the next day. I do not think that that is the way to run a health service but at the moment it is working for us. What can your office do in that respect? I am thinking of a case of bed blocking and delayed discharge in which a gentleman had to remain in hospital for 150 nights after being declared fit. He had got nowhere with the health board. Can you tell us what you could have done to help in that situation and then address the question about the split between real-time and after-the-fact complaints?

Jim Martin: You have to remember a couple of things. First—and this is very important—the ombudsman is not a regulator. As Niki Maclean said, the primary role of the ombudsman is to deal with cases that require individual redress. John Stevenson's work with the national health service on the standardised complaints process should mean—I say "should"; we will see how it works—that complaints are defined, investigated and concluded earlier, which should allow issues to come to the ombudsman earlier. One of the things that frustrates the team in my office—and I have a lot of good people who get very frustrated from time to time—is that we see cases late and the fact that it takes a long time for things to get through the system before they come to us.

However, we are not there to do the job of the health board or Healthcare Improvement Scotland. As I have said, at the moment we are precluded from looking at systemic issues. We could have looked at and come to a conclusion on the case of your gentleman who had to remain in a bed for 150 nights—perhaps even while it was still happening—but it would have been far better for the appropriate management routes to work effectively.

While I am on my high horse, convener, I just want to point out that the one thing that my office is about is naming and learning, not naming and shaming. I think that one of the barriers to learning in the health service in Scotland has been people's fear of being named and shamed and the reputational damage that comes with publicity of "failure"—and I put that word in inverted commas. I hope that this Parliament, which I think is, in many ways, far more mature than your colleagues' Parliament down south, will move towards understanding that, although it is good to highlight the things that have gone wrong, what is most important is to get the learning and ensure that those things do not happen again. The first thing that the vast majority of people who come to my office say is that they want to understand what happened and to ensure that it does not happen to anyone else ever again. If you want some advice, I do not think that naming and shaming advances learning.

Alex Cole-Hamilton: But sometimes it gets our guys out of hospital.

Maree Todd (Highlands and Islands) (SNP): On that note, I want to ask a little bit more about the learning and improvement unit. Is a systematic approach being taken to feeding into the bigger governance picture the themes that you are seeing from the complaints that you handle such as near misses, Datix and so on?

Niki Maclean: It is important to remember that previously the ombudsman service has not been resourced to undertake that wider analysis, but we have secured funding for this year and into the coming year to set up a very small unit of just three people to undertake some analysis. As we have said, the number of complaints that we actually see is very small relative to the whole of the health service, but I think that there are opportunities to identify some of the thematic issues, and one of the things that that unit will do is publish themed reports across the whole public sector. In March, for example, we will publish a report on informed consent and some of the issues in that respect.

We are looking for areas in which there is space for us to add our voice and make some comment that is unique with regard to what has already been said. Another example might be end-of-life care, on which a lot of research and investigation has been carried out and on which guidance has been produced by other bodies, and we need to think carefully about how we use our resource to ensure that we genuinely add a unique voice and picture to such areas.

Other pieces of work that we are pursuing through that unit involve, as we have said already, working with a small number of public bodies that attract high volumes of complaints and where there are high uphold rates. For me, that very much involves supporting organisations at that later investigation stage, where things become complex and intractable. That is where there is a skills gap and organisations genuinely need support, education and guidance.

Maree Todd: Can you tell me a little bit more about how you give out feedback? Do you feed information back to health boards rather than to the place where the complaint originated?

Jim Martin: When we arrive at a decision following an investigation, we report in one of two ways. One way involves our issuing a decision letter that goes to the body—a board, a practice, a dentist, a pharmacist or whatever—and the person who has complained. That letter contains the decision, the reason for the decision and recommendations for improvement.

If we find a matter that we regard as significant, either because it is in the public interest or because it offers a significant learning opportunity, we will issue that report individually as a separate report to Parliament. I think that we issued 38 health reports to Parliament last year. Every month, we publish summaries of all of the decisions—there are around 60 a month. We draw the matter to the attention of the board, and NHS Scotland draws all our decisions to the attention of all the boards and, where appropriate, GP practices and others. By doing that, we hope to ensure that learning from every decision that we take gets into the system. As an ex-teacher—although I was not a very good teacher—I can tell you that you can have all the teaching materials in the world, but if you have a bunch of kids in front of you who do not want to learn, you will struggle. I have been taken with the work that John Stevenson has done over the past couple of years, because the Scottish health council and the health service seem to be approaching complaints from the point of view of learning. In order to get learning through, you have to create an environment and a culture that accept that learning will come about from situations in which things go wrong. That means getting to a position in which, when things go wrong, you do not just shoot people.

The whole thing is a continuum, and the work that Niki Maclean and John Stevenson are doing is meshing together to help the national health service to learn from the experiences that we see people having with that service.

The Convener: In the analytical work that you are doing, have you identified a correlation between complaints and, for instance, budget pressures, demographic change, socioeconomic factors and so on?

Jim Martin: You have to remember that the learning improvement unit has been in existence for—how many months?

Niki Maclean: Nine.

Jim Martin: Nine months.

The Convener: Oh, that is plenty of time.

Jim Martin: We are looking across all the sectors. It is interesting that, whenever we go to places and talk about the learning improvement unit, we are asked whether we could consider the correlation between various things. I keep saying to people that we have three people and have a budget for one year that has been extended for another year, and we do not know whether that budget will be extended for a third year, so we have to cut our cloth in the first instance.

Niki Maclean: As I said earlier, the health service will be required to publish data on its statistics but, because the volumes that we see are small, I am not sure how useful that analysis would be. I think that the analysis has to be of the wider health service complaints data that the committee will have available to it. As Jim Martin says, there is a fantastic opportunity for Scotland, because we will be the first country in Europe that will be able to analyse this data across our public services. The data will be made available.

Richard Lyle (Uddingston and Bellshill) (SNP): First, let me say that I wish you well in your retirement, Mr Martin.

I want to put this discussion in context, so that we do not paint a bad picture of the health service. I think that, for every health service complaint that you get, you get three complaints about local government. Is that correct?

Niki Maclean: No. We receive probably a couple of hundred more complaints a year about local authorities than we do about the health sector.

John Stevenson: I think that we said that across the NHS we are looking at around 20,000 complaints—

Richard Lyle: Compared to 62,000—

John Stevenson: But that is the number recorded by the sector, not the number of cases that come to the SPSO.

10:45

Richard Lyle: That is the point that I want to clarify. You said 21,000 for the NHS and 62,000 for local government.

John Stevenson: Yes.

Richard Lyle: Every complaint is important—I certainly agree with that. I have one complaint sitting with you already. Yes, unlike Mr Cole-Hamilton, I only have one with you just now. However, if we take on board the fact that the NHS has at least a million appointments a year—maybe we will get that figure checked out—is the number of complaints that you get high in proportion to the number of activities that take place in the health service? I want your honest opinion.

Jim Martin: That point has been put to me for the past four or five years. It is a standard line—"We hear you Jim, but there are a million contacts." Local government says the same thing to me, and it is absolutely true. If I was sitting where you are, I would say that that is a given. However, the health service's own numbers—the numbers that John Stevenson was talking about—show an increase of 68 per cent over the past four years in the number not of complaints to my office but of complaints recorded by the ISD. Ivan McKee was explaining his business experience earlier. If I was running a business and I saw that complaints were going up at that rate, I would say that we had better look at it.

It is important to get the number in proportion. It is not an indication that the NHS in Scotland is failing or is on its last legs, or anything like that. It shows that the number of very serious complaints that are made both to the NHS and to me is increasing. Worryingly, I am upholding more than half of the cases that health boards have not upheld.

