Health and Community Care Committee

1st Meeting, 2001 (Session 1)

Wednesday 10 January 2001

The Committee will meet at 9.30 am in The Chamber, Assembly Hall, The Mound, Edinburgh

1. **Declaration of Interest:** The Committee will invite new members to declare any relevant interests

2. **Appointment of Deputy Convener:** The Committee will choose a Deputy Convener.

3. **Items in Private:** The Committee will consider whether to take items 9, 10 and 11 in private.

4. **Tobacco Advertising and Promotion Bill:** The Committee will hear evidence from the Deputy Minister for Health and Community Care on the Scottish Executive memorandum on the Tobacco Advertising and Promotion Bill.

5. **Subordinate Legislation:** The Committee will consider the following negative instrument—

   The Plastic Materials and Articles in Contact with Food (Amendment) (Scotland) Regulations **(SSI 2000/431)**

6. **Influenza Vaccination:** The Committee will consider the Executive's response to its report on Influenza Vaccination

7. **Consultation on Public Sector Ombudsmen in Scotland:** The Committee will consider the SPICe report

8. **Scottish Executive Joint Future Group Report:** The Committee will hear the Convener's report to the Committee and consider its response to the Executive.

9. **Consultation on Public Sector Ombudsmen in Scotland:** The Committee will agree its final conclusions on the consultation.

10. **Scottish Executive Joint Future Group Report:** The Committee will agree its final conclusions on the consultation.

11. **Work plan:** The Committee will consider its forward work plan.

Jennifer Smart
Clerk to the Committee
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The following papers are attached for this meeting:

Agenda Item 4

Memorandum -Tobacco Advertising And Promotion Bill

HC/01/1/1

Agenda Item 5

The Plastic Materials and Articles in Contact with Food (Amendment) (Scotland) Regulations **(SSI 2000/431)**

HC/01/1/2

Agenda Item 6

Response from The Executive to Report on Influenza Vaccination

HC/01/1/3

Agenda Items 7 and 9

Modernising the Complaints System - Consultation on Public Sector Ombudsman in Scotland

HC/01/1/4

Consultation on Public Sector Ombudsman in Scotland - Supplementary Information

HC/01/1/5

Agenda Items 8 and 10

Joint Futures Group Report (electronic copy only)

HC/01/1/6

Agenda Item 11

Briefing Paper - Forward Work Plan

HC/01/1/7

Agenda item 4

Health & Community Care Committee
10 January 2001

The Health and Community Care Committee

10 January 2001

MEMORANDUM -

TOBACCO ADVERTISING AND PROMOTION BILL

Background

1. Responsibility for tobacco advertising is devolved to the Scottish Parliament. The introduction of a ban on tobacco advertising is a Scottish Executive Programme for Government commitment. To effect a ban the Executive had prepared draft regulations under the European Communities Act 1972 which it was originally proposed to make before the end of 1999. However, this was prevented by a challenge against the Directive in the European Courts, brought by the German Government and joined by the UK tobacco companies, and by action in the English Courts brought by the UK tobacco companies to prevent implementation by the UK Government. On 5 October 2000 the European Court of Justice (ECJ) decided to annul the Directive which means that it is no longer possible to make regulations under the European Communities Act.

Content of the Bill

General

2. Following the ECJ ruling the Executive has worked closely with other UK Health Departments to find the best means to effect a ban in primary legislation. These discussions have led to the Tobacco Advertising and Promotion Bill which was introduced, and published, at Westminster on 14 December. The Bill introduces measures to ban tobacco advertising and promotion throughout the United Kingdom. The main provisions of the Bill are to: -

- Ban tobacco advertising in UK published print and electronic media.
- Ban tobacco advertising on billboards in the UK
- Ban direct mail advertising of tobacco products.
- Ban the free distribution of products that promote tobacco brands (beermats, umbrellas etc.)
- Restrict the display of tobacco products in shops and other sales outlets.
- Confer powers on Ministers to regulate the advertising of other products which have names or distinguishing remarks reminiscent of tobacco products (brandsharing).
- End sponsorship by tobacco companies (see para 3.3 below).

Regulation making powers

3. There are several regulation-making powers contained in the Bill. These powers are to:-

3.1 specify conditions for the purposes of the exemption for advertising at the point of sale;

3.2 specify requirements for the purposes of the defence that a retailer is a specialist tobacconist and, therefore, exempt from the advertising ban within shops and point of sale (this is a backup power);

3.3 to provide a timetable for when tobacco sponsorship will end and to set out the conditions under which it may continue in the interim;

3.4 restrict or prohibit the use of tobacco branding for non-tobacco products, or services and vice-versa (i.e. more commonly known as brandsharing or brand stretching);

3.5 to extend the ban on free distributions to nominal distributions; and

3.6 to amend the Act to cater for technological developments.

4. It is proposed that these powers will be conferred on the Scottish Ministers in respect to the first three sets of regulations listed (paras 3.1 to 3.3). These would all be subject to negative resolution procedure (i.e. regulations are made and laid and come into force 21 days later).

5. The regulations concerning brandsharing (para. 3.4) and nominal distribution (para 3.5) and technological developments (para 3.6) would be subject to affirmative resolution as an infringement would be a criminal offence. These sets of regulations are complex both from a technical and legal standpoint and may involve notification to the European Commission under the Technical Standards Directive. It is proposed that the Secretary of State should be allowed to legislate on these matters for Scotland. Scottish interests will be consulted on the terms of the draft regulations.

Offences, penalties and enforcement

6. The Bill creates offences and sets penalties in respect of tobacco advertising and promotion which will be enforced in the most part by local trading standards officers. There will also be a power for the Scottish Ministers to take over enforcement.

<u>The proposal</u>

7. Given the cross-border flow of newspapers media etc, Scotland can sensibly take only very limited action in isolation from the rest of the UK. Northern Ireland and Welsh Ministers have agreed to Westminster legislation. Having looked carefully at the options available to effect a ban, the Executive has concluded that there is a compelling case for a single Bill to effect a ban throughout the UK. A UK Bill would avoid any inconsistencies in statute which could be exploited by the tobacco industry and would ensure the ban comes into effect in all parts of the UK at the same time. Moreover, crucially, it would also avoid difficulties in enforcement.

SCOTTISH EXECUTIVE
December 2000

Agenda item 6

Health & Community Care Committee
10 January 2001

The Health and Community Care Committee

10 January 2001

Response From The Executive to Health & Community Care Committee 13th Report 2000 Report On Influenza Vaccination

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Ms Jennifer Smart
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Your ref:
Our ref:

December 2000

HEALTH AND COMMUNITY CARE COMMITTEE
13TH REPORT 2000
REPORT ON INFLUENZA VACCINATION

I am writing, on behalf of the Minister for Health and Community Care, to enclose the Scottish Executive's response to the Health and Community Care Committee's Report on Influenza Vaccination. The response has been assembled around the headings in the Report itself.

The Convener also wrote to the Minister on 5 October, conveying a further recommendation that community pharmacists be included in the staff to be offered vaccination. The Minister has asked me to say that we are making clear that community pharmacists, as well as general practitioners and other frontline staff, can be offered the vaccination this year.

IAN TURNER

SCOTTISH EXECUTIVE

HEALTH AND COMMUNITY CARE COMMITTEE

13TH REPORT 2000
REPORT ON INFLUENZA VACCINATION

RESPONSE BY THE SCOTTISH EXECUTIVE

SCOTTISH EXECUTIVE
HEALTH AND COMMUNITY CARE COMMITTEE 13th REPORT 2000
REPORT ON INFLUENZA VACCINATION

RESPONSE BY THE SCOTTISH EXECUTIVE

Introduction

1. The Scottish Executive welcomes the Health and Community Care Committee's Report. Influenza vaccination is a vital element of the Executive's strategy for preventing ill health, which in turn, reduces pressure on the National Health Service in Scotland over the winter months. The Executive therefore shares the Committee's view on the importance of a well co-ordinated and focussed vaccination programme. This has been reflected in the arrangements the Executive has made this year, including the most extensive ever advertising campaign, extending the eligible age group to include people of 65 and over rather than 75 as in the past, agreeing new arrangements for payments to general practitioners, enhancing the surveillance system at SCIEH, and increasing the availability of vaccine. Some £10m is being invested in the vaccination programme this year.

The Committee's Recommendations

2. In response to the Committee's recommendations, the Executive has the following comments:-

Supply and Distribution

- **The Management Executive of the NHS in Scotland (NHSiS) and the Common Services Agency (CSA) should be invited to consider whether alternative methods of production, including a state owned or jointly owned facility would be of any advantage to the NHS in Scotland. (Paragraphs 11-25)**

- **The Scottish Executive in discussions with the CSA and the Health Boards should consider alternative methods of supply particularly whether bulk purchasing of influenza vaccine would achieve economies. Options on preferred suppliers should take into account the recommendations with respect to possible supply in the event of a pandemic. (Paragraphs 11-25)**

- **The Management Executive of the NHSiS, the CSA and Health Boards should examine whether for the winter of 2001/2 alternative methods of distribution to those currently employed would be of any advantage to the NHS in Scotland. For the current season Primary Care Trusts should ensure that waste of stock is minimised. (Paragraphs 11-25)**

The Executive recognises that dependable and effective arrangements for the production, supply and distribution of vaccine are crucial to a successful vaccination programme. In line with the Committee's recommendations, therefore, it is considering the options for further improving supply and distribution in future years. In the current year, a helpful innovation has been the introduction of a centrally held supply of vaccine which has been successfully used to respond to any temporary shortages in different parts of Scotland. The Executive is not persuaded, however, that a state-or jointly-owned facility would be viable or cost-effective. The preferred option is to work through manufacturers to ensure continuity and adequacy of supply.

Miscellaneous

- **The UK wide arrangements for the registration and quality assurance of Influenza vaccines is satisfactory and should not be altered. (Paragraphs 11-25)**

- **The Scottish Executive should continue the present arrangements for policy advice from the UK Joint Committee on Vaccination and Immunisation (UKJCVI). (Paragraphs 11-25)**

- **The UKJCVI should keep under review the evidence for introducing pneumococcal vaccination for at risk groups and those over 65 years. (Paragraphs 99-102)**

- **The UKJCVI be asked to keep the role and relevance of RSV under review and make early recommendation on a vaccine if and when it becomes available. (Paragraphs 103-106)**

The Committee's recommendation that the arrangements for the registration and quality assurance of influenza vaccines are satisfactory is noted. There are no plans to alter existing procedures.

The Executive shares the Committee's view that the Joint Committee on Vaccination and Immunisation should continue as a source of advice on immunisation matters.

The Executive will ask the JCVI, as the Committee recommends, to keep under review the issue of whether pneumococcal vaccine should be routinely offered to those aged 65 or over. It is already policy to offer pneumococcal vaccine for all those aged two years or older in whom pneumococcal infection is likely to be more common and/or dangerous ie those with:

asplenia or severe dysfunction of the spleen
chronic renal disease
immunodeficiency due to disease or treatment
chronic heart disease
chronic lung disease
chronic liver disease
diabetes mellitus

It is expected that the JCVI will reach a view next year on the role of pneumococcal vaccine in the childhood immunisation programme generally.

The JCVI will also be invited to keep under review matters relating to RSV, as recommended by the Committee.

Management

Closer links should be established between SCIEH and

- **Bed managers/winter pressure managers in all NHS Trusts**

- **Local health care co-operatives (LHCC).**

- **Out of hours co-operatives.**

(Paragraphs 39-59)

- **In the event of supply difficulties the public campaign should particularly encourage uptake in the new target age group 65-75 and should be targeted:-**

    - **at high-risk groups**
    - **institutional groups.**

(Paragraphs 61-77)

- **In the event of supply difficulties a modified set of target payments to GPs should be agreed, for this year only, before the vaccination programme commences. (Paragraphs 61-77)**

- **In the light of research showing low uptake of high risk groups below the age of 65 this group should now be targetted to encourage uptake of the vaccination. (Paragraphs 61-77)**

- **Support should be provided for voluntary vaccination of staff in hospitals, nursing homes and residential homes and consideration of vaccination in sheltered housing units. (Paragraphs 61-77).**

[This recommendation has already been acted upon by the Scottish Executive see HDL (2000) 9 Influenza Immunisation Programme 2000-2001]

- **Depending upon the outcome of research consideration should be given as to whether or not influenza vaccination should be added to the list of vaccinations and immunisations which are mandatory for health professionals. (Paragraphs 61-77)**

- **Consideration should be given to setting realistic collective targets for the LHCCs with some form of incentive. (Paragraphs 61-77)**

The Executive has recognised the need for close working relationships among all the interests involved in the vaccination programme. SCIEH's important role in disseminating data to NHS

Trusts and other key interests has been reflected in the increased resources the Executive has made available for the enhancement of the Centre's surveillance systems. In the light of the Committee's recommendation, the opportunity has been taken by the Executive, in reviewing Health Board winter plans, to emphasise the usefulness of the data provided by SCIEH in giving Trusts, bed managers and other interests, the information needed to plan constructively for the delivery of services.

The Executive notes the Committee's recommendations on target payments for GPs and collective targets for LHCCs. Under the new financial arrangements agreed for winter 2000/01 with representatives of the BMA in Scotland, the maximum payment per dose of vaccine administered is set at 50%. This means that GPs will receive the maximum payment per dose, even if they do not reach the 60% target coverage for immunising those aged 65 and over. Moreover, payment will be based on a sliding scale (from £6 to £7.40 per dose), thus reducing the financial effect of failing to meet any particular level of coverage.

The payment incentive scheme remunerates GP practices rather than LHCCs. This is because practices are best placed to organise call and reminder systems for their own patients. We will review these arrangements in the light of experience in the current year and will consider how improvements might be achieved in future. The developing role of LHCCs – and the Committee's recommendation that a target be set – will be borne in mind in this regard.

As the Committee acknowledges, the Executive has this year agreed that NHS employers should offer immunisation to all staff involved in the delivery of care and support to patients. Along with private and voluntary sector health care employers, social care employers have been similarly encouraged to offer vaccination to relevant staff. Until evaluation confirms that immunisation of staff does confer clear benefits, the Executive believes that the current policy of offering vaccination – rather than making it mandatory - remains the most appropriate. The Executive looks forward to any further advice the JCVI might offer on this matter.

Campaign and Management Advice

- **The vaccination campaign should be both national and local and must be closely co-ordinated into the supply and distribution of vaccine. (Paragraphs 61-77)**

- **The campaign should be locality specific and should involve community pharmacies. This partnership with community pharmacists should be particularly aimed at high risk groups with literature encouraging uptake dispensed along with repeat prescriptions. (Paragraphs 61-77)**

- **There should be an earlier national publicity campaign for the self-management of influenza symptoms with reference to advice from community pharmacists. [These discussions should be the springboard for a full re-evaluation of the corporate role of community pharmacists as partners in the NHSiS]. (Paragraphs 61-77)**

- **The self management campaign should commence initially on a low-key basis with increasing output tied to the early warning systems made available via SCIEH. (Paragraphs 61-77)**

- **Consideration should be given to the establishment of an independent influenza helpline or one linked through NHS Direct and/or the out-of-hours co-operatives. (Paragraphs 61-77)**

- **The Scottish Executive should require the Health Boards in consultation with Primary Care Trusts and Local Authorities (Community Care) to establish plans for the provision of augmented community and out-of hours services in the community in the event of an above average or epidemic level of influenza. (Paragraphs 81-82)**

The most extensive campaign ever arranged in Scotland was launched in September to combat the threat of influenza. It has 3 phases, each of which has press and TV advertising components. The first phase focussed on encouraging those in the at risk groups, including for the first time people aged over 65 rather than 75 as previously, to come forward for immunisation; the second outlines the steps people can take to prepare for winter, including stocking up with cold and flu remedies; and the third, which, in line with the Committee's recommendation, will come fully into play in the event of increasing reports of infection, advises people what to do if they think they have flu. The Executive agrees with the Committee that campaigns at both national and local level should reflect vaccine availability; and the timing of the first 2 phases of the national campaign has had regard to

vaccine supplies. The campaign will be evaluated and the findings taken into account, along with the Committee's recommendations, in the arrangements for future years.

