Witness Name: Caroline Lamb
Statement No.: WITN7458001
Exhibits: WITN7458002-
WITN7458010
Dated: 28 November 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF CAROLINE LAMB

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 21 October 2022.

I, Caroline Lamb, will say as follows: -

Section 1: Introduction

1. Please set out your name, address, date of birth and any professional qualifications relevant to the duties you discharge on behalf of the Scottish Government.

1. My name is Caroline Lamb and my address is care of St Andrew's House, Regent Road, Edinburgh, EH1 3DG. My date of birth is GRO-C 1963. I am qualified as a chartered accountant.

2. Please outline your employment history and the positions that you have held.

2.1 I originally qualified as a chartered accountant in England and later moved to Scotland, where I worked as the Director of Finance and Corporate Resources

in NHS Education for Scotland (NES) from 2004 to 2014. I then became Acting Chief Executive for NES, before being appointed into the role on a permanent basis in 2015.

2.2 In December 2019, I joined the Scottish Government as Director for Digital Health and Care. During the Covid-19 pandemic, I also took on other roles, including:

- leading on the COVID-19-related intensive care unit surge requirements from March 2020;
- acting as Portfolio Director for Test and Protect from May 2020;
- becoming Delivery Director for the Extended Seasonal Flu and COVID-19 vaccination programmes from August 2020.

2.3 Since January 2021 I have been Director General for Health and Social Care in the Scottish Government and also Chief Executive of NHSScotland.

3. Please set out your membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement.

3. I have not been a member of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference.

4. Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations or criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products.

4. I have not as yet provided evidence to or been involved in any other inquiries, investigations or criminal or civil litigation in relation to these subjects.

Section 2: Public Health Structures

5. Please outline the public health structures and systems in Scotland. Please explain how these have developed, how effective they are (and in particular whether there are any gaps) and set out the arrangements for coordination with the other nations of the UK.

Public Health Reviews

5.1 The 1999 White Paper 'Towards a Healthier Scotland' [**WITN7458002**] established the public health agenda in Scotland following devolution. It set out a three-level approach to better health involving action focussed on life circumstances, lifestyles and health topics, with an overarching focus on tackling health inequalities. It called for a concerted drive to improve child health, a sustained focus on priority diseases, and established a cross-government approach supported by local demonstration projects.

5.2 Around the same time, the 1999 'Review of the Public Health Function in Scotland' [**WITN7458003**][1] was carried out. It confirmed the need for public health to have a high profile within Health Boards and Local Authorities, recommending that Health Boards develop as public health organisations and that there be a 'health in all policies' approach to policy making. There was a focus on strong leadership, on relationships and partnerships and on the specialist workforce.

5.3 A number of historic reviews have considered Scotland's approach to tackling health inequalities and how related resources are used. These include Audit Scotland's 2012 report on health inequalities in Scotland and NHS Health Scotland's 2013 Health Inequalities Policy Review. Both sets of recommendations confirmed the need for a clearer focus on the public's health in Scotland; greater coordination across structures and different levels of activity; and the need for partnership-based action informed by public health intelligence and evidence.

[1] Also available via: http://web.archive.org/web/20010217151407/http:/www.scotland.gov.uk/library2/doc09/rphf-00.asp

5.4 In 2013, the Scottish Government published '*Equally Well*' which confirmed that our greatest health challenge continues to be the inequalities which exist between the poorest and richest in our society. Subsequently, Scottish Ministers announced in November 2014 that they had asked for a Review of Public Health in Scotland [**WITN7458004**][2], the report of which was published February 2016. This Review found that Scottish public health needed to be more visible and that it needed to have a clearer vision. It concluded that public health needs to provide leadership which extends far beyond the NHS and health boundaries to influence wider agendas, policies and programmes in the public, private, third and independent sectors.

5.5 The Public Health Review emphasised the cost-effectiveness of preventative approaches and the need for a more proactive public health effort in Scotland. The Review Group's recommendations were:

- Further work to review and rationalise organisational arrangements for public health in Scotland, including greater use of national arrangements where appropriate;
- The development of a national public health strategy and clear priorities;
- Clarification and strengthening of the role of the Directors of Public Health (DPHs), individually and collectively;
- Supporting more coherent action and a stronger public health voice in Scotland;
- Achieving greater coordination of academic public health, prioritising the application of evidence to policy and practice, and responding to technological developments;
- An enhanced role for public health specialists within community planning partnerships and Integrated Joint Boards; and
- Planned development of the public health workforce and a structured approach to utilising the wider workforce.