I am not teaching my granny to suck eggs, but if I was sitting on this committee, I would be asking this question: if the ombudsman is upholding half of the cases that come to him, how many cases were not upheld by health boards and what is the likely proportion of those cases that the ombudsman would have come to a different conclusion on? That would lead me to ask whether we are satisfied that, even given the small proportion of complaints against the total number of contacts, that the investigation of complaints is thorough, robust and of an acceptable level. Given the work that Robert Francis did in his report, and the risk identified in it—where the chair's view was, "We always see lots of complaints and there is nothing that we can do about that"—I would argue that, although the number of complaints is not the only indicator that the committee will have, it is a very important indicator that might lead you to ask questions of the relevant people.

Richard Lyle: There is something that can be done about complaints—they can be solved before they are sent to you. That is why I asked you the question. In my experience of a discussion that I had with my health board, which is NHS Lanarkshire, I know that you can sit down with someone and look at the problem in depth. However, I agree with you that, all too often, organisations go, "No, there is nothing that we can do," and then people come to us to put complaints in. I think that I have flogged that point enough.

You made an interesting comment about the European Union and Brexit in your submission. I am sorry to bore people with that word again. You say that Brexit

"is something of which we are currently mindful but we are not yet clear what the impact may mean for the direct delivery of services. We will be monitoring this carefully."

Do you believe that when Britain—hopefully, it will not be Scotland—comes out of the EU, laws will be changed that will affect your service in some way? You may want to expand on that.

Jim Martin: Or not, convener.

Richard Lyle: Or not.

Jim Martin: I do not know what the Prime Minister is saying just now. She might be saying something that is of interest.

The Convener: I doubt it.

Jim Martin: As far as my office is concerned, the issues are what the public service in Scotland will look like post-Brexit and whether that is likely to bring complaints to us. Until we find out what happens, we will simply not know, but I am sure that my successor will keep an eye on this place and on what committees such as the Health and Sport Committee think about Brexit and the impact that it will have.

Richard Lyle: I have a small final question. We are all talking about budgets. What is the cost of your service at the moment? The level of complaints that you receive has increased right across the board. You do not deal only with complaints about the health service; you deal with complaints relating to other areas, including local government. Are you coping? Are you under pressure? Please be honest.

Jim Martin: The budget that I have is just over £3 million.

Thank you for giving me the opportunity to rant—I will try to keep it short. Today, I have roughly the same number of people investigating complaints as I had in 2009, when I took office. At that time, there were cases in my office that were three years old and more. When I walked through the front door, we had 92 cases that were more than a year old and a significant number that were more than nine months old. We have turned that situation around.

We took on prisons complaints. At that point, I went to the Presiding Officer and said, "I think that my office has enough capacity to deal with that without increasing our staff," and he said, "Well done—on you go." We then took on water complaints, and I had the same conversation with the Presiding Officer and was told, "On you go." Over that period, the number of complaints coming to my office has risen by about 40 per cent and productivity is up by 31 per cent, but when I go to the Scottish Parliamentary Corporate Body and say, "We now need more people," the answer is no.

At some point, the Parliament must work out what it is going to do with bodies such as the Scottish Public Services Ombudsman and the Scottish Information Commissioner, which, in effect, provide demand-led services that are financed by the Parliament. We are funded as departments of the Parliament—in other words, we are funded as if we were a finance department or a human resources department with a fixed budget.

Over the years, I have spoken to the chief executive and others about different funding models. For example, the committee will see in the material that we have provided it with that we worked with NES to put together new training materials, which 19,000-plus people in the national health service have used. My argument was that we should license those training materials for use outside Scotland, where they are used for free. I suggested that we should look at polluter-pays systems because, at the moment, the Parliament is funding the budget of the final tier of the complaints process for local government, health, prisons and so on. If we introduced the polluter-pays principle, that would impose a sense of responsibility on the bodies concerned.

I was extremely disappointed when, having said in my strategic plan for the next four years that we should consider such an approach, the response from the chief executives and legal officers of local authorities was that one of the ways in which we should control demand was by introducing a charge for people to access the ombudsman. That would only hit the most vulnerable, and I do not think that it is the way we do things in Scotland.

When my successor comes in, I hope that the Parliament will ask him or her, "What do you think you need to run your service efficiently?" I hope that Parliament will scrutinise that number and play hardball with them, but I make a plea for it to listen to them, because if we do not have the resource that we need, all that happens is that ordinary people—in many cases, families who are grieving—face inordinate delay in getting decisions that are of great importance to them. My parting shot as I go out of the door as ombudsman is this: for goodness' sake, listen to my successor, and if you want an efficient ombudsman service, please be prepared to fund it and resource it.

Richard Lyle: Thank you. I wish you well in your retirement.

The Convener: Congratulations. You took your opportunity with aplomb.

Clare Haughey (Rutherglen) (SNP): I thank the members of the panel. It has been very interesting listening to your answers to fellow committee members' questions.

You kindly raised the issue of prison healthcare, which is what I wanted to ask you about. In your briefing, you say that there were 137 complaints about prison healthcare in 2015-16. You will be aware that the committee is looking at conducting a short inquiry on prison healthcare. Does that figure cover the entirety of prison healthcare? Does it cover all the services that are provided in that context? What are the most common complaints about the prison healthcare service?

Niki Maclean: Yes, it covers all prison health complaints. I do not have the details with me, but it is fair to say that the most common complaints are about prescription medication and whether things have been prescribed appropriately.

Jim Martin: That takes me on to another hobby-horse of mine, convener, so I ask you to indulge me for a minute. If the committee is looking at the issue, I suggest that you might want to think about how the ageing prison population will be catered for. I am concerned about the ageing prison population and particularly the groups that are not the most popular, such as sex offenders. People in prison are getting older and all the things that

happen to people who are not in prison will happen to those prisoners. We will have more problems with dementia and mobility and all the rest of it.

If we are to be humane in our treatment of prisoners, there has to be more close collaboration and strategic planning between the national health service and the Scottish Prison Service, particularly on areas such as hospice care for people who are in prison. I am pleased that the committee is looking at that area, and I hope that you will test people's strategic thinking about how they are going to deal with that issue, which I think is a little time bomb.

John Stevenson: I can follow up on the numbers of prison healthcare complaints. It is notable that prison healthcare complaints have gone down as a percentage of all NHS complaints received in the past year. The number of prison healthcare complaints coming to the SPSO has gone down slightly, as has the number that we uphold. From working with NHS Tayside and NHS Lothian, for example, I know that there are some good initiatives in prison healthcare settings to try to resolve complaints quickly and early and at the point of contact. Perhaps some of that work is coming to fruition.

Clare Haughey: I was going to move on to that point, because the ombudsman previously provided information to the committee that, after the healthcare responsibility was transferred to the NHS from the Scottish Prison Service, there might be have been some barriers to prisoners making complaints. What have you done to make it easier for prisoners to access your service when required?

Jim Martin: In the early days of the transfer of responsibility from the Scottish Prison Service to the national health service, there was a patchy response across the health boards in dealing with complaints from prisoners. The health boards had different interpretations of the Scottish Government guidance on how to manage prisoner health complaints. We had a lot of informal chats with the Government about what we were seeing, because we did not think that things were working.

Eventually, in, I think, Ayrshire and Arran NHS Board, we saw an interpretation of the complaint guidance letter from the Scottish Government that we just could not match with what was happening elsewhere. That led to discussions on what the guidance actually means. For example, in one case that I can think of, people in a prison were told that they could not make a complaint until they had formally given feedback on a form because that was the way that it was meant to be and the way that the Scottish Government wanted it to be, whereas that was not an issue in other board areas. In some health boards, there were questions about the role of the Scottish Prison Service with prisoners when they were receiving healthcare advice, and that kind of thing.

The issues have largely been sorted out and we are now in a better place. I see fewer things coming through that I think are systemic faults. We will see the occasional thing that goes wrong—that happens in prison and elsewhere. In the early stages, it took a bit longer than it perhaps should have to get over the teething problems, but I think that we are now largely over them.

The Convener: As there are no other questions, I thank our witnesses for attending. I wish Mr Martin well when he moves on to pastures new. Thank you very much for your evidence.

I suspend the meeting briefly before we begin the next panel.

10:59

Meeting suspended.