The Winter Performance Group recommends that Health Boards and Primary Care Trusts should involve LHCCs, GP Sub-Committees and GP Out of Hours Co-operatives at an early stage in local winter planning and consider the level of resources that may be required over the winter. This would include plans for an above average or epidemic level of influenza.

The Executive has worked with Health Boards and Trusts to ensure any vaccine supply difficulties were addressed, and that community pharmacists and GPs collaborated with each other to co-ordinate clinics with availability of supplies.

Like the Committee, the Executive acknowledges the key role of pharmacists. The pharmaceutical professions have been fully involved in the winter planning arrangements; and the publicity campaign this winter has advocated the role of community pharmacy in the self management of symptoms.

The NHS Helpline is available to provide general information on health and health services, including advice on specific conditions such as influenza. The Helpline can be expanded to meet health emergencies or a major influenza outbreak as appropriate; and indeed the publicity campaign invites people to call the Helpline if they wish further information.

Data Collection and Research

- **Any Scottish equivalent to the NHS Direct helpline service should have a surveillance reporting system built-in from the outset. (Paragraphs 37-60)**

- **Such a surveillance scheme should be integrated with the out of hours co-operatives in Scotland. (Paragraphs 37-60)**

- **The Scottish Executive in consultation with SCIEH/CMR*/ISD** should introduce a laboratory based community monitoring scheme in Scotland. [The Scottish Executive have reported that this is already under discussion]**

***CMR =Continuous Morbidity Recording**

***ISD = Information Services Division of the CSA**

Paragraphs 37-60)

- **The Scottish Executive should "buy in" to the newly created scientific post in England established to co-ordinate surveillance through NHS Direct rather than creating a separate Scottish post. (Paragraphs 37-60)**

- **Current data collection systems should be continued by SCIEH until a new system is fully established and can be correlated to the long-term influenza pattern database. The new scheme should be managed by SCIEH. (Paragraphs 37-60)**

- **The primary care-based Continuous Morbidity Recording data system (CMR) should be expanded to ensure adequate cover of the whole of Scotland. The frequency of reporting should be increased to weekly for the purposes of identifying influenza. This will provide**

  - **a contemporary link with age and sex**

  - **a link with other illnesses again contemporary**

  - **a link which will provide the opportunity for a retrospective analysis connecting to SMR data.**

  (Paragraphs 37-60)

  - **The Area Health Board reporting of influenza levels should be reviewed to ensure that they are valid. If it is not possible to validate figures for individual Board areas then figures should not be issued. (Paragraphs 37-60)**

  - **Research should be continued into alternative methods of vaccine production including cell cultured vaccines, and purified neuroaminidase vaccines, improving**

efficiency of vaccines with possible adjuvants and alternative routes of administration e.g. intra-nasal. (Paragraphs 11-25)

- **Research into nasal or oral route of administration should be continued and funding sought from the European Community for this purpose. (Paragraphs 83-98)**

- **Further research should be undertaken to ensure that the antibody response is adequate in all groups for whom vaccination is recommended. (Paragraphs 26-36)**

- **Research on the minimum effective dosage of vaccine should be continued to determine whether a monovalent 10 microgram dose would suffice at least for first wave vaccination of all 'emergency' personnel. (Paragraphs 83-98)**

- **Further clarification on the efficacy of dose level in different groups of vaccines should be sought both in the interests of economy and in preparation for a possible pandemic.**
- **(Paragraphs 11-25)**

- **A major study should be undertaken in the United Kingdom to assess the effectiveness of mass annual vaccination of staff. This should be undertaken over more than one year.**
- **(Paragraphs 61-80)**

- **Any community laboratory data surveillance system should be extended to include RSV. (Paragraphs 103-106)**

The Committee's comments on NHS Direct will be taken into account as the development of the equivalent Scottish service proceeds. Its primary role will be to provide self-care help to callers or, if this is inappropriate, to pass the caller to the appropriate part of the NHS for the advice and care they need. But the Executive appreciates the project's potential to augment surveillance and early warning systems in the way the Committee suggests. A research initiative is underway in England to investigate the feasibility of using NHS Direct data as an early warning of increased influenza activity to supplement information from GPs on the extent of an outbreak. The Executive looks

forward to seeing the results of this assessment and will then consider whether the NHS Direct service in Scotland can be used as a tool for monitoring influenza activity.

As noted earlier, the Executive has given SCIEH additional funding to set up an enhanced influenza surveillance programme. This will give a more accurate and complete picture of a winter flu outbreak and will be able to distinguish influenza virus infection from other causes of viral respiratory illness. The enhanced scheme will comprise clinical data from sentinel computerised (CMR) general practices with linked virological testing for multiple respiratory viruses to differentiate the contribution of influenza virus alone to an outbreak. The virological samples from sentinel CMR practices will be Polymerase Chain Reaction (PCR)-tested by the West of Scotland Regional Virus Laboratory and will provide added information over influenza surveillance alone.

The new enhanced influenza surveillance programme will be managed by SCIEH. The key element of the new scheme is clinical data from sentinel computerised general practices linked to virological laboratory data. In addition, the new scheme will look at the feasibility of using hospital admission data, mortality data and vaccine uptake data. However, current data collection systems by SCIEH, namely the clinical data from existing voluntary flu spotter practices and unlinked laboratory reporting of hospital and community based diagnostic specimens, will be continued as these provide additional contextual information.

The enhanced influenza surveillance scheme has recruited approximately 40 sentinel CMR practices from the existing cohort of around 70 CMR practices and these provide representative cover of Scotland. They are reporting weekly and the data will provide links with age and sex, other illnesses and the opportunity for a retrospective analysis connecting to SMR data in line with the Committee's recommendations. The enhanced scheme will provide additional information to help with the validity and interpretation of local reporting; but it will be difficult completely to eliminate differences in reporting because influenza levels are variable.

The Executive will discuss with the other Health Departments the feasibility of a study to assess the effectiveness of mass annual vaccination of staff, as recommended by the Committee. The possible role of the JCVI in such an exercise will be considered.

The Executive notes the various recommendations in relation to research. It is primarily a matter for the industry to develop new production methods and approaches to improving vaccines,

including the scope for nasal or oral administration. But the Executive will explore with the other Health Departments how the recommendations might be taken forward, in conjunction with the industry.

Pandemics

- **The Scottish 1997 guidelines on pandemics should be up-dated to take account of both the changes in the NHS in Scotland and the WHO phasing (1999) and published as soon as possible. The updated version should take into account the lessons learned from the Hong-Kong chicken virus scare of 1997/8. The partners in any such update should include the STUC and the CBI (Scotland) and representatives of the vaccine manufacturers as well as COSLA and all NHS partners. (Paragraphs 83-98)**

- **Until and unless new methods of producing a vaccine are found which do not involve eggs Ministry for Agriculture and Fisheries (MAAF) should be prepared in an emergency to commandeer sufficient egg production to allow adequate vaccine production. (Paragraphs 83-98)**

- **Plans by the SCIEH/PHLS and others for scientific aspects of studying a pandemic should be incorporated into any up-dated guidelines. This should be co-ordinated with the UK Department of Health to achieve cost efficiencies. (Paragraphs 83-98)**

- **Scotland's emergency planning procedures for pandemics should be updated locally in each Health Board area. (Paragraphs 83-98)**

- **Any such up-dated planning should involve not only the potential opening of hospital emergency beds but also the utilisation of beds in residential and nursing home accommodation. The role of NHS Direct in Scotland and the out-of-hours co-operatives in the event of a pandemic should be addressed. The increasing dispersal into small group homes of individuals with learning disability and mental illness should be taken into account. Also the role of carers and home care staff in the increasing levels of support in the community should be reviewed in considering the need for vaccination. (Paragraphs 83-98)**

- **Lists of inactive but available personnel in the medical, nursing, paramedical, social services and other emergency services should be kept by the joint health board/local authority emergency co-ordinator. These individuals should be utilised in any early vaccination or treatment programmes(Paragraphs 83-98)**

- **Emergency simulation exercises should be undertaken in each health board periodically. (Paragraphs 83-98)**

- **Consideration should be given to the creation of a strategic reserve of Amantidine*. The proportion of such a reserve which would expire in any given year should be used for treatment of emergency staff by the NHS in Scotland each winter. Alternatively consideration should be given to an emergency supply agreement with the manufacturers of Relenza** and Tamiflu*****

***Amantidine is an antiviral agent inexpensive with moderate effect lifespan five years**

**** *** Relenza and Tamiflu are newer antiflu agents much more expensive but will moderate the length and intensity of influenza.**

(Paragraphs 83-98)

- **The role of pneumococcal vaccination and if it becomes available Respiratory Syncitial Virus vaccine in the early warning phase of a pandemic should be determined. (Paragraphs 83-98)**

- **The dangers for the national interest, particularly in the event of a pandemic, of having only one production unit in the UK should be reassessed. (Paragraphs 11-25)**

- **Agreement be reached with UK manufacturers of vaccine on the methods of supplying pandemic vaccine on an emergency order basis. Alternatively consideration should be given to the establishment of either a National Laboratory based production unit or a**

joint venture production unit which is part state owned (as in Holland). (Paragraphs 83-98)

The "National Health Service in Scotland Manual of Guidance: Responding to Emergencies" includes advice to the NHS on the planning and arrangements, which should be put in place to enable an appropriate response to emergencies. Guidance is included in the Manual on the action needed to counter an influenza pandemic and is complementary to the Pandemic Influenza Plan, which has been prepared jointly by the UK Health Departments, and deals with issues such as international liaison and surveillance, and the licensing, production and distribution of vaccines and anti-viral drugs. A review of the Scottish Manual of Guidance is underway. As the Committee recommends, this will take account of changes in the NHS in Scotland and experience of recent outbreaks. The revised phasing, recommended by the WHO, will be taken into account in any future review of the UK guidance.

The revised Manual of Guidance will be the catalyst for the review of local plans by health boards. The Committee's views on the aspects which local plans should cover, including the utilisation of additional personnel and emergency beds, are noted and will be considered in the review of the Scottish guidance.

Health boards are currently required to ensure their emergency plans are exercised every 2 years. These exercises take into account the spectrum of emergencies covered in the Manual of Guidance, including influenza.

The Executive will discuss with the other Health Departments the Committee's recommendations about the production and supply of vaccine in pandemic and emergency situations and will consider how best to manage sufficiency of supply of antiviral agents, including Relenza, in such circumstances. In this context, it is relevant that the Biotechnology Working Party of the European Medicines Evaluation Agency have been looking at the use of cell cultures to produce influenza vaccine and a consultation document is expected to be issued in the New Year which will discuss the use of cell banks.

Scottish Executive

December 2000

Agenda items 7&9

Health & Community Care Committee
10 January 2001

HC/01/1/4

The Health and Community Care Committee

10 January 2001

Modernising the Complaints System - Consultation on Public Sector Ombudsman in Scotland

Background

The Health and Community Care Committee considered reports on the document *Modernising the Complaints System: Consultation on Public Sector Ombudsmen in Scotland* at their meetings on and on 12 December 2000.

The Committee agreed to consider the matter further at this meeting. Members were invited to provide written comments to the clerks by 19 December 2000. No comments have been received.

The Committee also requested a note from SPICe to clarify various issues. This is also attached.

Recommendation

The committee is asked to agree that the points contained in the attached reports form the basis of a response to be submitted to the Executive.

Jennifer Smart
Clerk

Agenda item 4

Health & Community Care Committee
12 December 2000

The Health and Community Care Committee

12 December 2000

Modernising the Complaints System - Consultation on Public Sector Ombudsman in Scotland

Background

The Executive circulated the document *Modernising the Complaints System: Comsultation on Public Sector ombudsmen in Soctland* in October 2000.

The committee agreed at a previous meeting to invite written evidence from: the Scottish Parliamentary Commissioner for Administration, the Health Service Commissioner for Scotland, the Commissioner for Local Administration in Scotland, the Housing Association Ombudsman for Scotland, the Scottish Association of Health Councils, the Board of General Managers, Trust Chief Executives Groups and the Patients' Association.

Attached are responses from the following organisations:

- Joint response from: the Scottish Parliamentary Commissioner for Administration, the Health Service Commissioner for Scotland and the Commissioner for Local Administration in Scotland
- Housing Association Ombudsman for Scotland, and
- Trust Chief Executives Groups.

Also attached is a research note from SPICe which covers the key issues in the document

Recommendation

A summary of key points arising from the submissions will be circulated at the meeting on 12 December.

The committee is asked to consider the points raised. On the basis of this discussion, a report will be drafted for submission to the Executive by its deadline of 10 January 2001.

Jennifer Smart
Clerk

JOINT RESPONSE FROM SCOTTISH PARLIAMENTARY COMMISSIONER FOR ADMINISTRATION, HEALTH SERVICE COMMISSIONER FOR SCOTLAND AND COMMISSIONER FOR LOCAL ADMINISTRATION IN SCOTLAND

1. *This memorandum is submitted to the Health and Community Care and the Local Government Committees of the Parliament jointly by the Scottish Public Sector Ombudsmen (the Local Government Ombudsman for Scotland, the Health Service Commissioner for Scotland, and the Scottish Parliamentary Commissioner for Administration). We hope that it will be for the convenience of the Committees that it is closely based on the Executive's consultation document "Modernising the Complaints System".*

GENERAL

2. We very much welcome the publication of this consultation document. Before addressing the particular questions that it raises, we should like to make some general comments.

1 The "one-stop shop"

3. As will be seen from our comments later in this response, we strongly favour the setting up of a "one-stop shop". But the phrase could be applied to a variety of arrangements, including something going no further than the establishment of joint facilities, such as a single enquiry point for complainers, while largely preserving the existing separate ombudsman schemes. In our view, it is essential, in order to produce the most user-friendly and effective service to the public of Scotland, to replace the existing three separate schemes (for central government, local government and the NHS) with a single unified scheme. In particular, it is only by this means that the difficulties for those wishing to pursue a complaint involving bodies in what are currently separate ombudsman jurisdictions (for example, a complaint about discharge from an NHS Trust into care provided by local authority social services) can be removed.

4. It follows from this that any new legislative provision should, so far as possible, be uniform for all bodies within scope. Any differences will tend to recreate the existing barriers.