[2] Also available via: https://www.gov.scot/publications/2015-review-public-health-scotland-strengthening-function-re-focusing-action-healthier-scotland/

5.6 These recommendations were translated into the relevant commitments within the Health and Social Care Delivery Plan [**WITN7458005**][3] published in December 2016. This document set out a clear vision for the Health and Social Care system, including a more meaningful focus on prevention and a recognition that there must be a more comprehensive, cross-sector approach to the public's health and wellbeing. The Delivery Plan also set out specific commitments to publish public health priorities, deliver a new public health body and improve support for local health partnerships.

5.7 In 2017 Scottish Government and the Convention of Scottish Local Authorities (COSLA) established the Public Health Reform Programme to take forward these actions. The programme set a vision for 'A Scotland where everybody thrives', with an ambition for Scotland to be a world leader in improving the public's health, using knowledge, data and intelligence in innovative ways and with an economic, social and physical environment which drives, enables and sustains healthy behaviours. A new national public health body, Public Health Scotland, was to be created and have a key role in leading, driving, supporting and enabling change.

5.8 In June 2018, the Scottish Government and COSLA published Scotland's Public Health Priorities, following extensive work with a range of partners and stakeholders from across the whole system. The six priorities were:

- A Scotland where we live in vibrant, healthy and safe places and communities;
- A Scotland where we flourish in our early years;
- A Scotland where we have good mental wellbeing;
- A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs;
- A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all;

  A Scotland where we eat well, have a healthy weight and are physically active.

[3] Also available via: https://www.gov.scot/publications/health-social-care-delivery-plan/

5.9 These priorities reflected a widely-held consensus about the public health challenges to be tackled over the next decade if we wish to see the greatest possible improvement in the public's health and wellbeing. They provided a focus for all public services and wider partnerships across Scotland to improve and protect the public's health and wellbeing, reduce inequalities and increase healthy life expectancy. They also provided a basis, consistent with the Scottish Government's National Performance Framework, to guide everyone working in the health system and beyond to align their efforts to make a real difference to the social conditions in Scotland.

5.10 Work to improve the public health system in Scotland continues in the context of the Care and Wellbeing Portfolio and the Health and Social Care: National Workforce Strategy [**WITN7458006**][4] which commits to actions to strengthen the Public Health Workforce in the following areas: Recruitment; Workforce Planning; Specialist arrangements; Leadership and Succession Planning; and Workforce Development.

5.11 The Care and Wellbeing Portfolio (CWP) is the main integrated strategic reform framework in DG Health and Social Care and aims to bring coherence to, and accelerate progress on, efforts to improve population health, reduce health inequalities and create a more sustainable health and care system.

Legislation

5.12 Health policy is devolved under the Scotland Act 1998, subject to specific and limited reserved areas, such as in relation to medicines. The Public Health etc. (Scotland) Act 2008 [**WITN7458007**][5] (the 2008 Act) set out the duties of Scottish Ministers, Health Boards and local authorities to continue to make provision to protect public health in Scotland. These are without prejudice to existing duties imposed on the Scottish Ministers and Health Boards in the National Health Service (Scotland) Act 1978 and existing environmental health legislation.

[4] Also available via: https://www.gov.scot/publications/national-workforce-strategy-health-social-care/
[5] Also available via: https://www.legislation.gov.uk/asp/2008/5/contents

Structures

5.13 The National Performance Framework supports an outcomes-based approach to performance. Public health work is central to the delivery of a number of the national performance indicators.

5.14 There are four Ministers sharing portfolio responsibility for aspects of public health: Cabinet Secretary for Health and Social Care; Minister for Public Health, Women's Health and Sport; Minister for Mental Wellbeing and Social Care; and Minister for Drugs Policy.

5.15 The Scottish Government has a number of public health divisions: Health Protection (which leads on the Infected Blood Inquiry), Health Improvement, Drugs Policy, Active Scotland and, since the pandemic, Covid Ready Society, Future Threats Surveillance, and Vaccines divisions. They are based within the Directorate of Population Health, which includes within it Health and Social Care Analytical Services and Strategic Capabilities Division, and which works closely with the Chief Medical Officer's Directorate. The dental public health strategic component falls within the Dentistry Division, under the Chief Dental Officer. All have a direct role in improving the public's health, as well as working with other areas of the Scottish Government which also have a direct contribution to make.