11:03

On resuming—

Care Inspectorate

The Convener: Agenda item 7 is an evidence-taking session with the Care Inspectorate. I welcome to the meeting Karen Reid, chief executive, and Paul Edie, chair, and I invite Karen to make an opening statement.

Karen Reid (Care Inspectorate): Paul Edie is going to do that, convener.

Paul Edie (Care Inspectorate): The Care Inspectorate is the scrutiny body that supports improvement and is responsible for inspecting and reporting on the quality of care that older people experience. We were formed in 2011 from the merger of the old Scottish Commission for the Regulation of Care and the Social Work Inspection Agency, with some duties also being transferred from Education Scotland at that time. As well as inspecting and reporting on the quality of care, we highlight good care and work closely with care providers to support them and help them to improve. However, when they are not prepared to improve and their quality of care is not good, we have extensive enforcement powers.

We work wherever possible with providers to support innovation in health and social care delivery, and we regulate and inspect a broad range of services. Around 14,000 services register annually with us, and almost 9,500 of them are children and young people's services. We work collaboratively with a range of other partners including, among others, Education Scotland, Healthcare Improvement Scotland, Audit Scotland, the police, HM inspectorate of prisons for Scotland, the Scottish Social Services Council and NHS Education for Scotland, and we carry out joint inspections on how well organised services are in local areas and how well they work together in order to protect people and make a positive difference in their lives. For example, we carry out joint inspections of children's services everywhere in Scotland which bring together professional inspectors from care, social work, health, the police and education.

Similarly, we work with Healthcare Improvement Scotland to inspect jointly the effectiveness of collaborative working between health, social work and social care services for older people and their carers. We also provide independent scrutiny of criminal justice social work across Scotland, and we are developing a positive working relationship with community justice Scotland as the new community justice model is being implemented.

Almost every one of us will use a care service at some point in our lives and, as a body, we believe that every person should receive high-quality, safe and compassionate care that meets their rights, choices and needs. We are also changing the way that we work. We are building on our experience of, and building close working relationships with, other scrutiny partners in order to deliver new models and methodologies that focus on new statutory duties on integration and strategic commissioning.

We are embarking on a transformation plan of our own organisation, and our priorities over the next couple of years include consolidating excellence, changing our internal culture, building a competent and confident workforce and collaborating with external scrutiny and care delivery partners and people who experience care, their families and their carers. We are also seeking to move away from a traditional compliance-based approach to a more collaborative approach and from a regulatory perspective to a more modern scrutiny approach that acts as a diagnostic to provide assurance and which targets improvement.

Critical to all of that will, I think, be the new national care standards, which will be crucial for the delivery of care and scrutiny. Although the standards, which are currently out to consultation, come from the Government, the Care Inspectorate and Healthcare Improvement Scotland have co-ordinated their development, and they have been created in partnership with people who use care services themselves, which is to be welcomed. Once the standards are completed, they will, I think, be the most radical anywhere in Europe and perhaps further afield, and they will have the potential to transform significantly the planning and delivery of care. They will apply to all settings, including the commissioning of services by integration joint boards, and they very much represent a move away from the traditional approach of minimal or technical inputs to an increased focus on outcomes and a person's experience of care.

With that, we are happy to take questions.

The Convener: Thank you very much. Alex Cole-Hamilton will begin.

Alex Cole-Hamilton: Good morning and thank you for coming to see us. I have two questions, the first of which is on self-directed support. Obviously, we are still moving into what is something of an undiscovered country. Although the uptake has not been as great as people might have expected at first, it is still happening. Such support brings with it a great deal of very welcome choice and flexibility in the delivery of care to service users, which is in many cases directed by them. How has the Care Inspectorate found the implementation of SDS, particularly with regard to the response of the market to care-at-home

services? How do you regulate and inspect such services and what is perhaps a broader range of providers than existed before SDS came in?

Karen Reid: To date, we have undertaken 13 joint inspections of health and social care partnerships and, as you have said, we have found a variable picture with regard to the uptake of SDS. The Care Inspectorate actively supports people being able to make informed choices and decisions about their care, particularly with regard to ensuring that the care that they experience meets their needs, rights and choices.

Given the variable picture of the implementation of SDS that we have seen from the 13 joint inspections that we have undertaken, we are well aware of the need to do more work. As a result, we intend in 2017-18 to commence scoping a thematic review of self-directed support, and I would welcome the opportunity to report our findings back to the committee.

Alex Cole-Hamilton: My second question relates to your work with other organisations, which Paul Edie touched on briefly.

When I was elected, one of the first constituency cases that I took up was the campaign of a person who had been badly burned in a bath in a care home. That was partly a failure of the care that she had received and partly a mechanical failure. What are your links with the Health and Safety Executive? Who holds responsibility for learning in such cases?

Karen Reid: I recall the case, and I think that I responded to you about that tragic incident.

First and foremost, we expect every care provider to deliver safe, compassionate and high-quality care. Where that does not happen, we work with a range of bodies including the Health and Safety Executive. In that incident, we worked with the HSE to look at the details of the case.

Where the predominant focus is on the quality of care, the Care Inspectorate would be the lead investigatory agency. We bring in specialist support—on health and safety or on health, for example—wherever we require it. That is how we tend to work.

Critical to the incident that you described is the learning that came out of it. One thing that is very different about the Care Inspectorate is the statutory responsibility to support improvement that it has had since its inception in 2011. On the back of such an incident, we would work with the provider and ask it what has been learned and how it is supporting improvement and making sure that the changes that need to happen to ensure that people enjoy good-quality care across Scotland are in place.

Alex Cole-Hamilton: Thank you.

The Convener: It might be helpful—it would certainly be helpful for me—if you could describe the inspection process. I am sorry that we often dwell on negatives in order to exemplify our points, but often the experience of the people who come to us is negative. I was involved in the issue around the Pentland Hill care home. There was a catalogue of failures that ultimately resulted in the care home's closure. How did we get to a situation where the police were involved? There were deaths at the home. The dogs in the street knew that there were serious problems in that establishment, yet it took an age to get to a position where it was closed down. I am sorry to give you a negative example but why did it take such a long time? On a more positive note, can you describe your inspection process—at what point do you involve different agencies, the person who runs the establishment and so on?

Karen Reid: I welcome your focus on the fact that we sometimes dwell on negative areas, because I assure the committee that what we see across Scotland is, by and large, high-quality care.

On how we undertake inspections, over the past couple of years we have, as Paul Edie mentioned, moved away from the traditional approach to regulation, in which we focused on inputs, to one in which we look much more at collaboration to support improvement.

Scrutiny is a diagnostic that helps us to use our intelligence to delve in and to find out what is working well and what needs to improve. We have a range of mechanisms that enable us to form a picture of what is happening within the care service. For example, notifications come into us, because care service providers must tell us about particular incidents that happen within a care home or a care setting. We also get a lot of information through our complaints process; rather uniquely, our organisation has a statutory responsibility to investigate complaints, so complaints can be made to us by an individual in person or anonymously. I know that some committee members have been in touch with me to raise concerns and to make complaints.

11:15

We take all that intelligence, as well as intelligence from our own scrutiny activities, and use it as a diagnostic to help us to home in on where the concerns lie. Some things particularly help us with the intelligence that we receive. For example, the Care Inspectorate might go into a service such as a care home once every 12 months. Many health and social care professionals, as well as families, are often in and out of those care services; we really welcome the intelligence that we get from, for example, district nurses. In the case of the Pentland Hill care home,

we received information from nursing professionals that enabled us to be much more detailed in our scrutiny. Such information allows us to find out what is truly going on within a service and the quality of care that it provides.

To go back to the convener's point about the time it took to close the service, we must always remember that when someone goes into residential care, it becomes their home. None of us in this room would like to have to move every time a care setting was closed. Equally, it is critically important to note that we have enforcement powers that we use wisely. When there is a risk to the life, health or safety of any resident, of course we will use those powers. Unlike our sister organisation down south, we support improvement at every single turn if it is possible and if it does not impact on the health, safety and wellbeing of vulnerable people.