Independence and accountability

5. Secondly, it is essential that any new institution should be, and be seen to be, completely independent from both the Scottish Executive and all other bodies within its jurisdiction. It must, of course, be publicly accountable. But that accountability should lie exclusively to the Parliament. It should extend to all aspects of any new institution, except its handling of individual cases (in respect of which there would, of course, be the possibility of recourse to the courts by way of judicial review).

6. The legislation governing the existing schemes is contained in the Local Government (Scotland) Act 1975, the Health Service Commissioners Act 1993, and The Scotland Act 1998 (Transitory and Transitional Provisions) (Complaints of Maladministration) Order 1999 ("the Order"), which is closely modelled on the Parliamentary Commissioner Act 1967. The legislation is, in our view, unnecessarily detailed; and because in its essentials it dates back some 30 years, much of the detail is outmoded. It is, for example, uncertain whether the Ombudsmen have power to entertain complaints made by electronic means. This point obviously could not have been anticipated when the legislation was prepared. New legislation will be equally incapable of providing for all eventualities over the next 20 or 30 years. We therefore believe that it should be drafted in general terms, and leave as much as possible to the discretion of the Ombudsman or Ombudsmen, while ensuring that there is full accountability to the Parliament for the use of that discretion.

7. The following paragraphs set out our answers to the questions in the consultation document. Unless otherwise stated, paragraph numbers refer to the paragraphs in that document.

"ONE-STOP SHOP"

8. We believe strongly that there should be a "one-stop shop" on the basis described in paragraph 3 above. In our view, the advantages set out in paragraphs 2.9 and 2.10 clearly outweigh the disadvantages. We would also add that international comparisons point strongly in that direction. Whatever the merits arguments based on prospective workload in favour of having separate ombudsman schemes for a country of the size of England, they do not apply to a country the size of Scotland. We do not see the argument outlined in paragraph 2.13 as having force. It is an unavoidable consequence of the devolution settlement; and in any event it must surely be better to face potential complainers with two shops rather than four. The analogous situation in Northern Ireland, which has existed since 1969, has not given rise to difficulties. It should also be possible to make arrangements for investigations to be undertaken by the new Scottish institution at the request of the UK Ombudsman, should the need arise.

9. We agree with paragraphs 2.2 and 2.3. However it will be important to ensure, as now, that the actions of private sector bodies acting on behalf of bodies within scope are themselves within scope, and to cover the possibility of new types of partnership arrangement between public and private bodies designed to carry out essentially public functions.

10. Tenants of Housing Associations in Scotland have been well served by the Housing Association Ombudsman for Scotland. As new housing partnerships develop and major transfers of local authority housing stock take place it is possible that a reducing proportion of social rented housing in Scotland will remain in the ownership and control of local authorities. We believe that it is desirable for the same consistent complaints system to apply to Housing Association and Council tenants alike within the same statutory framework and therefore the scope of the new institution should cover both.

11. As noted in paragraph 2.5, the Millan Committee is currently reviewing the role and powers of the Mental Welfare Commission, including its role in complaint handling. It is hard to say much on the issues raised in this paragraph in advance of the conclusion of the review.

Other Commissioners

12. It would certainly be possible, in principle, to share facilities with other regulatory bodies, although there could be problems relating to the confidentiality of information in sharing staff. However, sharing of either staff or facilities with bodies within the jurisdiction of the new institution should be avoided, because it would give rise to suspicions of conflict of interest.

13. We believe that the new institution should be headed by a single Ombudsman.

    a. If there were more than one ombudsman, with different jurisdictions, the disadvantages of the present system would be perpetuated.

    b. It will be much easier to establish a single Ombudsman as a public figure, to whom complainers will naturally turn.

We take the point that the single Ombudsman would be unlikely to have personal experience of all areas within his or her jurisdiction. But that problem can be solved in large measure by ensuring an appropriate range of experience and expertise among his or her senior staff. There could also be advantage in establishing an advisory board for the new institution, with non-executive members drawn from a suitable range of backgrounds.

REMIT

14. This is largely a policy matter, which is for the Executive and the Parliament to decide; but we see no reason to dissent from the conclusion in paragraph 3.2. However, we have some reservations about the proposal in paragraph 3.3, since it seems to us that it may be difficult to frame a definition of "public authority" which is both sufficiently general and sufficiently precise. On the other hand, we would advise strongly against the approach of listing by name all bodies within scope as in the Order and the 1967 Act: experience has shown that this approach is cumbersome (and will be still more so if the number of bodies within scope is increased) and that it is hard to keep the list of bodies up to date. We would favour broad definitions of the categories of body within scope, as in the 1975 and 1993 Acts, with explicit designation of individual bodies whose status is special or uncertain, and with a power to add categories of body or individual bodies by subordinate legislation. The approach adopted in the Westminster Freedom of Information Bill appears to offer a good model.

15. The jurisdiction of the new institution cannot be limited to maladministration, since it would then be more restricted than that of the Health Service Ombudsman which, as paragraph 3.4 points out, extends to complaints about failure in service or failure to provide a service. For the reasons given in paragraphs 3 and 4 above, the statutory provision should be the same as regards all bodies within scope. We therefore suggest that the subjects of complaint should be as laid down in section 3 of the 1993 Act.

16. It should be left to the new institution to decide whether to issue guidance on good administrative practice (and warnings against bad practice) and to keep the guidance up to date. But there would be advantage in making this explicitly a function of the institution. The Health Service Ombudsman investigates complaints within a consistent, national structure. Local authorities have developed internal complaints procedures to reflect local circumstances. Whilst recognising the need for local authorities to maintain their independence and individuality, we see benefit in ensuring that all complaints procedures have the same key components based on best practice. In Health and Social Care advocacy schemes are helping service users to complain and make representations. Development of such schemes is a significant aid to making complaints systems work better in an inclusive way.

17. We broadly agree with the conclusions of paragraph 3.5. Regarding the matters raised in paragraph 3.6, our views are as follows.

18. There seem to be a number of misconceptions in this paragraph.

a. The House of Commons Select Committee on the PCA suggested in 1968 that "If [the PCA] finds a decision which, judged by its effect upon the aggrieved person, appears to him to be thoroughly bad in its quality, he might infer from the quality of the decision itself that there had been an element of maladministration in the taking of it and ask for its review". (Session 1967-68, HC 350, paragraph 14). The Parliamentary Ombudsman has subsequently worked on that basis; and the present Scottish Parliamentary Ombudsman would expect to do the same.

b. Although all the public sector ombudsmen are normally debarred from considering matters regarding which the aggrieved person has or had a remedy by way of action before a court or tribunal, they have discretion to do so if they consider that it would be unreasonable to expect the aggrieved to resort or have resorted to the remedy. They have often exercised that discretion to consider matters which could in principle have been the subject of judicial review, because that procedure has a number of disadvantages for the applicant and its cost is often disproportionate to any likely remedy.

c. However, since the Ombudsmen make recommendations, not binding awards, they have been advised that they do not determine civil rights or obligations and are therefore not subject to the requirements of Article 6 of the European Convention on Human Rights.

We therefore believe that the existing statutory position is satisfactory.

19. The UK Parliamentary Ombudsman has power to consider complaints about the actions of administrative staff of most courts and tribunals (except actions taken on the express or implied authority of a judge or member of the tribunal). However, the Scottish Courts Administration is not within the jurisdiction of the Scottish Parliamentary Ombudsman.

20. We agree, subject to the points made in relation to paragraph 3.6.1.

21. We believe that schools should be included within the jurisdiction of the new institution. Administrative activity in schools has developed significantly as a consequence of community use of schools and devolved school management initiatives. To restrict enquiries to education authorities alone and exclude schools is a potential barrier to a uniform, inclusive approach to complaints management. The Local Government Ombudsman has had advice that his jurisdiction does not include certain categories of local government official, for example Assessors, Mental Health Officers, Statutory Chief Social Work Officers, Monitoring Officers and Building Control Officers when those officials are exercising certain statutory duties placed on them currently present similar difficulties. The arguments for an inclusive system ought to mean that the legislation should ensure no relevant public official is outwith jurisdiction.

22. In our view it would be highly desirable to bring the position in Scotland into line with that which will obtain in England and Wales if the Bill mentioned in paragraph 3.8 becomes law.

ARRANGEMENTS FOR SUBMITTING COMPLAINTS

23. It seems to us clear that retention of the MSP filter would be inconsistent with setting up a “one-stop shop”: either the filter would have to be imposed on complaints against any body within scope (which would be constitutionally objectionable, especially as regards complaints against local authorities, as well as likely in practice to deter some complainers) or it would apply only to some complaints (which would negate many of the advantages of the “one-stop shop”).

24. However, this is not to imply that relations between the new institution and the Parliament and its Members should be other than close. We have already suggested, in paragraph 5 above, that the new institution should be fully accountable to the Parliament; and we are confident that any new institution would welcome the involvement of MSPs in particular complaints, as we do now even in the health and local government jurisdictions.

25. As the public sector ombudsmen have evolved in the United Kingdom, they are essentially concerned with the investigation and resolution of individual complaints. They are not, nor are they intended to be, auditors or inspectors, or allowed to pass judgment on the merits of policies or discretionary decisions. In our view, if persons other than those who have themselves sustained injustice or hardship were allowed to complain (or have others complain on their behalf) there would be a danger that the new institution would either become drawn into those areas of activity, or have to devote significant resources to screening out inappropriate complaints. We therefore favour retaining the existing position.

26. However, we believe that paragraph 4.6 may be based on a misunderstanding of existing practice. We already allow a good deal of latitude to complainers who wish to have their case put forward by, say, a solicitor or a local Health Council, provided that it is clear that these are acting with the authority of the complainer both in putting the complaint forward and in any subsequent exchanges.

27. In our view, this is precisely the sort of matter which should be left to the judgment of the Ombudsman rather than prescribed in legislation. In practice, no complaint will be taken very far without being reduced to writing because the dangers of relying exclusively on oral communication are so obvious.

28. In our view, the existing statutory provision is satisfactory. It creates a presumption against investigating old complaints regarding which it is likely to be hard to establish the truth, while allowing discretion to investigate where there are, for example, adequate written records.

29. Again, we doubt whether this is a matter which is suitable for legislation, though we certainly endorse the view that bodies within scope should be encouraged, and even in some circumstances required, to give information about the new institution to potential complainers.

30. Many of the considerations relevant to this question have already been set out in paragraph 25 above. In addition, there is the risk that the Ombudsman might be perceived as launching investigations for party political motives. We therefore would not favour allowing the possibility of Ombudsman-initiated investigations.

31. There is already provision, in section 10 of the 1993 Act, for a Health Service body to refer a complaint to the Health Service Ombudsman. The provision has been very little used. Moreover, the focus of an investigation initiated by a body within scope would be the adequacy of its internal systems and procedures (which are more appropriate for auditors or inspectors to consider) rather than injustice done to an identifiable person or persons. We are therefore sceptical of the need to allow for such a possibility.

INVESTIGATION PROCEDURES

32. Before answering the particular questions in the consultation document, we should like to observe that the existing legislation focuses heavily on the **investigation** of complaints. However, while investigation remains an essential activity, the work of the public sector ombudsmen has moved increasingly towards **resolving** complaints by such means as “local settlements”. It is important that any new legislation should allow, and indeed encourage, this development.

33. We see no reason to change the existing statutory position (and there would be objections to the Executive's appearing to prescribe the procedure to be followed by the Ombudsman). If the Ombudsman were to fail to observe the requirements of natural justice he or she would be open to adverse judicial review. Any further oversight should be for the Parliament, not Scottish Ministers.

34. The existing statutory provisions stem to a significant extent from the multiplicity of public sector ombudsman schemes: the need for them will be significantly reduced by the establishment of a "one-stop shop". Nevertheless, it will continue to be necessary to provide for consultation and co-operation with public sector ombudsmen in other parts of the United Kingdom. This should include empowering each public sector ombudsman to authorise the staff of another to act on his behalf.

35. However, we advise caution in going further. As Chapter 6 of the consultation document points out, the confidentiality of information given to or obtained by the ombudsmen in their investigations is closely guarded, even to the extent of forbidding its disclosure in civil and criminal court proceedings. The essential test, we suggest, is whether exchange of information is likely to be required for the effective investigation or resolution of a complaint. That will often be so as regards access to official information: many complaints against public bodies involve allegations of both maladministration and unjustified refusal to disclose information. That is the reason why it is appropriate to allow for exchange of information with the proposed UK Information Commissioner; and the same will hold good if legislation is enacted by the Parliament to set up a Scottish Information Commissioner. We doubt whether it would be wise to go much further.

EVIDENCE

36. The existing statutory provisions are broadly satisfactory.

37. Again, the existing statutory provisions seem satisfactory. The powers of the Health Service Ombudsman to disclose information in certain circumstances referred to in paragraph 6.3 should remain.

REPORTING ARRANGEMENTS

38. For the reasons set out in the first section of this response, we think that it would be a mistake to impose more onerous reporting requirements on a new institution than are now in force. It will, of course, always be open to the Parliament to require the institution to provide it with whatever information it may need, other than information covered by statutory prohibitions on disclosure. (We do, however, see objection to empowering Scottish Ministers to lay reporting requirements on the new institution). No doubt, too, the Parliament or one of its committees will wish to discuss the annual report of any new institution and to make suggestions regarding its content.

39. The example given in paragraph 7.4 – making a special report mandatory if there has been unremedied injustice in consequence of maladministration – well illustrates the difficulties likely to attend on over-detailed statutory requirements. It is not uncommon for a body within scope to accept in large measure an ombudsman's findings and recommendations and to agree to remedy any resulting injustice, but to disagree on some minor point. It would be very heavy handed to require the submission of a special report in such circumstances.

ENFORCEMENT

40. We do not believe that any new institution should have power to enforce its recommendations. Besides the arguments in paragraph 8.3, with which we agree, there is a further point. Most recommendations by the public sector ombudsmen have related to individual cases, not involving major points of principle or policy or large amounts of public money; and they have in the overwhelming majority of cases been accepted by the body concerned. But some have gone further: the former Parliamentary Ombudsman's recommendations regarding compensation for persons adversely affected by uncertainty about the route of the Channel Tunnel Rail Link is a case in point. In our view, it would not be right for a non-elected office holder to have the power to dictate to democratically elected institutions or organisations accountable to, and following policies approved by, such institutions.

41. It would, of course, be possible to establish procedures requiring Scottish Ministers and the Parliament to justify any rejection of recommendations by an ombudsman: such procedures are laid down, as regards the National Assembly for Wales, in the Government of Wales Act 1998. But those are matters for the Parliament to consider.

42. As for the issues raised in paragraph 8.4, we suggest that the arguments put forward in paragraphs 4 and 6 above are particularly relevant. Any new powers should be capable of being applied to any body within the scope of a new organisation; but they should not be over-detailed. The present system of reports, special reports, and statements which applies to local authorities would probably, though for very different reasons, be inappropriate for dealing with complaints against a department of the Executive or against a GP practice in the Highlands. We suggest that in broad terms what is needed is provision:

- authorising (but not requiring) the new institution to publish a report of an investigation;

- empowering the institution to require the body which was the subject of the complaint to state its response to the report;

- empowering the institution to publish such further material as it may see fit in the light of that response, and to require the relevant body itself to publish a further response.