NHS Scotland

5.16 Most of the core public health workforce in Scotland is employed within NHSScotland in the fourteen territorial Health Boards and also two national-level Special Boards and two other national-level bodies. The wider NHS workforce also makes a crucial public health contribution, including through the delivery of services, employment practices, leadership and resource allocation decisions, and partnership working.

NHS Territorial Health Boards

5.17 The fourteen territorial Health Boards have corporate Board-level responsibility for the protection and improvement of their population's health and for the delivery of frontline healthcare services. As mentioned above, these Boards have core functions under the 2008 Act in terms of public health. Each has a public health team led by a Director of Public Health (DPH). These public health teams are responsible for providing services across all of the domains of public health and for working in partnership within the Health Board and with external organisations and communities to improve population health outcomes. In a few areas, the DPH is a joint appointment between the NHS Board and the local authority. Public Health Directorates within Health Boards vary in size, organisation and linkages.

Directors of Public Health

5.18 The DPHs' role is central to the effectiveness of public health across the country, ensuring locally-sensitive responses to national priorities and policies. Thirteen functions are agreed to be part of the role, as follows.

Role of the Director of Public Health

(i) providing public health advice to the NHS Board;

(ii) providing public health advice to the Local Authority;

(iii) contributing to corporate leadership of the Board;

(iv) producing an independent annual report;

(v) providing leadership and advocacy for protecting and improving health and reducing health inequalities;

(vi) managing the Board's specialist public health team and associated support staff and resources;

(vii) ensuring the Board and its staff have access to timely, accurate and appropriately interpreted data on population health;

(viii) ensuring the implementation of NHS components of Scottish Government public health or health improvement policies;

(ix) overseeing the coordination and effectiveness of screening programmes;

(x) communicating with the public via the media on important public health issues;

(xi) contributing to emergency planning;

(xii) ensuring all appropriate infection and environmental surveillance and control measures are in place; and

(xiii) ensuring health needs assessments are carried out.

5.19 Additionally, DPHs meet collectively and have scope to ensure appropriate consistency of approach across Scotland.

NHS Statutory Bodies

5.20 The four NHS Statutory bodies operating at national level with specific strategic roles impacting on public health are: Public Health Scotland (PHS), NHS National Services Scotland (NSS), NHS Education for Scotland (NES) and Healthcare Improvement Scotland (HIS).

5.21 PHS is a Special Health Board and was established by the Public Health Scotland Order 2019 (the 2019 Order); it became operational in April 2020. It was created to consolidate the national public health functions of health protection, health improvement and healthcare public health, underpinned by data, intelligence and research functions. PHS is responsible for functions which were previously carried out by: Health Protection Scotland (previously a division of NSS), Information Services Division (also previously a division of NSS) and NHS Health Scotland (which was previously a national Special Health Board, now dissolved).

5.22 PHS is the national health improvement body which works with others in the public, private and third sectors to reduce health inequalities and improve health and

wellbeing, emphasising preventative approaches. It is involved both in developing and disseminating evidence and in shaping policy and programmes to help achieve a fairer, healthier Scotland. It also delivers specialist national services and provides advice, support and information to professionals and the public to protect people from infectious and environmental hazards. In terms of information services, the organisation is driven by data and intelligence and provides a range of statistical information and analysis. It uses the full range of data – national and local, quantitative and qualitative – to offer vital intelligence to partners across the system.

5.23 NSS (which is formally known as the Common Services Agency) is a body corporate established under the National Health Service (Scotland) Act 1978, which provides a number of support services to the NHS and other bodies in Scotland. NSS also commissions and manages national screening programmes for Scotland and contains ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) Scotland, who are responsible for the surveillance and monitoring of infectious disease in the healthcare setting, and antimicrobial resistance.

5.24 NES is a Special Health Board which provides education and training for those who work in the NHS in Scotland, including its core public health workforce, and ensures that the wider workforce's contribution to protecting and improving population health is supported.