We can issue requirements and improvement notices and we try to work with service providers and have on-going dialogue throughout our scrutiny process. There are no surprises: no provider should be surprised by the outcome of a scrutiny activity, whether it be an inspection or a complaints investigation, because we share information with them and ask questions about our findings and observations of practice all the way through the process.

We can apply to a sheriff, which is when delays can set in. The evidence base and the high level of tests that are required to close a service mean that we have to apply to a sheriff.

I also want to share with the committee that we have a responsibility to provide public assurance through our scrutiny activities, and we have a responsibility to support improvement. Under the regulator's code, we also have the responsibility to sustain economic growth and community empowerment. All those fit together; we need to think about how best to support vulnerable people in Scotland first and foremost to remain in their own homes and receive high-quality care.

The Convener: There have been other cases—very few, I hasten to add—in which an inspection has been carried out and the service has been given a "good" or "satisfactory" report, only for some horrendous practices to be exposed pretty soon afterwards. How does that happen?

Karen Reid: That is a really important question and I welcome it. The Care Inspectorate cannot be in the services 24 hours a day, seven days a week, 365 days a year. When we go in and undertake scrutiny, we are evidencing our findings based on the intelligence process that I have just described.

However, problems can escalate quickly in a care setting. For example, a change of manager or agency staff coming in can compound problems and mean that a good service changes overnight and problems escalate. If a member of staff is not sure about how best to support an individual, or agency staff do not know the needs, choices and wishes of an individual, that can escalate quickly. That is why we sometimes see issues such as you describe, convener.

Richard Lyle: My question is in a similar vein to those I asked of the earlier panel. I believe that you have received 2,000 complaints, the majority of which were upheld. Are you concerned by the number of complaints that you are getting?

I want to put it on the record that I believe that every complaint is important. The Care Inspectorate inspects 13,678 care services, including 1,430 care homes. Are the majority of complaints about care services or care homes, or is it a mixture of both?

Karen Reid: The vast majority of complaints that we receive are about care homes—particularly care homes for older people. Richard Lyle is right: in the past year we received 4,086 complaints and we investigated about half of those. There has been a 46 per cent rise in complaints made to us since 2011, when the Care Inspectorate was established. I would treat that figure with caution. We have undertaken significant public awareness-raising about the complaints process and have encouraged people to access it.

At every opportunity we encourage people to try to resolve their complaint with the service provider, but we recognise that that is sometimes not possible. That is one of the reasons why people can make a complaint to us in person or anonymously.

About 25 per cent of the complaints about care homes for older people focus on specific healthcare—on nutrition, medication, infection prevention and control and so on. We also receive complaints around staffing—about 16 per cent are about that. Communication also plays a big part and about 10.7 per cent of the complaints that we receive relate to it. We uphold about 75 per cent of the complaints that we receive about care homes.

Richard Lyle: Thank you.

Alison Johnstone (Lothian) (Green): You spoke about enforcement powers and said that you can apply to a sheriff. Is that a timely process? How often do you use enforcement powers?

Karen Reid: We have served just over 30 enforcement notices on 21 services over the course of the last year. We tend to focus on improvement first and foremost, because whenever we can support a provider to improve a service, people can stay in their own homes. We

are looking for improvement in the quality of care, people's experience and the outcomes. We always try to support improvement, first because of the benefits that it brings to people who reside in the service, but also because of the economic benefits.

With your permission, convener, I will digress slightly to illustrate my point. Every day, our inspectors work with care services across Scotland to carry out inspections and support improvement. For example—and this is one of many examples—about 20 vulnerable residents with high-dependency needs in a care home in quite a deprived area in the north-east of Scotland were looking at having to move out of a care service. The care service had bumped along for a short time and we were not happy about its ability to improve. We had two choices: apply to a sheriff to close the service; or bring in the local authority and local health liaison co-ordinator to work together with our team.

The Care Inspectorate has a health and wellbeing improvement team with a range of professional knowledge of, for example, pharmacy, tissue viability, rehabilitation, dementia and so on, and we brought that team in to work with the service. Significant improvements were made in a short time, and the service has sustained those improvements. The net result was that 20 people remained in their own home, people living in a quite a deprived community in Scotland retained their jobs and suppliers continued to supply the care service. That is not a one-off example—Care Inspectorate staff do that sort of thing day in, day out.

Alison Johnstone: You are in a very good position to study any pressures arising in the care service because of the move towards ensuring that people do not remain in hospital and in acute services. Is that growth in numbers putting increasing pressure on services, and is that increased pressure impacting on quality?

Karen Reid: The benefit of being a scrutiny body that looks at the national picture, through strategic scrutiny, and at local examples, through regulated care service scrutiny, is that we can draw some of the conclusions that you are referring to. We work closely with Healthcare Improvement Scotland in relation to adults and older people and Education Scotland in relation to children's services on looking at some of the outcomes of strategic commissioning across the integration joint board or community planning partnership. We are able to see what is happening in terms of some of those pressures and, equally, how those pressures are translating at local level and whether they are impacting on the experiences and outcomes of individuals. That is a precious golden thread for giving us a robust scrutiny and assurance regime, both at national and local levels.

Alison Johnstone: It seems that there are more complaints about care homes than there are in respect of those who are being looked after at home. Why is that? Is it a cultural problem? Is it about engagement with you and ensuring that improvement happens?

Karen Reid: It is a mix of all of those things. After people make the really difficult choice to place a loved one in a residential care setting, they will go in and visit, and on those visits, they will see and hear what is happening to their loved one. As a result, they are much more familiar with the issues and can think about whether that is the quality of care that they want for their loved one. Therefore, those people access the complaints process more quickly than those whose loved ones are cared for outwith that.

Alison Johnstone: Personal assistants are not covered by the regulatory regime. Why is that, and is it at all problematic?

Karen Reid: I cannot say why it is, but personal assistants are certainly not covered by the legislation. Of course, that poses risks, but—and it is really crucial for the committee to hear this—there is still a responsibility, through strategic commissioning and commissioning by local authorities, in relation to the use of personal assistants. We expect every local authority to undertake the necessary checks before they arrange for direct payment in relation to personal assistants, for example. People are—rightly—concerned about risk, but it is crucial to remember that there are checks and balances in the local authorities.

As the issue is critical, I will, if I may, digress slightly. We recognise some of those risks and, although we do not have a statutory responsibility to look at personal assistants, we have a statutory responsibility to look at adult support and protection, which traditionally has not had the same focus across Scotland as child protection. Next year, along with the thematic review of SDS, we will look at adult support and protection. That is by no means a coincidence. I would welcome the opportunity to come back to the committee in due course with the evidence that we find in the national overview of adult support and protection.

Donald Cameron: I have a number of questions about your relationship with Healthcare Improvement Scotland. In our earlier discussion with the ombudsman, we heard about a uniform complaints system across health and social care, which I think we can all see the sense of in this age of integration. From your submission, it is clear that you work with Healthcare Improvement Scotland and that there are new joint statutory

arrangements for commissioning. However, I think that you would accept that you and Healthcare Improvement Scotland are very different bodies; it is a non-territorial health board and you are an independent non-departmental public body. Do you have any observations about the continuing operation of those two distinct regulatory bodies in the world of integration?

Karen Reid: Yes, I do, actually. I have been asked that question a number of times of late. It is important that we consider the totality of both organisations' roles and responsibilities. You are absolutely right that we have very different and broad remits. From the Care Inspectorate's perspective, in addition to that small interface with Healthcare Improvement Scotland on strategic commissioning and improvement, we also have responsibility for social work services and 9,500 children's services, as Paul Edie mentioned in his opening statement. We have lead agency responsibility for joint inspection of services for children, child protection, adult protection, multi-agency public protection arrangements, community justice, significant case reviews, serious incident reviews and deaths of looked-after children. I hope that that sets out for you that we have a significant range of statutory responsibilities, including a statutory responsibility to support improvement across the social care sector.