J. APPOINTMENT

43. We have no strong views on this issue, except to stress that it is essential to employ a method which is seen to safeguard independence from the Executive. If, as we advocate, the appointee or appointees have jurisdiction over a large part of the public sector in Scotland, it is likely to be impracticable to consult representatives of all bodies within scope. That may be regarded as strengthening the need for the Parliament to be involved in the process.

44. The present system (indefinite appointment until age 65) appears to have worked well; and we see no pressing case for change. But if change is desired, we would advocate a reasonably long period of appointment, but without the possibility of re-appointment. The intention of both suggestions is to reinforce independence. Appointment for a period of 10 years, or until age 65, whichever is the shorter, might be appropriate.

45. Removal from office, otherwise than for medical reasons or at the request of the incumbent, should be for cause and require the approval of the Parliament.

46. There are disadvantages both to allowing Scottish Ministers to determine the pay and other benefits of the Ombudsman, and to frequent public debate of the issue. We suggest that a suitable approach would be to link the pay of the Ombudsman with that of a designated grade in the Scottish judiciary. Changes in the link would require the express approval of the Parliament.

47. The title “Ombudsman” is becoming increasingly familiar in this country and has the advantage of being much more precise than “Commissioner” or some of the other possibilities put forward in the consultation document.

K. FINANCING AND STAFFING

48. The funding of any new institution should be designed so far as possible to avoid any suspicion that the Executive (or any other body within scope) could "starve the watchdog". We would strongly advise against any arrangements which would allocate particular elements of funding to particular areas of work. That would create inflexibility, and probably lead to a good deal of fruitless debate about the allocation of overheads. Even the Office of the Parliamentary and Health Service Commissioners (which is much larger than any likely Scottish institution and therefore less subject to the difficulties we have mentioned) has always been funded by a single Vote at Westminster.

49. It will be necessary to specify in the legislation what the status of the staff of any new institution is to be – whether members of the UK Civil Service or employees of a separate body – and it will be necessary to consult the staff of the existing ombudsmen schemes about their future status and terms and conditions of service. But we agree that, so far as possible, matters should be left to the new institution to decide.

50. We would point out that some of the statements in this Chapter are not entirely accurate.

a. Paragraph 11 of Schedule 1 to the 1993 Act requires the approval of the Treasury as to the numbers and conditions of service of staff employed by the Health Service Ombudsman. (We are not aware of any legislative provision which has substituted "Scottish Ministers" for "the Treasury", although that would be the normal approach under the Scotland Act 1998). This requirement is discharged partly by approval of overall funding and partly as a result of the fact that the staff are members of the UK Civil Service. There is no separate control.

b. Staff employed in the Edinburgh office of the Scottish Parliamentary and Health Service Ombudsmen are in law employees of the latter, not the Parliamentary Commissioner for Administration. The problem canvassed at the end of paragraph 10.4 therefore does not arise.

MODERNISING THE COMPLAINTS SYSTEM - A RESPONSE FROM THE HOUSING ASSOCIATION OMBUDSMAN FOR SCOTLAND SERVICE

1. Preamble

1.0 The Housing Association Ombudsman for Scotland service welcomes the interest of the Scottish Executive in the potential contribution of effective complaints handling to the good government of Scotland indicated by this consultation and the contents of the consultation paper.

1.1 Furthermore, we are pleased that the unique status of the Housing Association Ombudsman for Scotland is recognised.

1.2 For our part, we understand that the Executive will have a particular interest in our views on the possible involvement of our service in a potential one-stop shop. We will therefore explain these in some detail. However, we also have a depth of experience in the work we do and will offer views we hope will be helpful on wider issues. In the following, numbers in brackets refer to paragraphs in the consultation paper "Modernising the Complaints System". The HAOS is sometimes used as an abbreviation for the Housing Association Ombudsman for Scotland.

2. One-Stop Shop (2.1-2.14)

2.0 The HAOS service recognises the value in terms of public coherence of bringing together the public sector ombudsman services under one umbrella. Indeed the logic of this in the context of a Scotland with devolved government is inescapable. Certainly we believe that the public would find a single public sector ombudsman identity an advantage. We also recognise the potential advantage in sharing resources particularly, but not only, staff.

3. The Place of the Housing Association Ombudsman for Scotland (2.4)

3.0 Less obvious is where the parameters of such a one-stop shop should lie. The consultation paper is surely right in excluding those Ombudsmen purely in the private sector. It is also correct in drawing attention to the ambivalent position of the Housing Association Ombudsman for Scotland. On the one hand, it is fully funded by the public sector and deals with complaints primarily against organisations in social housing which closely parallel public sector equivalents. However, none of these organisations are strictly within the public sector and a few are purely private. This makes the decision on placement a delicate one.

3.1 There is, indeed, confusion and duplication in having two different Ombudsmen working in social housing. This underlines the need for a close examination of provision. It is likely in the context of the present Housing Bill
that one system of regulation will apply to both sectors (Council housing and those landlords presently covered by the Housing Association Ombudsmen for Scotland.) The logic of having one Ombudsman service covering both sectors is therefore very strong and is, broadly, accepted by the Housing Association Ombudsman for Scotland service.

3.2 It is accepted that this would be most effectively and efficiently done within a one-stop shop for the public sector.

3.3 However, there are three points which would have to be explicitly addressed before the integration of the HAOS into a public sector one-stop shop.

a) There would have to be a method of ensuring that the enormous benefits of expertise in the field of housing was not lost in a process of homogenisation. This should not be too difficult.

It would, however, best be done by a distinct housing sector section within a unified public sector one-stop shop, with its own Ombudsman or Depute Ombudsman.

b) There would have to be a decision on what limits there would be on the acceptance of the landlords into the scheme. At the moment any landlord may seek acceptance on to the scheme and although few private landlords have done so, coverage does go well beyond housing associations.

We believe that the terms of reference for the Housing Association Ombudsman for Scotland for acceptance into the scheme should be retained. This would mean that the public sector one-stop shop would be dealing with organisations from the voluntary sector and even from the private sector. Any anomaly here would have to be recognised.

c) Most importantly, consideration would have to be given to the remit of
any Ombudsman working with housing within a one-stop shop. At the moment the HAOS is not established by statute and has a remit which contains a considerable degree of flexibility. In particular, he has the ability to report and investigate complaints other than those in which injustice has been caused by maladministration if he is satisfied that in the particular circumstances, it is in the public interest to do so; an important power which has been used with success.

The Housing Association Ombudsman for Scotland also has the ability to request changes in his remit. Good use has also been made of this provision.

It would be necessary to decide whether the more flexible remit would apply to all housing complaints, to those only within the sector presently covered by the HAOS. service or whether all housing complaints would be covered by the more restrictive remit of the Local Government Ombudsman.

We would strongly suggest that the more flexible terms of reference of the Housing Association Ombudsman for Scotland should apply to all the work of the proposed public sector one-stop shop. This would not only deal with anomalies within housing but greatly improve the ability of public sector Ombudsmen to provide an adequate response to complainants.

3.4 Given the salience of some of these points it may be that there is the need for some delay in moving the HAOS into a one-stop shop. Whether this is the case or not we would ask for two points to be kept very firmly in mind.

3.5 Firstly, that while the Housing Association for Scotland is not appointed by statute there is no doubt surrounding our complete independence of the bodies which we investigate.

3.6 Secondly, that it would be very regrettable if, as an unwanted by-product of the one-stop shop, those outside it were seen as in any way second class.

3.7 We would ask the Executive to take explicit note of these points.

3.8 If the above problems of remit and, particularly, inclusion prove to be intractable, we would recommend that the Housing Association Ombudsman for Scotland service develops the closest possible relationship with the proposed one-stop shop, including the possible sharing of premises but retains autonomy working to its own remit. This might be possible within a collegiate model for a one-stop shop.

4. Type of One-Stop Shop (2.7-2.8)

4.0 While we would not make detailed strictures on this point we would stress the benefits which flow from the detailed knowledge of one field which staff will often possess and this should not be risked in a generic approach. Moreover, and perhaps more importantly, the communication and relationship which an Ombudsman may have with the body of respondents may be important for eliminating some of the causes of complaint, therefore not only reducing the negative effects on individuals lives, but also the work of the Ombudsman services.

4.1 At the moment, the office of the HAOS produces a regular Bulletin containing explanations of issues going to the Ombudsman and advice on complaints handling. We believe this relationship is one important reason for the stability in the numbers of complaints despite the large annual increase in tenancies covered by the scheme.

4.2 To ensure skills and an expert knowledge base are retained, we would, as mentioned above, recommend that a specialist housing area of the one-stop shop with its own Ombudsman or Depute Ombudsman be established. The present staff of the Housing Association Ombudsman for Scotland should be at the heart of this service.

5. Remit (3.1-3.10)

5.0 Based on our own experience we would make two recommendations here:-

a) We believe there should be no attempt to produce a statutory definition of maladministration. This matter should be left to the judgement of the respective Ombudsman in the context of evolving legal judgements, public expectations etc;

b) We strongly support the suggestion that the Ombudsman should be able to investigate cases where there is no maladministration in the process leading to a decision but where the decision was manifestly unreasonable. The HAOS already has this power and has used it to good effect.

5.1 We would also point out that if the HAOS is to be part of a one-stop shop, then those organisations presently the focus of our work would have to be brought within the ambit of the new service. (See comments above on parameters.)

5.2 In drafting legislation on authorities <u>not</u> within the Ombudsman's jurisdiction, care would have to be taken to ensure that organisations presently covered by our service continue to be included.

6. Arrangements for Submitting Complaints (4.1-4.14)

6.0 We would strongly support the retention of the existing system whereby a complaint can only be dealt with if it is made by the aggrieved person or, in limited circumstances, by his/her representative (4.1). Otherwise, we would fear a lack of clarity and focus. The foundation stone of the Ombudsman concept is the aggrieved individual who believes he or she has suffered injustice.

6.1 We would strongly support the removal of the MSP filter for the reasons outlined in 4.3.

6.2 We would support the relaxation of the current provisions relating to complaints made by others on behalf of a complainant.

6.3 We would support the suggestion that the Ombudsman be allowed to accept oral complaints subject to a system being in place when the complainant was able to indicate his/her approval of the oral complaint which was recorded by office staff (4.7). Similarly, we would support electronic submission of complaints (4.8).

6.4 In terms of publicity (4.11) we would draw attention to the experience of our service. Last year we commissioned a customer-satisfaction survey. We are currently addressing the issues raised in the survey, including publicity. This response includes a "roadshow" delivery across Scotland of the survey results to the organisations against which complaints can be made under our scheme.

6.5 We believe the key to making our service better known is establishing a culture which welcomes complaints as a tool to improving service.

6.6 The Housing Association Ombudsman for Scotland service also gives a priority to providing inputs at conferences aimed at the social housing sector.
Again, the aim here is to nourish a culture where good-handling of complaints is recognised as being part and parcel of good practice.

6.7 It is also relevant to mention here our close links with the regulatory body for housing associations, Scottish Homes, which ensures that complaints policies make full mention of the Housing Association Ombudsman for Scotland and that records of complaints to the Ombudsman are part of the monitoring procedures of Scottish Homes. This, again, heightens the profile of the Ombudsman..

7. Investigation Procedures (5.1-5.5)

7.0 We support the proposal that primary legislation should continue to make only minimal provision for investigative procedures, and that it is best left to the individual Ombudsman to set up their own procedures, taking account of best practice and the individual skills of team members (5.2). Arrangements between the various Ombudsmen in Scotland presently work well, with the relationship between the Local Government Ombudsman and the HAOS including well-practised protocols for sharing information.

8. Evidence (6.1-6.5)

8.0 We strongly support the proposal that evidence provided to an Ombudsman in the course of his enquiries should continue to be confidential (6.3). We recognise that the final proposals on legislation will require to take into account any relevant requirements of the Human Rights Act particularly Article 6.

8.1 We are aware that a considerable amount of valuable work has already been done by a working group of the British and Irish Ombudsman Association to address these issues.

9. Enforcement (8.1-8.5)

9.0 We do not believe that Ombudsmen should be given powers to enforce their recommendations following an investigation or to impose sanctions on an authority or body which fails to remedy an injustice caused by maladministration (8.2).

9.1 We believe that this might lead to a pre-occupation with the punitive element in the relationships between the Ombudsman and the respective parties. In the Scottish context, existing powers have been fully sufficient.

10. Appointment (9.1-9.8)

10.0 We would strongly resist the concept of any Ombudsman being subject to political vote or appointment. The concept of political independence is of the first importance. There might, alternatively, be the possibility of scrutiny by parliamentary committee of the correctness of appointment (9.1).

10.1 In terms of the HAOS if the independence of the office is to be maintained then an alternative governance structure will be required given the proposed changes in the governance of Scottish Homes. This new structure would have to include new provisions for appointment, presently done by the Board of Scottish Homes.

10.2 The present arrangement for the HAOS is for three-yearly appointment and we would commend this model (9.2).

10.3 We would support the continued and extended use of the terms "Ombudsman", replacing Commissioner where necessary. Quite simply, the term has established itself accurately in the public mind in a way that other terms have not (9.6).

10.4 The title of our own service will also have to be considered. It is already somewhat inaccurate in that other types of landlord are within our scheme and it is possible that this might develop further in the future. Any decision on a title would be contingent on other decisions. If the Housing Association Ombudsman for Scotland is to remain outwith the proposed one-stop shop, then the title of Independent Housing Ombudsman might recommend itself. This is the title of our closest equivalent in England.

10.5 If the Housing Association Ombudsman is to be part of an integrated public sector one-stop shop then the title would have to reflect the exact delineation of duties which would be a matter for the Ombudsman and his or her Deputes or colleagues.

11. Finance and Staffing (10.1-10.6)

11.0 If the HAOS service is to remain as a stand-alone service, funding and staffing arrangements should stay as they are with full funding to come from Scottish Homes.

11.1 In an integrated one-stop shop, staffing arrangements should be left to the Ombudsmen in recognition of their independence. In this situation, existing HAOS staff should transfer to the one-stop shop.

Originator: Barney Crockett
Housing Association Ombudsman for Scotland
27 November 2000

Scottish Health Board Chief Executives Group

Consultation on Public Sector Ombudsmen in Scotland: Submission to Health and Community Care Committee.

1. Introduction.

1.1 The Scottish Health Board Chief Executives Group welcomes the opportunity to present written evidence to the Committee on this important matter. The Chairman of the Group, Neil McConachie, Chief Executive of Argyll & Clyde Health Board also stands ready to give oral evidence to the Committee if invited.

1.2 Of necessity, most of the evidence offered relates to the Health Service Commissioner role as it currently operates and as the Group understand the proposals for its operation in the Consultation Document laid before the Scottish Parliament.

2. Context.

2.1 The present consultation must be seen in the context of a UK wide review of the whole NHS Complaints Procedure which is expected to report early in 2001 and also in the context of the Scottish Health Plan due for publication on 14th December.

3. NHS Complaints and the Health Service Commissioner.

3.1 The vast majority of those who come into to contact with NHS services do not complain. The very low number of complaints when measured against the number of contacts with the NHS should not be used as a proxy for satisfaction. Service users who may be dissatisfied do not complain for a variety of reasons ranging from apathy to fear of being denied future treatment. Of those who do complain, most of their complaints are dealt with via the NHS Complaints Procedure and relatively few reach the Health Service Commissioner.