5.25 Healthcare Improvement Scotland is a body corporate established under the National Health Service (Scotland) Act 1978. It is the national organisation responsible for providing quality improvement support to healthcare providers in Scotland and for delivering scrutiny activity. It supports and delivers health and care activities which impact on public health, including evidence-based guidelines, public involvement processes, and health care quality and effectiveness assessments.

Scottish Public Health Observatory

5.26 The ScotPHO collaboration is responsible for providing a clear picture of the health of the Scottish population and the factors that affect it, including through improved collection and use of routine data on health, risk factors, behaviours and

wider health determinants. It is led by PHS, and includes the Glasgow Centre for Population Health and National Records of Scotland.

National Public Sector Bodies

5.27 There are also a number of public sector bodies with a specific public health remit which operate nationally in Scotland, working with the NHS, Scottish Government, local authorities, business and industry, consumers and others. For example, Food Standards Scotland (FSS) is responsible for ensuring that information and advice on food safety and standards, nutrition and labelling is independent, consistent, evidence-based and consumer-focused. The Scottish Environmental Protection Agency (SEPA) is the principal environmental regulator, protecting and improving Scotland's environment.

Local Government

5.28 Local authorities in Scotland play a pivotal role in delivering preventative, universal services, addressing the social inequalities which underpin health inequalities, and improving health outcomes. They are a key partner in the overall effort to improve the public's health and prevent ill-health.

5.29 Local authorities also have statutory responsibilities under the 2008 Act in relation to the control of communicable diseases and must cooperate with Health Boards in certain cases [**WITN7458007**][6]. They have prime responsibility for environmental health and employ core public health staff, most notably Environmental Health Officers. Local Government services also contribute to the public health function through important work within education, economic development, employability services, cultural and leisure services, responsibilities for the physical and social environments, and a range of other duties.

5.30 The COSLA Health and Social Care Board provides a focus for COSLA's considerations of public health issues, with COSLA's Leaders' meeting setting policy.

[6] https://www.legislation.gov.uk/asp/2008/5/contents - see in particular sections 4 and 5 and Parts 3 and 5 of the 2008 Act

Community Planning

5.31 There is one Community Planning Partnership (CPP) for each local authority area. Under the Community Empowerment (Scotland) Act 2015 public bodies work together and with the local community in CPPs to plan for, resource and provide services which improve local outcomes and reduce inequalities in the area. The Community Planning Improvement Board, with membership drawn from strategic leaders in public services and the wider community, helps to inform strategic policy direction for CPPs. As a matter of policy, CPPs are encouraged to focus efforts on addressing a small number of priorities for their area which reflect their understanding of the key needs and circumstances of the area and its communities (likely to include particular deep-rooted and entrenched social and economic challenges) and on which partners can make the most significant impact through effective joint working. Public health challenges frequently feature within these local priorities, either in their own right or as part of related themes.

Third sector

5.32 There are a wide range of voluntary and community sector organisations with health interests, and even more with a focus on the determinants of population health. These all contribute to the wider public health function in Scotland.

Academic public health

5.33 Public health teaching and research takes place in all of Scotland's universities and many members of the core public health workforce are employed in academic public health within universities and Research Units.

Networks

5.34 A number of networks of public health professionals operate in Scotland to enable sharing of expertise, coordination of efforts and collaboration to undertake joint work. There are networks for specific disciplines, for special interests,

geographical areas, and obligate networks, such as the Scottish Health Protection Network (SHPN).

5.35 The Scottish Public Health Network (ScotPHN) is responsible to the Scottish DPHs and PHS and its role is to bring together the public health resources within the fourteen Territorial Health Boards, the National Health Boards, academic public health departments and wider public health agencies, including local authorities and the independent sectors. ScotPHN undertakes national prioritised pieces of work as well as facilitating information exchange. Given the size of Scotland, there is also strength in informal networks which operate (e.g. in a given field/speciality) where core staff know one another and can agree between them what activity needs to be undertaken and how to resource it.

UK Coordination

5.36 In previous years the Scottish Ministers conferred on the UK Health Protection Agency (HPA) responsibilities and functions allowing the organisation to operate in Scotland. Following the abolition of the HPA by section 56 of the Health and Social Care Act 2012, Public Health England (PHE) was established in April 2013 as the expert service provider for the public's health in England. PHE performed the Secretary of State for Health's statutory functions in relation to public health under the National Health Service Act 2006.