With Healthcare Improvement Scotland, we have mapped out the two bodies' differing roles and responsibilities, where we have a small interface and how we add public value, which is the critical question. With your agreement, convener, I am happy to send that to the committee for information. In our relationship with Healthcare Improvement Scotland or Education Scotland, the key question is how the organisations come together to add public value and therefore ensure that the quality of care, learning and justice is what we would want across Scotland. I hope that that answers your question.

11:30

Paul Edie: I would like to add to that, because I sit on the board of HIS as well, and Denise Coia sits on our board. We employ a lot of inspectors and carry out thousands of inspections. HIS has things such as SIGN, the medical devices body, the Scottish Medicines Consortium and the Scottish health council. It carries out a wide variety of activities that are not about registration or inspection and although, as Karen Reid has said, the interface is important, it is quite small. HIS employs a handful of inspectors compared with us.

The Convener: You talked about providing the committee with more information. The SPSO provided us with an analysis of the complaints about the sectors—well, it was obvious that he was talking about health. You cover a number of sub-sectors. Could you provide us with an analysis of the complaints about the various sub-sectors that sets out whether those complaints are about workforce issues, communications or whatever?

Karen Reid: Absolutely. We have recently produced our five-year report on our findings in complaints, and I will ensure that the committee receives that.

Alex Cole-Hamilton: First of all, I should declare an interest. Before I came to this place, I worked for eight years for the social care provider Aberlour Child Care Trust, which does exemplary work.

I want to ask about context. As someone who knows about the social care environment and, in particular, the higher-tariff-needs end of the spectrum when it comes to care home provision, I know that social care can be quite a visceral and frenetic environment. How does the balance work in, say, the context of a pattern of injuries at a care home for people with very severe behavioural needs, as a result of the use of passive restraint? Do your inspectors have sufficient expertise to understand the nature of the care that they are inspecting?

Karen Reid: Yes. A couple of years ago, we changed the way in which we undertook our inspection activities, and we will also be changing our methodology in the coming months. Our inspectors now focus on their area of specialism. Previously, they had generic case loads; now they have specialisms. Only those with a background in adult services inspect adult services, and only those with a background in children's services inspect children's services. We play to the professional knowledge and skill that our inspectors bring.

Restraint, which you mentioned, is an interesting area. We are a member of the National Preventive Mechanism, which is a UK-wide body, and we regularly work with organisations such as the Mental Welfare Commission for Scotland when we believe that our intelligence tells us that there might well be some issues to do with the use of restraint. We reach out and get specialist expertise—I think that I mentioned that earlier in relation to the point that was made about the Health and Safety Executive. Similarly, if there are issues with regard to restraint that we are concerned about, we will reach out for specialist expertise. By and large, however, I am absolutely confident that the inspectors who work for the Care Inspectorate have the knowledge and expertise to conduct inspections and fulfil our statutory responsibilities effectively.

Alex Cole-Hamilton: That is very good to hear.

My second question is about the point that you made about your role in relation to the death of looked-after children. Part of my work with Aberlour Child Care Trust involved seeking to influence the passage of the Children and Young People (Scotland) Bill. The big battle that we faced with legislators and, indeed, with all stakeholders was getting people to understand that our responsibility to looked-after children does not end with the removal of their supervision order. When that happens, they become care-experienced young people, to whom we still have a duty of care. Before that bill was passed, there was no knowledge of the life outcomes for care leavers and no mechanism to deal with the premature death of a care leaver, even though it is demonstrably the case that care leavers are far more likely to die prematurely than people who have not been in care. Finally, we managed to get included in the bill a provision whereby the Scottish ministers would be informed on the death of a care leaver. What role will your organisation play in helping to deliver on that responsibility and to disseminate learning and investigative work in that area?

Karen Reid: When we are notified of the death of a looked-after child, we have a statutory responsibility to look into what has happened and what can be learned from the situation. Every death of a looked-after child is a tragic situation, and what we want on the back of that is for the partners involved—primarily local authorities, but the other partners, too—to take the learning from our review of a death of a looked-after child and to think about how we can make things better for looked-after young people in future.

We take the learning from our review and put it into practice in terms of improvement. We also have a link inspector who, as part of their role, works closely with local authorities and will soon work across the integration joint board. We expect our link inspectors to have conversations with the local authorities if there has been a death of a looked-after child and to support them in some of the improvements that they need to make. That is the added public value of an organisation that both undertakes the scrutiny element and supports improvement. That is quite unique and different from what is happening down south.

Alex Cole-Hamilton: May I tease out one of the points in your answer, Karen? The looked-after child population in Scotland is such that, on any given day, we have 15,000 children in care, and the majority of those children are looked after at home. Because Aberlour did not deliver services for looked-after children at home, I am not really familiar with that aspect. What are your powers and responsibilities with regard to having some sort of oversight of those children? Given that their life outcomes are demonstrably worse than those of any other looked-after cohort, I imagine that there is probably a higher ratio of deaths in that cohort as well. Can you speak to your responsibility to children who are looked after at home?

Karen Reid: Certainly, and I am happy to follow this up with a subsequent conversation with you if that would be useful.

As part of our joint inspections of services for children, we have a particular responsibility to look at outcomes for looked-after children, whether they be looked after at home or away from home. We utilise our responsibilities and discharge them through that process.

We have an update report, which I will be happy to share with the convener, on our first two years of joint inspections and some of the findings. The critical issues that we find around looked-after children in particular and child protection in general and around children on the child protection register include local authorities' responsibilities to undertake appropriate assessment; chronologies, which is a big issue; and the ability to respond to immediate concerns and need. As well as being able to identify hot spots and what needs to improve in terms of delivering better outcomes for children and young people in Scotland, we also have a responsibility to help support improvement through our link inspector role, in which we work more closely with local authorities to ensure that they actually learn and share that learning.

The other thing that I would add for committee members' information is that the Care Inspectorate website contains a hub setting out a range of good practice that we see during our scrutiny activities. We promulgate that good practice on our website. If you have a particular area of interest, I actively encourage you to go to our website and access some of the good practice that we see across the country.

Clare Haughey: I thank the panel for their answers so far, and I would like to expand on Alex Cole-Hamilton's question about learning from experience and your reports. Earlier, we heard the ombudsman refer to the Francis report. One of its major criticisms was that there was no corporate memory in the NHS in England at that time, and I am keen to hear about how you disseminate your learning—both the good and the bad aspects—from your inspections.

You have talked in particular about the nursing home sector, where there is a high level of complaints. Nursing homes are often small businesses that are isolated and, perhaps, not as plugged into bigger support networks as the NHS is. How do you ensure that you disseminate your findings to those areas?

Karen Reid: Every single inspection that we undertake results in a public report, which is available on our website. We also expect providers to share our reports with people who experience care and their families and carers. In the past year, we have produced 7,400 inspection reports at regulated care service level, and they are all available on our website.

As for learning, which you asked about, scrutiny is not, as I have said, a compliance-based process. We are not where we were perhaps five years ago; scrutiny is now a process of working with a provider to identify what is working well, to highlight good practice and to support improvement. Although scrutiny happens over a short time, we expect to have on-going dialogue—with no surprises about our findings—and support for improvement at the end of the scrutiny intervention. At the last count, we had made 12,000 to 14,000 scrutiny and improvement interventions, of which about 7,400 were actual inspections. The figures show that there is a significant focus on supporting improvement.

If we see good examples of practice that is working really well, we will, after undertaking two inspections, highlight that practice in the media. Similarly, if we see poor practice, we will not only take immediate action to support improvement or move forward with enforcement but give the information to the press. After two episodes of good practice or two episodes of poor practice, the information goes into the public domain.

Over the past 18 months or so, we have developed a strong relationship with Scottish Care. Given that the majority of care home providers in Scotland are in the private sector, we work closely with Scottish Care to support improvement and ensure that care home providers across the country can deliver high-quality care.

Paul Edie: We have also beefed up our engagement with service providers through quality conversations, in which we can tease out some of the running issues and take soundings from various sectors as well as keep people in the loop on our thinking. We have also had some successful conferences. Indeed, Karen Reid might want to talk about our continence conference.