3.2 As noted above the 4 UK Health Departments have commissioned a report into the operation of the NHS procedure. Its outcome, as yet unknown, may impact on the work of the Health Service Commissioner. The three principal criticisms are laid against the procedure as it currently operates are, a perceived lack of independence until the Commissioner is involved, the length of time taken to deal with complaints and perceived bureaucracy. It is important that any modified procedure is simple, transparently independent of the body complained against, rapid and user friendly. These same criteria should underpin the future development of Ombudsmen services.

4. Response to the Issues Raised in the Consultation Paper.

4.1 For NHS complainants, access to an Ombudsman is the final stage (outwith litigation) of the NHS Complaints Procedure. The Group would not envisage any significant change in these arrangements in the future. The Group firmly believe that the Ombudsman should not become involved in investigating complaints until local procedures have been exhausted.

4.2 In terms of the number of Ombudsmen and the concept of a `college' of Ombudsmen; given the population of Scotland and the number of complaints received by the present Parliamentary Commissioners in Scotland, the case for more than one Ombudsman does not appear to have been made. Our favoured approach would therefore be a single Ombudsman supported by either deputies or specialist advisers in the discrete areas of jurisdiction.

4.3 Having a single Ombudsman may also make it easier to publicise his existence and his powers. To achieve the Government's stated aim of an open and modern complaints procedure, effective marketing including the use of technology is vital. Another way of enhancing access to the Ombudsman service would be for some of his staff to either be based in or visit main centres of population outside Edinburgh on a regular basis, and/or the establishment of a telephone advice line.

4.4 Given that Health Boards and NHS Trust Boards are appointed by Ministers, there may be merit in extending the role of the Ombudsman to cover complaints about irregularities in appointment procedures. Cognisance must be given to the need to avoid overlap with the Standards in Public Life legislation and the role of the UK Commissioner for Public Appointments.

4.5 As a general principle, the Group would commend leaving those parts of the existing systems which work well and concentrating effort and resources in those areas which are proven to require attention and improvement. The Group would also support the normal principle of as little as possible being enshrined in primary legislation to allow maximum flexibility for services to respond in a timely manner to changing circumstances.

4.6 Given the work of the Joint Future Group and the hospital discharge programme associated with the implementation of the Government's strategy for people with a Learning Disability published earlier this year[1], there is merit in combining the Ombudsman service covering the NHS, Local Government (Social Work and Housing) and Housing Associations.

4.7 The Group have reservations over the handling of complaints relating to mental health care. As the consultation document points out, there is a Memorandum of Understanding in place between the Health Service Commissioner and the Mental Welfare Commission (MWC). Experience would suggest that this arrangement causes confusion in the minds of both complainants and NHS staff. Additionally, as the Commissioner can investigate certain aspects of the MWCs handling of complaints this introduces an additional layer into the procedure with the possibility of further delay and bureaucracy. Clearly, given the vulnerability of those with mental health problems, procedures should be as straightforward and consist of as few steps as possible. One way of facilitating a change in the system would be for the Ombudsman to be the repository for all complaints not resolved locally and for the professional staff of the MWC to act as his advisers and in appropriate circumstances his investigators. One caveat to be borne in mind is the propensity, due to their medical condition, for some patients with mental health difficulties to make frequent and frivolous or vexatious complaints. The professional staff of the MWC could handle these complaints on the Ombudsman's behalf.

[1] The Same as You, HMSO 2000

4.8 There are other health bodies who may be able to offer professional advice and support to the Ombudsman, most notably the Scottish Health Advisory Service, the Clinical Standards Board for Scotland and the Health Technology Assessment Board for Scotland.

4.9 Whilst the Group would support in principle the notion of the Ombudsman's powers being extended to cover FHS and independent providers who have ceased to provide a service, there must be doubts over the practicality of such a move and the willingness of individuals and bodies to comply. The Ombudsman may find himself using his powers of compulsion on a regular basis. This may have a negative effect on his relationships with other parties.

4.10 The Group do not believe that the case has been made for extending the t` ime limit for cases to be brought to the Ombudsman beyond the present one year from the date when the person first had notice of the matters complained about.

4.11 A limited extension to those permitted to make a complaint to allow a complainant to nominate an advocate or other (non-legal) adviser to act on his behalf could be useful. The Group would not support allowing someone not directly affected or not acting on behalf of someone directly affected by the matters complained about to make a complaint to the Ombudsman.

4.12 As a basic principle, the Group believes that complaints reaching the stage of investigation by the Ombudsman should be in writing. This is essential for the avoidance of doubt for the complainant, the person or body complained against and the Ombudsman's staff. Where there are difficulties, the Group would support the Ombudsman's staff helping complainants to document their complaint. Clearly, there are other bodies who could also do so e.g. Citizens Advice Bureaux.

4.13 There would appear to be merit in allowing `authorities' to ask the Ombudsman to conduct investigations into matters of concern.

4.14 The Group would support the requirement for special reports on cases of unremedied injustice to be made to the Parliament. The Group would also support consistency of approach to the publication of reports in all areas of the Ombudsman's jurisdiction. Given the nature of complaints to the Health Service Commissioner, particular regard will need to be placed on confidentiality.

4.15 The Group would support the change of title to Ombudsman and can offer no comment on method of appointment, remuneration retirement age or arrangements for finance/staffing.

Agenda item 6

Health & Community Care Committee
8 November 2000

The Health and Community Care Committee

8 November 2000

Modernising the Complaints System – Consultation on Public Sector Ombudsmen in Scotland

1. Introduction

The purpose of this report is to allow Members the opportunity to consider and respond to the Executive report on the proposed modernisation of the ombudsmen in Scotland.

2. Background

The Scottish Executive consultation document *Modernising the Complaints System: Consultation on public sector ombudsmen in Scotland* was circulated to all Members of the Scottish Parliament in October 2000. The document is also available on www.scotland.gov.uk.

The purpose of this document is to consult Members of the Scottish Parliament on the proposed new complaints system.

As a consequence of devolution the past arrangements where any complaints of maladministration against the Scottish Office were investigated by the Parliamentary Commissioner for Administration (PCA) ceased on 1 July 1999.

Until the Scottish Parliament makes its own arrangements for the investigation of complaints, a transitional system is established by the Scotland Act 1998 through the Scotland Act 1998 (Transitory and Transitional Provisions) (Complaints of Maladministration) Order 1999 (SI 1999/1351) which establishes temporary arrangements for the investigation of complaints. This Order establishes the new post of the Scottish Parliamentary Commissioner for Administration (SPCA) who investigates certain complaints of maladministration.

In addition the Health Service Commissioner for Scotland continues to deal with complaints about the health service and the Commissioner for Local Administration in Scotland with local government related complaints of maladministration.

3. Proposed New Complaints System

The Executive proposes to establish a new complaints system designed to suit the Scottish circumstances. In particular it proposed to explore the establishment of a “one-stop shop” to which members of the public could direct complaints against the Scottish Executive, the Health Service or local government.

The Executive report invites comments on this proposal as a first step in the policy development process. The responses to the consultation will be used to prepare firm proposals.

4. Process and Timescale

Given the impact that the proposals will have on the health service, the Health and Community Care Committee may wish to submit its views to the Scottish Executive.

SPICe will be producing a research note on the proposals outlined in the document which would inform the Committee's consideration of the matter.

The Executive is seeking views on its proposals by **10 January 2000**. Given the Committee's timetable of business the options for conducting this exercise are as follows—

- Hear evidence on the proposals at the meeting on 13 December 2000 and formulate its conclusions at this meeting
- Appoint a reporter to the Committee with a view to reporting back to the meeting on 13 December 2000

If the Committee agrees to hear evidence, it is suggested that the following witnesses be invited to give evidence—

- The Minister for Finance and Local Government/The Minister for Health and Community Care
- The Scottish Parliamentary Commissioner for Administration
- The Health Service Commissioner for Scotland
- The Commissioner for Local Administration in Scotland
- Housing Association Ombudsman for Scotland
- COSLA
- Scottish Association of Health Councils
- Scottish Consumer Council
- Citizens Advice Bureau

5. Recommendations

The Committee is asked to consider the options outlined in this report and decide what course of action it wishes to take.

Jennifer Smart
Clerk

Agenda item 7 & 9

Health & Community Care Committee
10 January 2001

The Health and Community Care Committee

10 January 2001

Consultation on Public Sector Ombudsman in Scotland

SUPPLEMENTARY INFORMATION FOR HEALTH AND COMMUNITY CARE COMMITTEE

Relationship of the Health Service Commissioner to the Mental Welfare Commission (MWC)

The Commissioner's jurisdiction extends to all complaints by, or on behalf of, NHS patients with the **exception** of complaints about any action by a Health Service body to which the protective functions of the Mental Welfare Commission may be exercised in accordance with its remit under the 1984 Act. Therefore, at present, the Health Service Commissioner cannot examine matters that fall within the function of the MWC. Where a complaint is made regarding mental health care, the "ombudsman role" falls to the MWC. Like the Commissioner, it cannot investigate complaints until the appropriate local procedures have been completed. Initial complaints about mental health care must first be addressed to the relevant NHS body or local authority.

In distinguishing between the roles of the two organisations, however, it is not enough to say that all complaints by, or on behalf of, persons with mental disorder should be directed to the Mental Welfare Commission. For example, some complaints relating to persons with mental disorder will be unrelated to the mental disorder or its treatment and will fall within the remit of the Commissioner.

In addition, the Health Service Commissioner **can** consider complaints about the way the MWC itself has handled a case (although not complaints about the MWC's decisions).

The relationship between the MWC and the Health Commissioner is set out in a Memorandum of Understanding. This states that the Health Service Commissioners (Amendment) Act (which came into force on 1 April 1996) adds the MWC to the list of bodies which the Health Service Commissioner for Scotland may investigate and specifies certain functions of the Commission which are excluded from such investigations. Specifically:

> *… the Health Service Commissioner will have jurisdiction to investigate a complaint made by or on behalf of a person who claims to have suffered injustice or hardship as a result of a failure in service by the Mental Welfare Commission, a failure by the Mental Welfare Commission to provide a service which it should have provided or maladministration connected with any other action taken by or on behalf of the Mental Welfare Commission.*

The Millan Committee, which is currently reviewing the Mental Health (Scotland) Act 1984, is considering the role and powers of the MWC. Its report is expected early in 2001. Its second consultation paper (issued in April 2000) stated the following:

It could be that the Principle of Non-Discrimination (which requires that mental healthcare be treated in the same manner as other types of healthcare) suggests that the role of the Health Service Commissioner should be extended to cover all types of complaints about treatment. This would also be less confusing for service users. On the other hand, the MWC has expertise on the particular issues surrounding mental health services that a general Ombudsman might not have. If the Commission were to retain this role, it has been suggested that the appointment of a Commissioner with specific responsibilities for complaints might be appropriate.

The Commission [MWC] can undertake full and formal complaints investigations but, in practice, rarely does, partly because of resource difficulties. However, it carries out a great deal of detailed informal investigation about complaints. This allows the MWC to recommend good practice, and can help facilitate communication between relevant authorities and parties making complaints. Some would argue, however, that the perception of some users that the MWC is "in league" with mental health services is not aided by this type of approach.

It went to ask the following specific questions:

11.6 Should the monitoring of complaints about all types of healthcare be dealt with by the same authority?
11.7 If not, should the MWC undertake formal investigations of complaints about mental healthcare more frequently?

The Executive's consultation paper on Ombudsmen left the relationship between the Health Service Commissioner and the MWC open pending publication of Millan's recommendations:

In the light of their [Millan's] recommendations, the Executive will consider how best to reconcile any changes to the overall structure of public sector ombudsmen with the particular arrangements for mental health services. We would welcome your views on this issue.

Relationship of the Health Service Commissioner with the Scottish Health Advisory Service (SHAS)

SHAS was established in 1970 and has a remit to examine services provided for those with mental illness, learning disability or physical disability, and frail older people. It gives professional advice and information to Scottish Ministers, colleagues in the Scottish Executive and the general public. Its reports on service provision by boards, trusts or hospitals are publicly available.

There is no formal relationship between the Health Service Commissioner and SHAS.

Members should note that the Executive's recent Health Plan recognised the large number of organisations ensuring or monitoring clinical standards:

Although rapid progress has been made in developing the clinical standards agenda, the number of different groups involved may sometimes have dissipated energy and effort.

- *the Chief Medical Officer will work with relevant interests to achieve better integration and co-ordination of those national organisations and professional bodies with an interest in clinical quality*

Remit

Health Committee Members asked for further information on the extent to which the Commissioner can investigate complaints against private health care providers, private dental care, non-NHS hospitals, nursing homes and complementary medicines.

The guidance from the Health Service Commissioner makes clear that:

*The Ombudsman cannot look into …. **Services in a non-NHS hospital or nursing home, unless** they are paid for by the NHS.*[1]

At present, the Ombudsman **can** investigate services provided by private providers only if those services have been purchased by the NHS.

Therefore, unless a service has been purchased from the private sector by the NHS, the Commissioner has no remit to investigate complaints of maladministration. Individuals with complaints against these bodies or individuals may:

- have recourse via the relevant professional regulatory body[2]
- attempt to seek recompense through the courts

The Executive's consultation paper does not propose extending the remit of the Health Commissioner (either separately or as a 'one-stop-shop) to include private health care provision. However, it does draw attention to those areas about which it would welcome views. One of these is as follows:

Are there any matters which public sector Ombudsmen cannot investigate but which you think they ought to be able to investigate? …. Any other comments or suggestions you would like to offer on remit will of course be welcome.

Clearly, it is for the Committee to decide whether or not to recommend that that the Executive extend the remit of the Health Commissioner beyond its current limits.

Staff of the Health Service Commissioner

In the consultation document, the Executive proposes that:

[1] Emphasis in original
[2] Regulation of health professions is reserved under the Scotland Act 1998.

10.4 There would seem to be little need for change if the existing structure were to continue but for a one-stop shop the staffing arrangements would need to be harmonised. Whether the one-stop shop operates as a college of Ombudsmen or under one Public Sector Ombudsman there could be only one set of arrangements for recruiting staff and determining their terms and conditions of service. In line with the objective of maintaining the independence of the Ombudsmen, the Executive is minded to leave these matters entirely up to the Ombudsman or Ombudsmen. Therefore, neither the Scottish Ministers nor Audit Scotland would have any further interest or powers to intervene. However, provision would need to be made for staff of the existing Ombudsmen to transfer to the one-stop shop. The staff of the SPCA and the Health Service Ombudsman, who are presently employees of the PCA, would also need to be given the option of remaining with the PCA's office and perhaps being seconded to the one-stop shop to provide continuity until the one-stop shop is fully established.

10.5 Any one-stop shop would be subject to audit by the Auditor General for Scotland in the same way as the existing SPCA and Health Service Ombudsman and would have to account to the Parliament for its financial and staffing arrangements.

In their joint response to the Health and Local Government Committees (circulated to Health Committee members in the papers for the meeting of 12 December), the Scottish Parliamentary Commissioner, and the Health and Local Government Commissioners stated that:

> *It will be necessary to specify in the legislation what the status of the staff of any new institution is to be – whether members of the UK Civil Service or employees of a separate body.*

It should be noted that section 51 of the Scotland Act 1998 makes clear that all members of staff employed by the Scottish Executive remain UK civil servants, i.e. staff of the 'Home Civil Service'. There is no specifically 'Scottish' civil service.