5.37 Section 60 of the Health and Social Care Act 2012 provides for cooperation between bodies exercising public health functions. To allow PHE to perform functions required by the Scottish Government and PHS agreement was sought from Scottish Ministers and a Memorandum of Understanding (MOU) reflected their assent to PHE operating in Scotland. The MOU detailed the health protection services to be provided (specialist radiological and poisons advice), how they should be provided and the relationships between the Parties.

5.38 The UK Health Security Agency (UKHSA) was formally established in April 2021 and replaced PHE in this role. It is responsible for protecting every member of

every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats.

International Health Regulations

5.39 UKHSA is the designated 'National Focal Point' for the UK for the International Health Regulations (IHR) 2005. The National Focal Point must be accessible at all times for communication with the World Health Organisation (WHO), both to consolidate and send information to WHO concerning the implementation of the IHR in the UK and to receive and disseminate information from WHO to those involved in surveillance and response in the UK.

5.40 When acting as the IHR National Focal Point, UKHSA's principal point of contact in Scotland will be the Scottish Government, which will liaise with PHS accordingly. In discharging this role, UKHSA agrees to liaise closely with both Parties to share information and ensure their views and concerns are represented accordingly.

Liaison with the European Centre for Disease Prevention and Control (ECDC)

5.41 The Secretary of State for Health had the lead UK role as the 'Competent Body' defined under EU legislation. The Secretary of State performed the following functions through PHE in the following areas:

a) Provided input to the ECDC Advisory Forum and other relevant groups;
b) Reported to the European Surveillance System (TESSy) which incorporates the existing Disease Specific Networks and expands the range of surveillance to cover the list of organisms which each Member State must monitor and report on under the terms of the EU Directive, and
c) Sent alerts to and from Scotland in accordance with the ECDC Early Warning and Response System for communicable diseases (EWRS).

5.42 As part of the health security arrangements contained within the Trade and Cooperation Agreement (TCA), the UK and EU agreed to cooperation between the

ECDC and the UK body responsible for surveillance, epidemic intelligence and scientific advice on infectious disease. On 1 December 2021, the ECDC and the UKHSA, signed a memorandum of understanding which aimed to strengthen the collaboration between the two agencies on matters of communicable diseases prevention and control.

Public Health Protection and Health Security Common Framework

5.43 In light of EU Exit, new UK-wide regulations replaced the EU legislative regime and a Public Health Protection and Health Security Common Framework [**WITN7458008**][7] was developed to set out arrangements to strengthen strategic and operational cooperation between the Governments and national public health organisations of the UK. Accordingly, both the Scottish Government and PHS are parties to the provisional Framework.

5.44 The Framework takes a broad approach to public health matters, covering threats from infectious diseases, as well as non-infectious hazards, such as radiation, chemical or biological threats. Arrangements covered by the Framework include:

- Strengthened UK-level communication and coordination of health protection activities, including policy development, public campaigns and messaging and expert committees;
- Principles for coordinated use of mutual aid;
- International engagement;
- Workforce;
- Education and Training;
- Research;
- Data and Intelligence.

[7] Also available via: https://www.gov.uk/government/publications/public-health-protection-and-health-security-provisional-common-framework

5.45 Although the Framework aims to develop common approaches to health protection and the sharing of expertise and resources, it also recognises and allows for the potential for divergence across nations. Scottish Government officials, together with their counterparts in the UK Government, Welsh Government and the Northern Ireland Executive worked jointly to develop this Common Framework.

5.46 The Framework is governed through a tiered system of Senior Official, Strategic and Operational fora, comprising representatives from the UK Department of Health and Social Care, the Devolved Governments and the national public health organisations. This tiered approach recognises that public health protection and health security relies on technical and policy input.

- Four Nations Health Protection Oversight Group – this forum includes members representing the governments and public health agencies of each nation. It will progress implementation of the Framework, the associated Memorandum of Understanding and delivery of the work programme. The Group meets four times per year and may have extraordinary sessions as required. The Chair rotates annually and is currently held by Public Health Scotland.