Karen Reid: We were grateful to the chief nursing officer for providing part funding for us to run a conference that supported the development of a continence resource, particularly but not exclusively for people with dementia. The conference attracted more than 350 delegates and had a waiting list. There is a range of things that we can do to share information and promote our findings.

We tend to have our quality conversations with providers by sector type, so that we can find out what the issues are and how we can work more collaboratively. We all have the same goal in mind: we all want people in Scotland to experience high-quality, safe and compassionate care. A stick-based approach to compliance does not enable that to happen; undoubtedly the way to go is working much more collaboratively, sharing information and highlighting good practice.

The Convener: I think that you said that 75 per cent of complaints are upheld—

Karen Reid: Yes, in care—

The Convener: Yes, in relation to care homes. Will a complainer have gone through the particular organisation's complaints procedure before they come to you?

Karen Reid: I do not have that information to hand, but I can check that and come back to you.

The Convener: Earlier, the committee was quite surprised to hear from Jim Martin that 56 per cent of the complaints that fall into in his remit are upheld. In your case, the rate is 75 per cent. Does that alarm you?

Paul Edie: The 75 per cent rate applies to complaints about care homes. I think that it is 67 per cent—

Karen Reid: It is 59 per cent across care services.

The Convener: Those are still quite high rates. Do they cause you concern and alarm?

Karen Reid: They do. First, let me say that wherever we see a complaint, we investigate it, but we do not just leave things when we have published the results of our investigation; we work with the care provider to support improvement. Our involvement does not stop when we have undertaken a complaints investigation. We want to follow through and think about how to support improvement in a care setting, because that leads to better experiences and outcomes for individuals. That tends to be our focus now. We do not draw a line under things once the complaint has been investigated.

I hope that that assures the committee that, although the statistics might sound alarming, with 75 per cent of complaints about care homes for older people being upheld, we follow through and support providers to improve, regardless of the area in which they need to improve—it might be health, in which case we bring in our health and wellbeing improvement team, or another area.

The Convener: Have you analysed trends? For example, care home providers tell us that they are under financial pressure. Is that an issue?

11:45

Karen Reid: We do not see that in the complaints that we investigate. We have analysed the sources of the complaints and found that they tend to come from family members or, indeed, staff who work in the social care sector. About a year ago, we ran a public awareness campaign and suggested that social care and healthcare professionals who do not see good-quality care in a facility that they enter have a professional responsibility to highlight those shortcomings to the care service provider and the Care Inspectorate so that the circumstances can be investigated.

The briefing that I said that I would send you on the five-year overview gives a range of distilled information about complaints across all kinds of care settings, including where the complaint came from, the type of complaint and whether the complaint was upheld. I am sure that that information will be particularly helpful to you. Again, I am happy to have further conversations about these issues either in the context of a committee meeting or with individual members.

The Convener: I think that it is good that members of the workforce are approaching the Care Inspectorate individually. However, does that show that there is a shortcoming on the part of the owners, in that the staff do not feel confident about approaching them about a particular issue?

Karen Reid: Not always, although there is no doubt that there are pockets of that. We could be talking about, for example, a nurse who is concerned about the quality of care in a care home and raises it with the care home manager but also comes to the Care Inspectorate. It is not an either/or thing.

The Convener: So people do not have to exhaust the process before—

Karen Reid: Not at all. We always encourage people to try to resolve complaints at the earliest opportunity with the care service provider, if at all possible. However, we recognise that, sometimes, it is not possible to do that. That is one of the reasons why we take complaints regardless of whether they have been through the care service provider's process, as well as taking anonymous complaints.

The Convener: We have taken evidence from social care staff about a range of workforce issues relating to their employment, and you have raised issues about agency staff. Obviously, there are implications for continuity of care—their concerns about continuity of care were among the first issues that the social care staff raised with us. However, on top of those are concerns about low pay, the lack of value that they see society placing on their work, insecure contracts and so on. Do you believe that those issues contribute to the feeling that the social care system is not as good as it could be? Do you think that we treat our social care staff fairly and value them enough?

Karen Reid: To put the issue in context, more than 85 per cent of care services in Scotland have evaluations of good, very good or excellent. That is quite significant in terms of the quality of care that is being delivered. As you said, the things that tend to cause us the most concern are the really negative things that we find out about.

We evaluate the quality of staffing in care services in Scotland, looking at practice, qualifications and training, and we find that the majority of care services in Scotland are getting good, very good or excellent evaluations. That said, we know that there is an issue around the use of agency staff and temporary contracts. Those are specific issues for the Care Inspectorate only when they impact on the quality of care.

At the moment, because of health and social care integration, we have an opportunity to examine integration in action. For example, in the private healthcare sector, there is an opportunity to work more closely with the NHS in terms of nursing staff. There is also an opportunity in relation to recruitment and retention. Recently, we have been working with the Scottish Social Services Council, which is, as you know, the professional regulator for the social care workforce, to produce safer recruitment guidance. That means that we are looking at not only the recruitment process but the values and qualities that staff members bring to social care with regard to their ability to deliver both the clinical side of care and the value side of care—that is, their ability to be compassionate and nurturing, and to perform in a way that is much more in line with the new national care standards, which are out for consultation at the moment.

The Convener: Do we treat staff fairly with regard to those workforce issues, pay and conditions?

Karen Reid: Without a doubt, the progress that has been made in implementing the living wage is great. You will bear in mind that we do a retrospective look at quality of care over the past 12 months, so it is too early for us to tell, but we are not seeing the implications of the living wage. However, you should rest assured that we are looking to see whether the living wage has implications for quality of care.

We are pleased to see the implementation of the living wage and we want to see whether it results in any impacts on the sustainability and therefore the quality of care.

The Convener: I am not sure whether the answer to my question was yes or no.

Miles Briggs (Lothian) (Con): My question follows on from yours, convener. Again and again, constituents raise the issue of the 10 or 15-minute visits that many people who are being cared for at home receive. It is not really enough time. There are concerns around that, such as hearing aids being lost and people being left without their hearing aids properly fitted.

Is 10 or 15 minutes enough, in your view? If it is not, what should the Government and local authorities do to lengthen those visits, in order to improve care in Scotland?

Karen Reid: It is very difficult to say whether 10 to 15 minutes is enough without knowing the context. For example, if the visit is primarily to ensure that someone is taking medication, perhaps it is enough time. If the concern is about the quality of personal care or an individual's needs, rights and choices, it will depend. It is not easy for me to answer that without having a context, but I know that there is a particular issue.

Where we hear about hearing aids being lost and people not being treated particularly well, and where we see quality-of-care issues in some of the care that is delivered at home and by housing support services, of course we will take immediate action. Indeed, we would encourage you to encourage your constituents to lodge a complaint with the Care Inspectorate.

Colin Smyth (South Scotland) (Lab): In your written submission, you note that you

"report publicly on emerging themes or trends in relation to the quality of care".

Are you concerned about or aware of problems in care services resulting from extra pressures on increasingly limited resources? Is there an impact on the number of enforcement actions that you have taken or the learning that you recommend?

Karen Reid: Five years ago, when the Care Inspectorate was established, the good, very good or excellent quality-of-care rate was probably around 80 per cent. We are therefore seeing an improvement in overall quality of care in Scotland, at a time when we recognise that there are challenges to the social care sector. However, with those challenges come opportunities, in terms of innovation. We are currently looking at the fact that the pressing funding constraints across Scotland mean that service providers are considering different care models. We are working with a large national care provider on the Buurtzorg model and different ways of designing, delivering and commissioning care.

We recognise that there are financial challenges. We recognise that both at a strategic level, in terms of our responsibility in relation to strategic commissioning, and with regard to the golden thread that I mentioned, which runs from strategic commissioning to the outcomes and experiences of care in a regulated care service. That puts us in a robust position as a scrutiny and improvement body.