Murray McVicar
Senior Research Specialist
Health and Community Care/Public Finance/Governance
SPICe

4 January 2001

APPOINTMENT OF OMBUDSMEN IN OTHER COUNTRIES[3]

OMBUDSMAN	APPOINTMENT	REPORTING ARRANGMENTS
Northern Ireland Ombudsman (popular name for the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints)	By HM. No specific limit on length of appointment. Compulsory retirement at 65.	**AONI:** investigation report goes to member of Assembly who referred complaint. **NICC:** investigation report goes to complainant **Both:** investigation report goes to dept or body, and any individual, investigated. Each lay before Assembly annually a general report on performance of functions and such other reports on functions as he sees fit.
European Ombudsman	Appointed by the European Parliament after each election. Can be re-appointed.	Outcome reported to complainant and institution. Annual report to European Parliament on activities as a whole, including outcome of inquiries. May make such other special reports as he considers appropriate to fulfil responsibilities under Treaty. Special and annual reports may contain such recommendations as he thinks appropriate to fulfil his Treaty obligations.
Office of the Ombudsman (Ireland)	Appointed by President of Ireland on recommendation of both Houses the Parliament. Office is independent of Government.	Most complaints resolved informally. Investigation reports are sent to department or body concerned and may recommend review of its action or change of decision. No enforcement power but can report to Parliament.
Mediator of the French Republic	By decree of the President during meeting of Council of Ministers. 6 year, non-renewable appointment.	Annual report to President and Parliament on activities. Contains summary of activities, inc number & type of complaints; most significant reform proposals; discusses difficult or sensitive questions highlighted by Mediator's activities. Report is published and widely distributed and quoted in press.
The Defender of the	Elected by the Parliament for a term of 5 years.	Ombudsman must inform complainant and authority

[3] Thanks to Stephen Bruce of the Scottish Executive

People (Spanish Ombudsman)		or civil servant etc who was subject to investigation of outcome of investigation. Must present annual report to Parliament of the action he has taken, including number and type of complaints filed, of those rejected and reasons for rejection and of those investigated and the results. No personal data is to be included. Where the seriousness or urgency of the situation makes it advisable to do so, he may submit a special report to Parliament. Annual and special reports must be published.
Office of the Parliamentary Ombudsmen (Sweden)	There is a Chief Parliamentary Ombudsman and 3 Parliamentary Ombudsmen. Each has their own main area of responsibility for which they are answerable to the Parliament. All are elected individually by the Swedish Parliament for a term of 4 years. Deputy Ombudsmen may be elected in the same way, but for a 2 year term.	Ombudsmen present an annual report to Parliament containing an account of proposals made for changes to legislation; prosecutions and reports calling for discplinary measures; other significant Ombudsman decisions and a survey of their other activities. Report is examined by the Standing Committee on the Constitution. It is also distributed to the courts and all public authorities.
Parliamentary Ombudsman (Norway)	Elected by Storting (parliament) after each general election. Appointments last 4 years - can be reappointed.	Must notify complainant, others involved in case and superior administrative agency of outcome of case. Ombudsman decides whether, and in what manner, he will inform public of outcome of a case. Has to submit an annual report on his activities to Parliament - directive sets out detail of what report should contain. Annual report is published. May make special report to Parliament on errors or negligence of major significance.
Parliamentary Ombudsman (Finland)	Ombudsman and 2 Deputies elected by Parliament. Each deals independently with different matters. Appointments last 4 years.	Decision on complaint sent to complainant, person complained against and often released to media.
Danish Ombudsman	Elected by Parliament after each general election. Must retire at age 70.	Always gives complainant his views on case. Reports to Parliament and responsible Minister on cases in which he finds errors or derelictions of major importance. Any deficiency in law must notified to

		Parliament and Minister. Submits annual report on his work to Parliament, which is printed and published.
Petitions Committee of the German Bundestag	Parliamentary Committee which fulfils broadly same role as an Ombudsman. All local, county, Land and Federal offices and authorities have a petitions committee.	Committee reports to Bundestag on petitions which it has processed in the form of a list with recommendations. May be debated in Bundestag. After Bundestag has taken a decision on the recommendation for a resolution, the petitioner is infomed of outcome. Committee can also decide to notify outcome to public. Committee must submit annual report to Bundestag on its work.
Ombudsman for Rhineland-Palatinate (1 of only 3 local Ombudsmen in Germany)	Elected by State Parliament for 8 year term. May be re-elected.	Annual report to State Parliament on exercise of functions. At request of Petitions Committee, a parliamentary party or one-fifth of the members of the Parliament, the Ombudsman must report to the Petitions Committee at any time on individual cases.
Austrian Ombudsman Board	Board has 3 members elcted by the Lower House of Parliament for a 6 year term. They may be re-elected once. The 3 largest parties in the Parliament can each nominate 1 ombudsman candidate. The Chair of the Board is rotated annually.	Board reports to Lower House of Parliament and to regional diets. Also regularly informs public, through the media, about its observations and criticisms.
National Ombudsman (Netherlands)	Appointed by Lower House of Parliament for 6 year term. Can be re-appointed. One or more Deputies can be appointed in the same way.	Annual report to both Houses of Parliament and to Ministers. Published as a Parliamentary paper at a press conference and widely distributed. Ombudsman also issues press releases on important reports and copies of selected reports. Ombudsman has regular newspaper columns; important decisions and his annual report are covered in news programmes on radio and TV.
Ontario Ombudsman	Appointed by Lieutenant Governor in Council for 10 year term. Can be reappointed. Compulsory retirement at 65, Where he has served less than 5 years at 65, retirement is at end of 5 years	Where satisfactory action is taken on his recommendations, the Ombudsman must still report the result of investigation to the complainant. Annual report on affairs of Ombudsman office given to

	service.	Speaker of Assembly who lays it before the Assembly.
Quebec Ombudsman	Elected by parliamentarians in National Assembly. Term of office is 5 years.	Reports to National Assembly and public on his actions.
Ombudsman of British Columbia	Officer of the provincial legislature. Independent of government.	Annual report to Legislative Assembly.
Australian Commonwealth Ombudsman.	Appointed by Governor General for up to 7 years. Can be re-appointed. Cannot be appointed or re-appointed for a period that extends beyond age 65. At least 1 but not more than 3 Deputy Ombudsmen are appointed by a Minister.	Investigation report goes to complainant and to dep't or authority complained about. Where the Ombudsman has informed the Prime Minister of a failure to take action on his recommendations, he can also prepare a report on the investigation for presentation to both Houses of Parliament. Annual report to Parliament on operations of Ombudsman. Can submit further reports on operations during year or other reports on his functions.
Australian Capital Territory (ACT) Ombudsman.	Appointed by Executive for up to 7 years. Can be re-appointed. Cannot be appointed for a period that extends beyond age 65.	Investigation report goes to complainant and to dep't or authority complained about. Where the Ombudsman has informed the Chief Minister of a failure to take action on his recommendations, he can also prepare a special report on the investigation for presentation to the Legislative Assembly. Ombudsman may from time to time prepare report to Legislative Assembly on his operations or on any matter relating to his powers or functions.

REPORT OF THE JOINT FUTURE GROUP

Contents

November 2000

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JOINT FUTURE GROUP

CHAPTER 1

INTRODUCTION

1.1 Susan Deacon, Minister for Health and Community Care, set up the Joint Future Group (JFG) chaired by Iain Gray, Deputy Minister for Community Care, to:

- agree a list of joint measures which agencies need to have in place to deliver effective services, and to set deadlines for that;
- advise on the balance between residential and home based care;
- advise on options for charging for care at home; and
- advise on how to identify and share good practice.

The Group's remit is set out in full in Appendix 2.

1.2 Modernising Community Care: An Action Plan[1] had set the agenda, not only for joint working but also the organisation and delivery of services within agencies. It had sought specifically:

- quicker and better decision-making, through delegated decision-making and financial responsibility;
- more flexible and better quality home care services, including a shift in the balance of care towards these services; and
- agencies working in partnership in localities, through better operational and strategic planning, joint budgets, joint services and joint systems.

Context

1.3 When the Scottish Executive came into being in May 1999 it was clear that the principles of Modernising Community Care were accepted, but progress on the ground was mixed. As is the case today, there were many examples of good practice in pockets, pilots or projects. But the positive outcomes, especially as a result of joint working, were not available consistently. At the seminar of leaders of councils, health boards and NHS trusts in November 1999, Ministers made clear that they were not seeking structural change, but that the status quo – in terms of joint working – would not do. A new lead was needed. The Joint Future Group was charged with providing that lead.

1.4 At the same time the expected shift in the balance of care for older people towards more care at home, first expressed in Caring for People[2] and subsequently

[1] Scottish Office, (1998) *Modernising Community Care – An Action Plan*

[2] Department of Health et al, (1989) *Caring for People – Community Care in the next Decade and Beyond.*

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reaffirmed in Modernising Community Care, has not materialised. Indeed, it could be said that the balance has got worse. A number of factors have combined to undermine this long -standing policy objective, as discussed more fully in Chapter 3.

1.5 Community care is now far more organised than prior to 1993. But as the origins of the Group suggest, there is a long way to go if people across Scotland are to receive consistently high standards of care which match their rising expectations. We recognise that many areas of Scotland have made considerable progress, and our approach reflects that. The task for the future is to ensure that these higher standards are achieved more uniformly.

Policy Context

1.6 Community care does not stand still. The policies introduced in 1993 have been updated, expanded and refined as community care as a whole develops and improves. Modernising Community Care (together with its companion "The Housing Contribution")[3] remains the cornerstone of how we want agencies to work together. But there are also major new policies, which need to be read alongside it. The Framework for Mental Health Services in Scotland, the Learning Disability Review and the Carer's Strategy all advance significantly the way people should be supported both within and between agencies. And the development of national standards will define what users should expect from services, and influence outcomes. We have had regard to that changing agenda as we went about our work.

1.7 Planning and financial systems are also changing. Community planning offers an opportunity for comprehensive area-based planning, and to rationalise the range of plans currently produced. More generally, the Scottish Executive's 21st Century Government Agenda will focus much more on outcomes, on which development work is currently being progressed through pilot studies.

1.8 Best Value, which aims to secure sound governance and continuous improvement in the way agencies perform, both individually and together, is also part of the context. So too is the thinking emerging from the Strategic Issues Working Group of a new resourcing framework for local government, focusing more on the relationship between new resources and outcomes, and measures to gauge performance.

The Joint Future Group's Role

1.9 Our task was specific. It was not to develop new policy, but to identify ways of making existing policies work better. The task was short-term and focused, and principally about statutory agencies working better together. That does not diminish the roles of or the need for joint working with the voluntary or private sectors or, indeed, people who use services and their carers.

[3] Scottish Office, (1999) *Modernising Community Care – The Housing Contribution.*

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1.10 The seminar in November 1999 underlined that responsibility for the success of community care is shared. It rests with local authorities, usually through their social work and housing departments, with health boards and NHS trusts, and with Scottish Homes. The interfaces between parts of the system - for example between acute hospital services for older people and services in the community - are often critical.

1.11 We have drawn up an action plan, mostly for the short to medium term, with timescales for implementation. In accordance with our remit, some measures relate only to services for older people; some are based on older people but extend equally to other care groups; and finally those on joint working apply across the board. We aim to make these distinctions clear in this report.

1.12 Our recommendations will deliver a step change. We have identified a challenging but fair agenda. Many of our proposals are not new: they already exist in parts of Scotland. More importantly, they have been proven to work. That is one of the strengths of our work. The measures should make a real difference to people who use services. People now deserve access to the essential services we recommend to see for themselves the benefit of joint management of services, more focused assessments, and better organised equipment services.

1.13 We believe the climate is right to offer a strong lead on some of the most important aspects of community care. We now want agencies to grasp the opportunity to make real progress, not based on theory but on sound, effective approaches that will make a real difference.

1.14 Our membership was drawn from a range of backgrounds. But in building for the future we concentrated on what is best for community care. We achieved broad consensus on our chosen way forward and presented our findings accordingly to the consultation seminars towards the end of September.

1.15 We note that the Minister for Health and Community Care's statement on older people on 5 October included the Executive's intention to implement a number of the Group's recommendations, as follows:

- more intensive care at home;
- rapid response teams in every local authority area;
- free home care for the first 4 weeks after discharge from hospital;
- a shopping/home maintenance service in every area;
- more short breaks;
- joint resourcing and joint service management of services for older people.

The statement also indicated that the Executive would provide new resources to support change.

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CHAPTER 2

RECOMMENDATIONS AND TIMETABLE FOR IMPLEMENTATION

REBALANCING CARE OF OLDER PEOPLE

Intensive Support and Care Schemes

2.1 Every local authority area should have in place a comprehensive, joint discharge/rapid response team, by mid 2001-02.

3.15

Intensive Home Support/Augmented Care Schemes

2.2 Every local authority area should have in place a comprehensive, joint intensive home support team, by mid 2001-02.

3.18

Short Breaks

2.3 Each year, agencies should provide both more short breaks (to reduce the number of carers providing most care, without a break), and more breaks at home.

3.22

Practical Shopping/Domestic/Household Maintenance Service

2.4 Every local authority should identify the need for a practical shopping/domestic/household service, and arrange it comprehensively, by mid 2001/02.

3.27

A Service Development Centre for Older People

2.5 The Executive should, in 2001, set up an older people's service development centre to champion the development of good and innovative community care services, promote training and assist implementation of the Group's proposals.

3.33

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IMPROVING JOINT WORKING

Single Assessments

2.6 Agencies locally should have in place single, shared assessment procedures for older people and for those with dementia by October 2001, and for all client groups by April 2002.

4.12

2.7 Agencies locally should have in place by October 2001, a single shared assessment tool for older people and people with dementia. Local agencies should either adapt existing systems or develop systems to achieve the outcomes specified in the report, or adopt Carenap 'D' & 'E'.

4.12

Intensive Care Management

2.8 The Scottish Executive should redefine care management as 'Intensive Care Management', which will be for people with complex or frequently changing needs.

4.23

2.9 Care managers should be trained in 'Intensive Care Management' throughout 2001-2002. Only those who have undertaken such training should carry out 'Intensive Care Management'.

4.23

Information Sharing

2.10 The Scottish Executive should, by 2002, offer a strategic lead on the development of community care information, information sharing and systems integration.

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2.11 Locally, the arrangements for single shared assessments should include specific proposals for the necessary sharing of information between agencies, by obtaining explicit client approval.

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Equipment and Adaptations

2.12 To modernise and improve equipment and adaptation services, the Scottish Executive should establish a strategic overview, and set out a programme of change that will require agencies locally to integrate equipment and adaptation services with the rest of community care services, and put in place a number of specific measures that will result in a better-focused and more effective service for the user.

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Occupational Therapy Services

2.13 To target occupational therapy services more effectively, agencies need to modernise equipment and adaptation services, and to remove duplication between hospital and community based occupational therapy services wherever practical. For community based care services that reoganisation needs to begin as soon as possible, followed by the rest of health and social care within the context of the wider agenda for joined up health, housing and social care services.

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PLANNING, FINANCIAL AND SERVICE MANAGEMENT FRAMEWORKS

National Planning and Financial Framework

2.14 The Scottish Executive should set up a programme planning and financial framework, beginning with services for older people in 2001.