- UK Health Protection Committee ('the Committee') – through the Health Security (EU Exit) Regulations 2021[8], the Framework also establishes this group with senior membership from each nation's governments and public health agencies. It serves as the main forum for strategic level discussion and decision-making to monitor the application of the Framework. The Committee is also responsible for several statutory functions as set out in the Regulations, for example UK-wide surveillance of communicable diseases and related special health matters. The Committee meets bi-annually and is chaired by the Department for Health and Social Care.
- The UK Chief Medical Officers (CMOs) Group will act as an additional senior-level body in the decision-making process where necessary and the UK Health Protection Committee is accountable to the UK Health Ministers.

[8] https://www.legislation.gov.uk/uksi/2021/877/contents/made

Section 3: Statutory Duty of Candour

6. The Inquiry is aware of the organisational statutory duty of candour in Scotland [DHSO0000001]. Please set out:

a. What training healthcare professionals are given about the duty of candour.
b. What if any audits have been done to assess how embedded the duty of candour is in day to day medical practice?
c. What training personnel in NHS organisations have had about the duty of candour?
d. What if any audits have been done to assess how embedded the duty of candour is in NHS organisations?
e. Is any data kept on the way in which healthcare professionals and/or NHS organisations have implemented the duty of candour since it became a statutory obligation? If so, please give details. If not, why not?

6.1 The Duty of Candour Procedure (Scotland) Regulations 2018[9] came into force on 1 April 2018; these regulations were made under Part 2 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, which gives the statutory basis for the duty of candour procedure. The regulations set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm.

6.2 Alongside the statutory requirements in following the duty of candour procedure, the Scottish Government has published non-statutory guidance (see [**DHSO0000001**]), which outlines the issues organisations will want to consider at each point in the procedure, suggests best practice, and provides a checklist of the steps to be taken to fulfil the duty.

6.3 Organisations must ensure that relevant training and guidance on the organisational duty of candour procedure is available to staff; this should include any

[9] https://www.legislation.gov.uk/ssi/2018/57/made

services and support which may be available to the relevant person (the person who came to harm or someone acting on behalf of that person). This is regardless of who they are employed by, i.e. the NHS or in a social care facility. An e-learning resource has been produced by NHS Education for Scotland, the Scottish Social Services Council, the Care Inspectorate and Healthcare Improvement Scotland. It is available on a number of websites.[10]

6.4 Organisations are expected to complete and publish an annual report which details the process of activating the duty of candour procedure; the nature and number of duty of candour incidents identified over the preceding year; the policies and/or processes which have changed as a result of the incident, including learning; and support available to staff and patients involved in an incident. These must be published in a publicly accessible place, such as on a Health Board or practice's website.

6.5 In 2019 the Scottish Government commissioned a piece of work to review the first year the organisational duty of candour procedure was in place. The review was conducted through interviews with duty of candour leads in the Boards and qualitative evidence. The report [**WITN7458009**][11] made a series of recommendations and suggestions, which have been considered and implemented.

Section 4: Patient Safety and Involvement

7. Please outline the Scottish Government's response to Baroness Cumberlege's recommendation for a Patient Safety Commissioner [RLIT0001833], including the consultation [DHSO0000002], the Specialist Reference Group [DHSO0000003], the Patient Reference Group [DHSO0000004] and any next steps.

7.1 The Scottish Government formally committed to establishing a Patient Safety Commissioner for Scotland in September 2020.

[10] See https://learn.nes.nhs.scot/24970 - requires a TURAS account to access
[11] Also available via:
https://www.gov.scot/publications/organisational-duty-candour-procedure-review-first-year/pages/1/

7.2 The team leading this work convened two reference groups to help develop the proposals for the Patient Safety Commissioner: a Patient Reference Group, comprised primarily of patients affected by the issues dealt with in the Cumberlege Review, which included representatives from Haemophilia Scotland, and a Specialist Reference Group, comprised primarily of clinicians.

7.3 The Scottish Government ran a public consultation on the Patient Safety Commissioner from 5 March to 28 May 2021. This asked 16 questions about current policies and organisations to support patients' voices to be heard within the safety system; the potential scope and status of the Patient Safety Commissioner; and how having a Patient Safety Commissioner might impact people with protected characteristics and other groups, such as island communities.

7.4 Responses to the consultation made clear that there is strong public support in Scotland for a Patient Safety Commissioner who is independent of the Scottish Government and the NHS and who has statutory powers. On 7 October 2022, the Scottish Government introduced the Patient Safety Commissioner for Scotland Bill [**WITN7458010**][12] to the Scottish Parliament to establish the independent Commissioner that patients and the public have told us they want. Timings for the progress of the Bill will be a matter for the Parliament to determine.