There are funding challenges and improvement and innovation opportunities. We are watching the impact of the living wage carefully, and we are supporting care service providers to think differently about the models of care that they are designing and developing. I have no doubt that the care that we will see in the next three to five years will be significantly different from the care that we are familiar with today, in terms of the way in which it is designed, delivered and commissioned. The Care Commission is front and centre in empowering care providers and enabling that change to happen.

Colin Smyth: I take on board what you have said, but it does not really answer my specific question, which was whether the pressure on resources is one of the "emerging themes" that your written submission refers to and whether it impacts on, for example, the number of enforcement actions that you take or the learning that you recommend.

Karen Reid: I apologise—I should have answered your question about enforcement actions.

We are not seeing a year-on-year increase in the enforcement actions that we undertake. That is primarily because over the past couple of years the Care Inspectorate has moved away from that traditional compliance-based approach to an approach that is about supporting improvement. At every opportunity, we try to work with a provider to improve.

With regard to some of the financial challenges and constraints that you mention, our work on supporting improvement has meant that we are not seeing an impact on the quality of care. However, we are not naive, and you can rest assured that when we see such an impact we will make that clear in some of the thematic statements that we make.

The Convener: It seems that the issue of the new care standards has been kicking around for ever. What is the delay? I have another question on the back of that. Reducing health inequalities is a priority area for the committee. How will the new standards impact on that?

Karen Reid: Around the end of 2014, the Care Inspectorate was asked to work with Healthcare Improvement Scotland on developing the new set of national care standards. Initially we developed a set of principles that were very broadly consulted

on across Scotland, leading to more than 1,700 consultation responses, I think, which was absolutely fantastic. The principles were agreed and signed off by the cabinet secretary, and we have commenced a period of wide consultation and involvement of a range of organisations and, more important, individuals experiencing care on what the new national care standards should look like. The consultation closes on 22 January.

On the question of how the standards will address health—and, I hope, social—inequalities, the new national care standards are in my opinion perhaps the most radical and progressive set of standards to have been seen not just in Scotland or the United Kingdom but across Europe. Instead of 23 standards that start by saying "You should receive" this or that, the new standards are written from an individual's perspective—in other words, they say "I experience" this or that. That is a significant difference.

We no longer have 23 standards and, I think, 2,402 indicators. Instead, we have four general standards, three standards for specific groups of people and a total of 177 statements. That will make things much simpler. It will be much easier for individuals to understand the quality of care that they receive and make it simpler for us to expand on where we are not seeing high-quality care or, indeed, where through our strategic and regulated care scrutiny work we are seeing inequalities, and to report on those issues publicly.

The Convener: How will the new standards impact on inequality?

Karen Reid: The standards will impact on inequality quite simply because, using our intelligence, we will be able to aggregate up what we are seeing in individual experiences across Scotland. Let me give a practical example of that. We will be able to evidence the quality of care that an individual receives, regardless of the care setting, and correlate that right down to postcode level through working with the integration joint board or partners on the board. That should in future give us a much more mature and sophisticated range of intelligence that tells us, for example, the postcode areas in which people are presenting most to their GPs. That will give us really robust information. Equally, we will be able to use that information from a children's perspective with regard to looked-after children, children on the child protection register and that type of thing. I am therefore absolutely confident that the standards will go a long way towards addressing health and social inequalities across Scotland.

The Convener: Thank you very much. I thank the witnesses for their attendance, and I suspend briefly for a change of panel.

11:59

Meeting suspended.

12:01

On resuming—

Health Service Medical Supplies (Costs) Bill

The Convener: Agenda item 8 is consideration of a legislative consent memorandum from the Scottish Government on the Health Service Medical Supplies (Costs) Bill. I welcome to the meeting Shona Robison, the Cabinet Secretary for Health and Sport, who is accompanied by Rose Marie Parr, chief pharmaceutical officer, and Martin Moffat, policy adviser, pharmacy and medicines division, Scottish Government.

Cabinet secretary, do you want to make an opening statement?

The Cabinet Secretary for Health and Sport (Shona Robison): Yes, convener, and thank you for the invitation to speak to the committee. I am grateful to the committee for taking the time to consider this important legislative consent motion on the information powers proposed in the Health Service Medical Supplies (Costs) Bill, especially given the challenging timescales surrounding the bill's passage.

We all have a shared responsibility to deliver value for money in our public services and to look at every opportunity to control costs better, and healthcare is no exception. Medicines are by far the most common form of healthcare intervention used by clinicians. In 2015-16, the NHS in Scotland spent a total of £1.67 billion on medicines and appliances or approximately 13.6 per cent of the total healthcare budget. In primary care alone, the gross costs of drugs and appliances dispensed increased by over 14 per cent between 2006-07 and 2015-16. With advances in science and our ageing population, those costs can only continue to grow, and the measures in the bill will enable the four UK administrations to secure better value for money for the NHS from its spend on medicines and other health service medical supplies.

The information powers, which are the focus of the LCM, are a key plank of the bill and will be instrumental in achieving its aim of better control of the costs of health service medical supplies, particularly medicines. They will augment the existing quarterly drug pricing inquiry survey in Scotland, which we conduct through the provisions in the NHS (Pharmaceutical Services) (Scotland) Regulations 2009, and will help provide greater transparency and insight for the Scottish Government and NHS Scotland with regard to the costs of health service products. Moreover, they will help to evaluate whether the supply chain or specific products deliver value for money and control costs and to assess whether adequate supplies of health service products are available for the health service.

In particular, the information powers will open up access to information on sales and purchases of health service medicines and other medical supplies from other parts of the supply chain, particularly manufacturers and wholesalers. Through the development of memorandum of understanding arrangements, the powers will allow the UK Government and devolved Administrations to work together to access and share data on more products and from more parts of the supply chain.

As well as collaboration on health service costs, the approach offers a more streamlined framework for the application of the information powers and reduces duplication of effort across the four UK countries. Data requirements on UK suppliers of health service products will be set out in regulations. The process of developing those regulations, including consultation with stakeholders and the impact assessment, will ensure that data requests put a minimal burden on industry while ensuring that the Government has the information that it needs to make decisions on health service medicines and other medical supplies. Subject to the bill's passage through the UK Parliament, it is anticipated that the consultation on regulations will take place over spring and summer this year for commencement in the autumn.

I am happy to take questions from the committee.

The Convener: Okay. Richard Lyle will go first.

Richard Lyle: Reading through the background paper, I was quite astounded. I will focus on two bits. There are two systems—a statutory scheme and a voluntary pharmaceutical price regulation scheme, or PPRS. A comparison shows that

"a number of single source unbranded generic medicines manufacturers have recently been able to significantly increase prices, often by over 1000%."

Is that really the case?

Shona Robison: In some cases, yes. One of the important elements of the LCM is to consider how costs can be controlled. Martin Moffatt can say more on the PPRS and its relationship with the statutory scheme.

Martin Moffat (Scottish Government): The bill aims to create level playing field between the PPRS, which is a voluntary scheme, and the statutory scheme, and to prevent switching. That would give us far greater insight and control over the costs of drugs and how those costs are investigated and examined. The drugs that we are specifically talking about are unbranded medicines that would not naturally fall under either the

voluntary or the regulated scheme, because those focus on branded medicines. As soon as something comes off patent or the licence is sold on and it is marketed as a generic drug, it falls outside the scope of either the voluntary or the regulatory scheme. The bill aims to close that gap.

Richard Lyle: Am I right in saying that this is a reserved matter? The Scottish Government does not set the prices, but the UK Government does. Bear with me. The original clause applied only to England—as suggested by the paper from the Association of the British Pharmaceutical Industry—and that was resolved following agreement between the Department of Health and the Scottish Government. However—and I just love this—the ABPI says:

"Clause 9 of the Information Regulations states that all 'English producers' must keep the following information re. all 'English health service medicines' and produce it when requested by the Secretary of State".

We are being asked to resolve the issue by next week, but prior to this, it was only England that came under the regulations until they thought, "Oops, we've got to add other people in" and now they have amended the bill to include us. Is that correct?