5.15

Joint Resourcing and Joint Service Management Locally

2.15 Local authorities (that is social work and housing), health boards, NHS trusts and Scottish Homes should draw up local partnership agreements, including a clear programme for local joint resourcing and joint management of community care services collectively or for each care user group individually.

5.15

2.16 As a step towards that, and recognising current progress on the ground, every area should introduce joint resourcing and joint management of services for older people from April 2002, and in preparation for that introduce shadow arrangements in the course of 2001-02.

5.15

CHARGING

2.17 COSLA should develop guidance on charging policies to reduce the inconsistencies in home care charging.

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2.18 The Scottish Executive should consider introducing:

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- free home care for up to 4 weeks for older people leaving hospital

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- free home care for older people receiving “extended home care”, (though they would still pay for ‘ordinary’ services)

7.19

GOOD PRACTICE

2.19 The Scottish Executive should, by mid 2001-02, identify measures to improve the collection and dissemination of good practice by linking together the bodies in the field in a more cohesive structure, using the benefits of networking and information technology.

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CHAPTER 3

REBALANCING CARE FOR OLDER PEOPLE

Context

3.1 All the evidence points to most older people wanting care at home whenever possible. That is what the research says; that is what older people continue to tell us; that is what the policy aims for; and that is what agencies say they are aiming to do. One of the issues therefore is to understand better the paradox of that strong commitment, both nationally and locally, towards home based care and the patterns of expenditure and services, which seem to move in the opposite direction.

3.2 Between 1994 and 1999:

- Long-stay geriatric beds decreased by 2,500 (33%);
- Nursing home places increased by 5,000 (34%);
- Residential home places decreased by 1,200 (11%);
- LA home care clients reduced by 15,000 (17%), partly on redefining the role of the home help service; but staff increased by 1,300 (13%), meaning more people got intensive packages of care;
- Older people seen at home by community nurses rose by 8,000 (3%), but the number of home visits fluctuated and eventually reduced at a time when 100,000 more older people were discharged from acute hospitals; and
- Local authorities' expenditure on home care services rose by £7m, but that on residential and nursing home care increased by £65m (both 1995-99).

3.3 A number of factors influenced these outcomes. Reducing the number of long-stay hospital places dominated the agenda. But the emphasis was much more on using services such as nursing homes which were readily available in increasing numbers, rather than on providing care at home. And the DSS transfer, despite its intention of assisting the balance of care, tended to perpetuate existing patterns. Partly that may have been affected by increases in demographic pressures and life expectancy, resulting in lower than expected turnover of existing residents. Community care as a whole was also under financial pressure – sometimes as a direct consequence of shifts in the balance of care - and often needed firmer and more focused leadership, both nationally and locally. Finally, home care services have taken time to become more flexible and respond to the challenge.

3.4 In practical terms there is also the eternal 'bridging' question: how to place people appropriately in residential care or nursing homes, and at the same time develop better and more flexible home care services, with due regard to Best Value.

3.5 These factors alone do not explain the imbalance between policy aspirations and reality, but they clearly influenced the outcome. Evidence is now emerging

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through SCRUGS[4] of a significant number – perhaps as many as one in five - of residents in nursing homes capable of being looked after at home with appropriate support. There is also evidence that interventions from occupational therapists can sustain people at home, who otherwise would be in residential care.

3.6 There are also many positives. Although the alternative to hospital care was not home care, the significant reduction in inpatient beds for older people is one part (from hospital to community services) of the balance of care shift. And there is considerable innovation in both services and in partnership working. But much of this good work is found in pockets, in pilots or in projects. The resulting impression is of agencies' ability to innovate, but an inability to convert that innovation into mainstream services. To see where the future should lie, we do not need to 're-invent the wheel'. There are already many innovative and effective approaches; but they need to be applied more generally. Using what works well is fundamental to our proposals. We want to raise the standard to that of the best.

The Way Forward

3.7 It was not appropriate for us to draw up the 'ideal' balance of care. That should be a matter for local determination within the broad policy framework which already exists. Rather, we identified 2 complementary, practical approaches to support rebalancing services for older people:

- "key" services which must be in place to support people properly at home; and
- new national and local financial, planning and service management frameworks.

3.8 These frameworks are, however, about much more than rebalancing care for older people. They are also part of the new joint working agenda. To include them in a chapter about one or the other would be inappropriate. Our proposals are therefore set out separately in Chapter 5.

Key Services to Look After Older People at Home

3.9 To achieve the desired rebalancing of care, home care services need to be integrated, robust and focused on sustaining people at home. Home care services have to change to achieve that. This is not just about social care and health services. Housing's expertise operationally and strategically also has a part to play.

3.10 Change is also required in service priorities and ways of working. There is scope, for example, for discharge arrangements to be better co-ordinated; and rehabilitation services developed to support actively people's independence and inclusion, as opposed to reacting to changes in their circumstances. This calls for a more concerted approach, with more multi-disciplinary inputs, including from occupational therapy.

3.11 Older people need access to a range of services – a continuum of care - if they are to be properly supported at home. We were particularly conscious of critical

[4] Scottish Care Resource Utilisation Group

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gaps, and identified 3 key services to which every older person who needs them should have access. They are:

- intensive support and care schemes;
- more flexible and comprehensive short break services; and
- a practical, low level shopping/domestic/household maintenance service.

What characteristics of these services do we value?

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Intensive Support and Care Schemes

3.12 We recognise the need for two types of scheme:

- hospital discharge/rapid response teams; and
- intensive home support/augmented care schemes.

3.13 Hospital discharge/rapid response teams support early or timely discharge from hospital or prevent inappropriate admissions by providing short periods of intensive home-based support. Teams need to be multi-disciplinary, comprising a mix of health and social care and, where appropriate, housing professionals, have devolved budgets and clear service goals. Some schemes can also be ward or condition-specific, and some divert older people who present at accident and emergency departments. That broad effect makes joint resourcing a prerequisite.

City of Aberdeen Rapid Response Team

The key characteristics of the scheme are that care is short-term and intensive, available quickly (within 24 hours), and the service is time limited (max of 14 days). It has a dedicated joint budget (via the Council, the Primary Care and Acute NHS Trusts) to purchase services (including access to independent home care providers), or simple equipment and adaptations and install them quickly.

The team comprises a social worker/care manager, dedicated home carer/access to independent providers, home care organiser, district nurse, physiotherapist, occupational therapists, and an occupational therapy technician/assistant.

The majority of users are supported successfully within the scheme's planned timescale. It handles about 60 cases a month, 80% of whom are supported for less than two weeks and sometimes for as little as one day. 40% of interventions enabled early discharge, and about 17% prevented admissions in the first place. The scheme supports people successfully and cost-effectively across the spectrum of care, including interaction with the acute sector.

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3.14 The key factors which makes these schemes successful are:

- the speed of response to referrals;
- joint resourcing;
- dedicated and flexible resources; and
- the multi-disciplinary team providing co-ordinated, targeted care and support.

3.15 **We recommend**:

Every local authority area should have in place a comprehensive, joint discharge/rapid response team, by mid 2001-02.

Intensive Home Support/Augmented Care Scheme

3.16 In contrast, these schemes provide longer-term support for people becoming frailer to enable them to return to or remain at home, rather than enter long-term residential or nursing home care. These schemes provide personal care of a higher level of intensity and need, more flexibly and for longer periods of the day than mainstream services. They also provide support for informal carers, usually spouses.

3.17 The key factors which makes these schemes successful are the skilled response from a multi-disciplinary team, the flexible and intensive care, and a positive relationship with users.

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Augmented Care at Home (South Ayrshire)

Augmented Care at Home is a joint scheme run by the Health Board and the Council to provide intensive and flexible home care services for, mostly, physically frail older people. It aims to maintain them in their own home; enhance their quality of life; support carers; co-ordinate care delivery; and inform the future development of home care services.

Care is provided by a team of trained home care support workers who carry out any task that a caring relative might perform. These teams work: the evaluation identified the importance of the closely managed team, the flexibility of the service offered, the satisfaction of users and the good relationships formed between home care support workers and users.

Similar schemes have also been developed in Falkirk, North Ayrshire, North Lanarkshire and West Dunbartonshire.

3.18 **We recommend that**:

Every local authority area should have in place a comprehensive, joint intensive home support team, by mid 2001-02.

Short Breaks

3.19 Previously known as respite services, we recognise firstly the continuing levels of unmet need. Of an estimated 150,000 carers who provide more than 20 hours a week of care, half have not had a break for more than two days since beginning to care. We also need more effective and personalised short break services – at home - to widen choice as part of a continuum of care. Improving these services is already part of the National Carers' Strategy, the Learning Disability Review and the Social Justice Report. And almost every policy or strategy document locally recognises that short break services do not meet needs, and are probably not sufficiently flexible or focused. A particular problem is responding effectively to emergencies. Much of the current service is directed to carers' rather than users' needs. The term 'short breaks', however, applies to both.

3.20 Short breaks should provide choice: of location (either at home or in other settings), and of frequency and duration (weekends or evenings, or in more substantial blocks). To be effective, certain key elements need to be in place. Resources need to be dedicated to short break supports and not to any specific provider, such as a residential care or nursing home. Though emphasising breaks at home, we recognise that some people want or perhaps need a break in a different setting, such as a residential care or nursing home. Users themselves and their carers are often best placed to advise agencies on the criteria for short-break services.

3.21 We cannot realistically resolve these problems overnight. Agencies need therefore to increase incrementally both the level of short break services and the

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proportion of short breaks available at home. The Group's thinking, though founded in older people, is translatable across all care groups, and should be interpreted as such.

Share Project (South Lanarkshire)

The Share Project provides a supportive, caring, flexible respite service within the community for older people, older people with dementia and their carers. The service can support individuals either in their own homes or in the homes of registered family-based carers.

The registered carers offer blocks of time from two to five hours, in mornings, afternoons or evenings. Where appropriate, overnight services are also available. This initiative provides an alternative short break service within the community and offers older people and their carers a positive choice.

3.22 **We recommend**:

Each year, agencies should provide both more short breaks (to reduce the number of carers providing most care, without a break), and more breaks at home.

A Practical Shopping/Domestic/Household Maintenance Service

3.23 A number of studies point to many older people and disabled people being unable to do key daily living activities without assistance. For those living alone or without close natural support this is a particular issue. Alongside that, in some areas of Scotland older people not requiring personal care cannot get assistance with meal preparation, shopping, cleaning or other tasks. These are not daily needs, but are usually intermittent.

3.24 To address these needs we want local authorities to arrange a low intensity, practical shopping/domestic/household maintenance service. It can help older people retain their independence at home and prevent further deterioration; ensure they live in a healthy and safe environment; and reduce potential exclusion. (The service may operate alongside the low intensity advice and support which help people sustain tenancies, funded at present through Housing Benefit and from 2003 under 'Supporting People'[5]).

3.25 This service can be provided in a more structured way than under the former home help service. We envisage a new style service with a focused approach, separate from personal care services, and which could be provided by local authorities but more likely through the local voluntary or independent sectors. This is the kind of service we think authorities should charge for. Some places already have these types of service. Again, the issue is making them available consistently across Scotland.

[5] *DSS (1998) Supporting People: - A Policy and funding Framework for Housing Support*

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3.26 Changing times offer changing solutions. We live in an electronic age, and agencies need to look at the role of, for example, home delivery of food stuffs, telephone ordering services and, indeed, the Internet.

Skye and Lochalsh Handyperson Project

Skye and Lochalsh Community Care Forum's Handyperson Project carries out small repairs/tasks for older/disabled people, and also offers advice and information. The project provides semi-skilled assistance and general help which users otherwise find very difficult to access. Dealing effectively with small tasks (such as hanging curtains, changing light bulbs, doorbells, re-routing and extending telephone points, fixing taps) greatly increase comfort and independence.

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3.27 **We recommend**:

Every local authority should identify the need for a practical shopping/domestic/household service, and arrange it comprehensively, by mid 2001/02.

A Service Development Centre for Older People

3.28 We recognise that there is a huge change agenda surrounding older people. It is not just about rebalancing care and improving joint working in areas that affect them, but also in recognising the contribution that older people can make more generally. We considered at length whether or not a dedicated centre should lead and support change, to ensure that older people can in future access better quality services more consistently. On balance, we concluded that a centre was necessary, which our consultation seminars broadly supported.

3.29 A centre for older people's services would be a focal point for change management, not just for rebalancing care but also more widely, and for advice to those at the 'coal face'. It would provide a lead on:

- winning the hearts and minds for the change agenda and for its implementation;
- supporting the change agenda by identifying "champions" and enabling them to support and encourage others, and sharing good practice generally;
- addressing quality co-ordination, by helping develop good and consistent quality services;
- promoting older people's involvement in service planning and delivery;
- supporting the organisational and cultural changes facing staff in a number of agencies;
- developing multi-disciplinary and advanced training for care managers and other professionals across the care spectrum.
- broader issues such as the application of 'Better Government for Older People';

3.30 The centre would also become a source of expert advice on service and organisational issues, on good practice and on research and information on older people. It would also have a role in ensuring quality services are in place in hospitals, in the community and in people's homes by working alongside those responsible for standards and monitoring.

3.31 Without in any sense making direct comparisons, such a centre would perform a similar function to the Scottish Dementia Services Development Centre, the Scottish Development Centre for Mental Health and the proposed Centre for

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Learning Disabilities. Indeed one of its tasks would be to address interrelated questions with these other sources of expertise.

3.32 Most people recognise the need for a centre; but some are concerned that resources which could be applied to services would be tied up in infrastructure costs. We do not see this as a new structure per se. It could be attached to an existing facility or facilities – almost virtual in its physical presence, but far from it in effect. Costs should not therefore be significant, but the value substantial.

3.33 **We therefore recommend:**

The Scottish Executive should, in 2001, set up an older people's service development centre to champion the development of good and innovative community care services, promote training and assist implementation of the Group's proposals.

Summary

3.34 Older people have not been able to access the services they need to support them at home. We address that. Our proposals to rebalance care for older people require more services focused on care at home. The Framework for Mental Health Services and "The same as you?" do the same for people with mental health problems and learning disabilities respectively.

3.35 Our approach to rebalancing care for older people focuses on putting in place within set timescales 3key services. Investment in these services – which are flexible, responsive and joint - will strengthen agencies' ability, together, to care properly for older people in their own homes. To underpin these measures, we recommend new planning/ management systems focusing initially on older people, as set out in Chapter 5. The new national planning and financial framework will identify the collective new resources available for improving services for older people, and set priorities for action locally. And local joint resourcing and joint management of services will improve the way services are organised and delivered on the ground.

3.36 In making these recommendations, we recognise that one size does not fit all. Every area must put in place each service we recommend. But agencies locally will decide for themselves how to organise any particular service to suit their own circumstances. In particular, while urban areas may use the opportunity to employ more specialised staffing, rural areas may look for more multi-skilling and multi-tasking.

3.37 The key services we have identified are already in place in some areas, and have been proven to make a difference. They now need to be available across Scotland, and everyone who needs them should have access to them. The task facing all agencies is to reconfigure their services locally to focus on sustaining people at home. This may not be easy, but some have risen to that challenge and are already doing so successfully. Our combination of measures will enable many

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more people than at present to be cared for at home – properly and appropriately - and thereby reverse the trend since the community care policy came into being. That is what older people in Scotland want.