8. How are patients involved in (i) the development of healthcare policies and (ii) the way in which healthcare services are delivered, in Scotland? Please explain how this is achieved, and how effective this is. How well, in practice, does patient involvement shape policy and services in Scotland?

8.1 Ensuring that the voices of people who use healthcare services are heard and can influence the design and delivery of healthcare policies and services is a priority for the Scottish Government. In relation to healthcare policies, the Scottish Government holds public consultations on a wide range of policy areas and seeks as

[12] See Bill, explanatory notes, policy, financial and delegated powers memoranda at https://www.parliament.scot/bills-and-laws/bills/patient-safety-commissioner-for-scotland-bill/introduced

far as possible to promote awareness of them to organisations who can encourage patients who may be affected or otherwise interested in the policy to respond. The Scottish Government also seeks to involve patients where possible in providing steering groups which are developing policies or in gathering their views in other ways, such as commissioning formal research, carrying out focus groups or undertaking regular surveys (either done by the Scottish Government itself or via another organisation).

8.2 For example, recently the Scottish Government has been seeking to encourage the involvement of people with lived and living experience, those who deliver care services and stakeholder groups which represent them, in co-designing the new National Care Service[13]. The new Lived Experience Experts Panel will allow officials to work alongside the people with experience of community health and social care services to ensure the Scottish Government can develop a future National Care Service that is built with the people that it serves, and those that deliver it, at its very heart. Another innovative way of involving patients was taken forward in 2018-19 as part of the Chief Medical Officer's Realistic Medicine Programme. A Citizens' Jury was established to help the Scottish Government consider the question 'What should shared decision making look like and what needs to be done for this to happen?' in relation to provision of healthcare[14]. This brought together a group of people who were representative of the entire population, and allowed them to consider evidence from a wide range of experts on that particular question.

8.3 In addition, in the area of Health Protection, a number of organ transplant recipients have been involved over the years in the Scottish Donation and Transplant Group[15], with the group currently having two patient representatives. This Group advises Ministers on increasing organ and tissue donation and transplantation in Scotland. Views of transplant patients were also sought by NHS National Services Scotland's National Services Division via a survey (in 2020) and then focus group meetings (in 2022) to help shape future commissioning of and improvements to transplant services.

[13] See https://www.gov.scot/publications/design-the-national-care-service/
[14] See https://realisticmedicine.scot/citizens-jury-recommendations/
[15] https://www.gov.scot/groups/scottish-donation-and-transplant-group/

8.4 The Scottish Government has also introduced a range of ways for people to tell us what they think about their NHS service. We support NHS Boards to engage with the independent website Care Opinion, where people can share their stories of care in Scotland – whether good or bad – anonymously online and engage in constructive dialogue with healthcare service providers about how those services could be improved.

8.5 We have funded and supported the NHS Healthcare Improvement Scotland – Community Engagement Citizens' Panel[16], which has enabled the voices of people to be heard on a range of important issues including how to make communication between health and care services and those that use them more inclusive.

8.6 Finally, the Scottish Care Experience Survey Programme is a suite of national surveys which aims to provide local and national information on the quality of health and care services from the perspective of those using them. Surveys within this programme ask a series of demographic questions to allow further analysis of responses by different groups of people, including a question on long-term conditions.

[16] https://www.hisengage.scot/informing-policy/citizens-panel/

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 28 November 2022

Table of exhibits

Date	Description	Exhibit number
20 August 1999	Scottish Office Department of Health White Paper: 'Towards a Healthier Scotland'	WITN7458002
1999	1999 Review of the Public Health Function in Scotland"	WITN7458003
February 2016	2015 Review of Public Health in Scotland	WITN7458004
December 2016	Healthier Scotland: Health and Social Care Delivery Plan	WITN7458005
March 2022	National Workforce Strategy for Health and Social Care in Scotland	WITN7458006
2008	Public Health etc. (Scotland) Act 2008	WITN7458007
October 2021	Public Health Protection and Health Security Framework Outline Agreement	WITN7458008
January 2020	Organisational Duty of Candour Procedure – Review of First Year	WITN7458009
7 October 2022	Patient Safety Commissioner for Scotland Bill	WITN7458010

	(as introduced)	