Martin Moffat: Yes. The bill is largely predicated on the reserved matters around price regulation. However, after discussion with the four countries concerned, it was agreed that the best and most practical approach was to involve all the UK countries in discussion in how we can better monitor and control the cost of drugs.

Given the UK character of the manufacturers and wholesalers, it was thought that rather than taking a separate approach it would be better for us to work together to take a more aligned approach to managing costs.

Richard Lyle: This is my last question. Was it ever previously the case that drug manufacturers were charging different prices in England, Wales, Northern Ireland and Scotland? Has that ever been found to happen?

Shona Robison: Some of that information would be quite hard to ascertain. We are now talking about a slightly different issue, which is more about when medicines are taken through the various approval systems, such as SMC, NICE and so on. The offer that is put forward to different health services by pharmaceutical companies often differs. That is not just the case for the UK, but for other countries as well, although the situation is more marked when the offer differs across the four nations.

Rose Marie Parr (Scottish Government): Generally with the cost of medicines, it is correct that our health service is treated separately. However, we have a close relationship with the UK. As Martin Moffat said, it is important that the wholesalers and the supply chain are mostly UK-based. Going back to the bill, it is now up to the Scottish Government and the NHS to do our best on the price of drugs and perhaps to change some of the areas where there is not a level playing field.

Richard Lyle: My final question is: will the bill stop that practice?

Shona Robison: Martin Moffat laid out the issues of generic and branded medicines and ensuring that action can be taken on things such as the 1,000 per cent increase. Mr Lyle then moved on to the issues when drugs are taken through the approval systems and the prices that companies offer, which can be different for different health systems. The important point on that is that our health system and our approval process through the Scottish Medicines Consortium try to achieve the best and fairest price. There is a responsibility on the pharmaceutical industry to offer the best price. Some of the changes that the Montgomery review recommended will give the Scottish Medicines Consortium more options. For example, it might be able to put a product into the market for a period to test the clinical evidence on it. It will also be able to get the help of NHS National Services Scotland to be more robust in price negotiations at an earlier stage.

We want patients in Scotland to get access to medicines as quickly as possible and we want the health service to get the best price and deal for those medicines. The recommendations on SMC changes that I have approved will help with that.

The Convener: Why are medicines regulated under two systems—one voluntary and one non-voluntary?

Rose Marie Parr: The voluntary pharmaceutical price regulation scheme, or PPRS, has been a UK Government system for a long time and it relates only to the control of branded medicines. Obviously, those drugs are not the same as generic medicines, which is what we are trying to get a level playing field for through the bill. The PPRS is a payment mechanism through which companies pay back to the Department of Health based on, I suppose, aspects of sales. The bill amends things so that there will be no doubt that both schemes will have a level playing field, which will allow us to look at both. Historically, the approach has been on a UK level, looking at the different aspects of generic and branded medicines.

Shona Robison: It is also fair to say that the PPRS has not worked as well as anticipated, which is why Jeremy Hunt and his health officials have been in negotiations to try to secure a better

deal. Work is still going on to try to get a better deal for 2017-18 while other longer-term changes are made. Obviously, we have a close interest in that, because the PPRS receipts are important for the new medicines fund.

The Convener: My experience as a member of Parliament for the past almost six years is that I have been lobbied heavily by drugs companies, as I am sure other members and officials are. I have a problem with the way in which drugs companies do that. The conversations usually go along the same lines. The representative comes in and says that the company has a new drug, which is usually to deal with life-limiting or very serious conditions, and they say that they want it in the NHS system. They say that it will make a difference for patients and they really want our help or anybody's help to get it through the system.

The question that I always ask is, "How much is it?" The representatives then take in a lot of breath through their teeth and kind of shrug their shoulders and say, "Well, we could have a good discount for the NHS." Then I say, "How much is it?", and they say that it is £50,000, £60,000 or £70,000. The companies have never lobbied me on anything that costs a fiver, a tenner or 20 quid.

There is a problem with the way in which the drugs industry behaves in dealing with the Government and the Parliament and with the way in which it promotes products. In many senses, I think that such companies are playing God, because they have the power to help people, but they engage in that game. Will the bill help us to get away from that and see what the real cost of medicine is?

Rose Marie Parr: In some ways, the bill will help, because it will bring back into line the very small number of companies that might be flipping between the systems—the bill will stop them doing that. The problem of the drug that comes off patent and is then subject to a huge price increase—of up to 1,000 per cent—will absolutely be stopped, which is a benefit.

The bigger picture on medicine supply and cost is very complex. As the cabinet secretary said, we have systems in Scotland that look at clinical effectiveness and cost effectiveness, which is important when we consider the whole population of Scotland and what medicines are coming through. There is also national procurement to try to get the fairest and best price once a medicine has been approved. There will always be discussions about that. The pharmaceutical industry operates in a global market, of which the UK is an important part, and price is a part of that.

I would not like to say that the bill will end our difficulties. We will need to continue to ask for fair prices.

Shona Robison: The Montgomery recommendations on the SMC process will also help. What we are looking for is a fair price. We recognise that a lot of research and development costs arise in the development of drugs and that costs are borne by the pharmaceutical industry.

Quite often, when a company makes a submission to the SMC for a second or third time, it attaches a different price. With the involvement of NSS and others, we want to get the best and fairest price early, so that drugs can get to patients earlier, rather than go through a process of rejection and resubmission with a better price. If there can be a better price at resubmission, why cannot there be a better price the first time the drug is submitted? I hope that the Montgomery recommendations, which are not what we are talking about today but are nevertheless important, will help to get drugs into patients' hands more quickly and at the fairest price.

The Convener: The bill will not shed light on what it costs to produce a tube of ointment or packet of pills.

Rose Marie Parr: Most of the information that we have is about the cost to the NHS. In a global market, it is difficult to work out the development and marketing costs.

Maree Todd: I declare an interest: I am a pharmacist, registered with the General Pharmaceutical Council. Like many members, I am pleased that the loophole is being closed. It is galling to see the price of old drugs being hiked up because there is a small market and there are few alternatives. Audit Scotland highlighted the issue in its report on the NHS, and I welcome the proposed approach.

I do not want to be the defender of the pharmaceutical industry, but I note that the Association of the British Pharmaceutical Industry expressed in its submission concern about the data requirements. Is what the bill asks the industry to do achievable? Can the information on individual generic drugs at UK level be extracted from the global information?

Shona Robison: I do not think that the proposed approach is onerous. A lot of the systems are already in place. I note the concerns that have been expressed, but companies are already required for tax purposes to keep information on sales and income for six years, so the requirement to record similar information will not create a huge additional burden. The UK Government is going to undertake an impact assessment for the regulations, which I hope will take account of concerns that the industry has raised.

Martin Moffat: The intention is not to look at every product. Specific instances might require

further investigation, which will be to do with value for money for the product across the supply chain. It would be wholly unreasonable to collect such information routinely. The best example that I can cite concerns high-priced unbranded medicine. Gathering information on such medicines will give us further intelligence about whether the prices are justified or need to be amended in some way.

However, as the cabinet secretary said, there will be a consultation on all this, and industry will have an opportunity to respond to that consultation, to consider any practical areas that might be a cause for concern and to address them through the consultation process.

Maree Todd: I will ask a further question, which is based on the submission from the Royal College of General Practitioners. A dispensing doctor from that organisation expressed concerns about the particular issue of pregabalin, which I suspect that the bill will not tackle. I understand that the licence for the generic drug did not cover all the indications that the licence for the proprietary drug covered. Is the bill likely to close that loophole or would we need further legislation for that?

Martin Moffat: We would need further legislation, but we need to make it clear up front that there is an issue around pregabalin and that its use has been subject to judicial review and the appeal process. We probably should not get into the detail of that at this stage, but I believe that once all that has gone through the proper judicial process, there will be an opportunity to look again at the prices that are associated with drugs such as pregabalin and to control those costs better.

The Convener: As there are no other questions, I thank the witnesses for their attendance.

12:21

Meeting continued in private until 12:31.

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