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CHAPTER 4

JOINT WORKING

4.1 Despite the continuing emphasis on and improvement in joint working since the community care policy was fully implemented in 1993 there remains, as indicated in Chapter 1, a long way to go. We want to use the positive developments in many parts of Scotland to overcome instances of resources not being used to the best effect, of systems and services not delivering for either users or agencies, and of professional skills not being properly utilised. We want to raise standards and achieve greater consistency.

4.2 Many of our proposals for rebalancing care will also improve joint working. Our task on joint working was to identify a set of measures which must be implemented. We may have wanted to do that across the whole of community care but in practice focused on a few key areas where better joint working will make a real difference. The 3 areas are:

- assessment and care management;
- sharing information; and
- equipment and adaptation services.

4.3 They are all at the heart of community care. Assessment and care management and sharing information are key processes which can contribute to effective outcomes. Equipment and adaptation services need modernisation. They have a large user base and a significant effect, but are often marginalised, fragmented or disjointed. Each will be more effective if more joined up.

4.4 Our approach to improving joint working – across all care groups - restores the person to the centre, and uses proven systems and practices, against a backdrop of joint resourcing and joint management of services as set out in Chapter 5.

Assessment and Care Management

A Single, Shared Assessment

4.5 There is widespread acknowledgement that assessment arrange-ments need to improve. Too often people are visited by several different professionals and require to repeat the same basic personal information. And because individual agencies do not accept others' assessments the whole process is often repeated. The experience in Perth & Kinross, as described in the 'Patients' Journey', of 37 steps in the assessment of an older couple - with the health and social care professionals meeting first at step 25 - illustrates the need to do better. Assessment has to focus on the needs of the person and should be organised to do this efficiently - not to suit professionals or agencies.

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4.6 There is also scope to make fuller use of self-assessment for lesser needs, as suggested in Modernising Community Care. Thinking needs to be more about how best to get effective outcomes for people, not about how to get them into systems (sometimes unnecessarily and with limited effect). Reducing unnecessary bureaucracy allows scarce resources to focus on those cases with greatest needs.

4.7 We aim to reduce that bureaucracy and duplication in assessments. We propose that there should be a *single,* shared assessment. For complex cases**,** different professionals with special expertise need to contribute (either from a multi-agency team or from a more specialist background). Housing professionals have an important part to play too, especially where housing is an issue. And through local protocols and training, the outcome of the assessment must be accepted by fellow professionals, irrespective of the lead professional. Responsibility for the assessment and ownership of the outcome will therefore be shared.

4.8 We expect single, shared assessments:

- to promote a structured exchange between the user and the assessor about perceived needs, including where relevant the views of informal carers. A separate assessment of the carer's needs should also be offered.

- to be undertaken by **one member** of the multi-agency team (the most appropriate lead professional), drawing on contributions from other members of the team as necessary. Contact with the service user for assessment purposes should be through the lead professional. If the assessment points to the need for specialist opinion, this should be sought, building on the basic information already collected.

- to be a passport to the full spectrum of community care services, with no subsequent reassessment necessary unless needs change.

- to include a financial assessment completed by the assessor (which recognises this being an integral part of the assessment).

- to be available to the person, and with their consent the main informal carer, together with the agreed care plan to meet their needs.

4.9 The single, shared assessment creates a single "gateway" or point of entry to the multi-agency team and community care services. It also presents a logical opportunity to seek the explicit consent of the person being assessed to sharing of information between agencies to help them respond holistically and efficiently to need.

4.10 Effective assessments have to be underpinned by an effective assessment tool. Some agencies have or are developing single, shared assessment tools. Further work may, however, be needed to meet our objectives.

4.11 We reviewed the Care Needs Assessment Packages (Carenap) for Dementia (D) and the Elderly (E) and their associated databases. We believe that these tools

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offer significant promise and with some refinement would meet our vision of a single, shared assessment tool. We understand that the Scottish Executive aims to support that refinement in partnership with the developers, and also enable more systems integration between primary care and local authorities.

Carenap E Pilot (Govan)

Carenap E was developed to reduce duplication of core assessment details. The tool has now been used in more than 460 assessments of older people, and has proved highly reliable. Assessors have begun to access services across professional boundaries using Carenap E as a form of "service passport". In general, assessments have been well accepted by service providers. The level of reassessment by other professionals has reduced, as has duplication. These are the outcomes users want. Because Carenap E focuses on need (met and unmet) it also brings direct benefit to service planning and provision.

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4.12 **We recommend that:**

Agencies locally should have in place single, shared assessment procedures for older people and for those with dementia by October 2001, and for all client groups by April 2002.

Agencies locally should have in place by October 2001, a single shared assessment tool for older people and people with dementia. Local agencies should either adapt existing systems or develop systems to achieve the outcomes specified in the report, or adopt Carenap 'D' and 'E'.

4.13 Our proposals will change markedly both the role of professionals and their participation in assessments. Two steps seem essential - firstly, through joint protocols agencies need to secure agreement locally on the systems for and ownership of assessments; and secondly, to train staff jointly in assessment practice. Putting these in place has to be an early priority.

'Intensive Care Management'

4.14 Care management was introduced in 1992, but has not developed uniformly. Like many parts of community care, it lacks consistency. It is not always clear who should receive care management; its meaning is interpreted differently; and while in some areas only social workers carry out care management tasks, in others a range of professionals are care managers. A recent conference referred to over 600 models of care management in the United Kingdom.

4.15 There is a need to refocus care management so that it is clear:

- what needs require care management;
- what tasks are involved;
- who carries it out; and
- what skills and knowledge care managers need.

4.16 Our first step is to change the title to reflect its purpose. For the purposes of this report, we suggest "Intensive Care Management". The second is to define its scope. It is for people with complex needs, or frequently or rapidly changing needs.

4.17 Most referrals for community care services can be dealt with by the provision of a straightforward service immediately, or following a brief assessment. To help, a number of screening tools are available (as set out in the 1998 circular[6]). For more complex cases, intensive care management will co-ordinate and deliver services in a way that is tailored to meet these people's needs.

[6] Circular SW 10/98: Community Care Needs of Frail Older People.

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4.18 The care manager can be a social worker, community nurse, occupational therapist or other similar professional. In integrated services, professionals lose their label and assume a more corporate role. The key qualities are their skill to judge the person's and any carer's needs, the knowledge and skill to secure and co-ordinate the full range of services, the skill to assess and manage inter-personal relationships between the person cared for and the carer; and the ability to manage a devolved budget. Research shows that better results emerge where care managers have devolved budgets - ultimately to individual professionals - and access to a wide range of resources from different services. Care managers need that flexibility if they are to respond to individual circumstances. Concerns about resource management and control of devolved budgets need to be addressed through systems development and training, rather than inhibiting the scope of care managers.

4.19 Local authorities and the health service must provide the organisational framework to support effective care management. We expect care managers to work in a climate of multi-disciplinary, multi-agency teams with joint resources, shared objectives and agreed priorities. Care management also needs to be more user-led; greater use of direct payments could, for example, be one of the results.

4.20 As a consequence of these changes, we envisage individual care managers being responsible for the long-term support of up to 40-45 people at any one time. Broadly speaking, this model of intensive care management parallels that developed in Kent[7], which has been evaluated extensively and proven to be successful.

4.21 Some people attending the seminars were concerned that the emphasis on care at home could result in very expensive care packages for older people, and suggested that there should be some form of cost limit. That is clearly not within our remit. But it is a matter for individual authorities to consider.

4.22 To redefine and reinvigorate care management, staff from different agencies will need training. We propose a new initiative to strengthen and develop the skills and knowledge of care managers - on a joint basis. It would be aimed at post-qualifying level, but the underlying concept also needs to be part of qualifying training across the respective professional groups. The outcome would be that only suitably qualified persons would act as intensive care managers.

4.23 **We therefore recommend:**

The Scottish Executive should redefine care management as 'Intensive Care Management' which will be for people with complex or frequently changing needs.

Care managers should be trained in 'Intensive Care Management' throughout 2001-2002. Only those who had undertaken such training should carry out 'Intensive Care Management'.

<u>Information Sharing</u>

[7] *PSSRU (1992) Care in the Community: Challenge and Demonstration.*

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4.24 We want to see our thinking on the joint management of services, more joined up assessments, etc. underpinned by a culture of information sharing which, in turn, seizes the opportunities for information systems integration. But we also need to reassure service users that personal information will be treated sensitively and stored securely in accordance with the law.

4.25 To support person-centred services, we need person-centred information systems. They need to extend beyond the starting point of sharing information between mainly statutory agencies in social care and health, to include housing, education, the voluntary sector and the Benefits Agency. That is the intention of e-government generally.

4.26 These issues are heavily influenced at the moment by action nationally. Firstly, the NHS Programme Information Management & Technology Board will take the lead in developing a strategic overview on how modern technologies can support community care services. It will report by October 2001.

4.27 Secondly, the Confidentiality and Security Advisory Group for Scotland (CSAGS) will take the lead in specifying the principles for information sharing to be incorporated in agencies' local protocols, to meet the requirements of the Data Protection Act (1998). It will report by April 2001.

4.28 Thirdly, the Social Work Information Review Group (SWIRG) will take the lead in identifying the information needs for community care, and its exchange. It expects to report by mid-2002.

4.29 In its short life, the Joint Future Group has been successful in ensuring that the separate health and social work information developments under the Programme Board and SWIRG respectively now cut across the wider community care information spectrum and take account of e-government's focus on the citizen, not agencies.

4.30 At a local level, while the developments above will bring their influence to bear in due course, enabling the transfer of information about a user by obtaining their consent must be an integral part of the assessment tool described earlier in this Chapter. This approach can indeed be implemented now, through specific agreement with the user.

Personal Record of Care (East Ayrshire)

To address apparent overlaps in the care of people with complex needs, a multi-disciplinary group developed a protocol to clarify agency/professional roles. As a result, multi-disciplinary care planning was consolidated in the user's personal record of care. The record is held in the user's home, as a communication tool for professionals, and clients and their carers. The record is therefore the common bond and commonly owned. The arrangement is supported by joint training and clear guidance on when and how to use the record.

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4.31 **We therefore recommend:**

The Scottish Executive should, by 2002, offer a strategic lead on the development of community care information, information sharing and systems integration.

Locally, the arrangements for single, shared assessments should include specific proposals for the necessary sharing of information between agencies, by obtaining explicit client approval.

Equipment and Adaptation Services

4.32 Equipment and adaptation services can make a very positive impact if they are organised and managed effectively. Demand in this area represents 25-45% of all referrals to social work departments, and adaptations are also a significant part of the work of housing agencies. We benefited from a detailed analysis of the problems facing equipment and adaptation services and their users. Our generic recommendation below is underpinned by a series of specific measures to achieve the desired outcomes. Our starting point was obviously joint working but our interest spread to related issues such as the role of occupational therapists who currently carry out most of the work in this area.

4.33 **We recommend:**

To modernise and improve equipment and adaptation services, the Scottish Executive should establish a strategic overview, and set out a programme of change that will require agencies locally to integrate equipment and adaptation services with the rest of community care services, and put in place a number of specific measures that will result in a better-focused and more effective service for the user.

Strategic Direction

4.34 To give equipment and adaptation services a much needed sense of direction we believe it is necessary to set up a national Strategy Forum – not necessarily a permanent feature – to be led by the Scottish Executive but with its membership drawn from leading players and users. It will review existing services and how they interact, develop a programme for change that will identify minimum service standards for information and self selection of equipment, and suggest research on the effectiveness of equipment, adaptations and rehabilitation services. **The Scottish Executive should set up a Strategy Forum by the end of January 2001.**

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Informed Choices

4.35 One of the weaknesses in equipment and adaptations services is a lack of good and accessible information for both potential service users and for professionals. We see this being addressed in 3 inter-related, ways:

- Firstly, **local agencies need to produce information for the public on existing equipment and adaptation services, by June 2001**. This can be in the form of booklets but could also use the opportunities afforded by IT.

- Secondly, the **Strategy Forum will produce guidelines on core information requirements for service users and assessors, by Autumn 2001**.

- Thirdly, we need local advice and demonstration services to help people make better choices by having a much better understanding of what is available and being able to try out potential solutions. A few facilities already exist, usually in the form of Disabled Living Centres, but a range of flexible and innovative services will be needed across Scotland. They can be developed in tandem with IT solutions or existing facilities such as one stop shops, healthy living centres, etc. In rural areas they may need to be mobile. The Strategy Forum will provide a lead. **Local agencies should put these services in place, in response to the Forum's guidance, across Scotland by April 2002**.

Joint Equipment and Adaptation Services

4.36 Developing more joined up services will be helped considerably by our recommendations in Chapter 5 on joint resourcing and joint service management. A joint approach will increase access across the often artificial boundaries between equipment and adaptations funded and supplied by the NHS, local authorities (social work or housing) or other agencies. It should also improve the efficiency and cost effectiveness of procurement, storage and distribution, and enable better access to stock through IT networks and other systems. Alongside these structural changes, we need to encourage recycling of equipment no longer required.

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Recycling of Used Equipment (Lothian)

The joint store in Lothian in one year had 23,000 items with a value of £0.9m returned for cleaning, refurbishment and ultimately re-issue. In the same period 63,000 new items were issued at a value of £1.4m.

4.37 North Lanarkshire Council reviewed its adaptation services between social work and housing in 1996. Many authorities across Scotland have used the resultant practice document. East Ayrshire Council has taken this further and developed a detailed service specification on work quality, timescales for completion and providing information to users, all with built-in penalties for default. These more specific purchasing criteria resulted in twice as many adaptations for half the cost. From a joint resourcing perspective, the housing department also transferred its adaptation budget to the social work department.

4.38 **Agencies should jointly resource and jointly manage equipment and adaptation services, by April 2002, and should consider the benefits or combined storage facilities as soon as possible thereafter**.

4.39 We were impressed by the contribution of care and repair schemes to sustaining people in their own homes, and welcome the commitment nationally to establish care and repair schemes in all areas of Scotland. But we also saw a need for agencies to be better informed of the level of adapted properties in their area (on which Scottish Homes issued guidance in 1999); for, in the light of initiatives on common housing registers, a single point of access to housing services; and for greater consistency in the allocation of tenancies.

Housing Registers: Disabled Person's Housing Service

The Disabled Person's Housing Service (DPHS) facilitates, through provision or advice and information, the welfare of people with disabilities with housing needs. Its Disabled Persons' Housing Register matches disabled people with suitable available housing.

4.40 **All local authorities should create, with their partners, (Scottish Homes, registered social landlords and the private sector) registers of adapted properties, by mid-2002**.

4.41 **The partner agencies (local authorities, Scottish Homes and registered social landlords) should have one point of contact for applications and a more joint approach to allocations through consistent and shared allocation arrangements, by 2002**.

Simple Solutions

4.42 We want to reduce inefficiencies and improve user choice by enabling users to decide for themselves on 'simple' equipment and adaptations. A number of

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studies show this is feasible and effective, if good information and advice is available. This is obviously related to our proposals in that field.

Self-selection: (Cornwall)

This study showed most people with modest needs – 80% of the total – were able to identify needs for themselves. They gained little from interventions of nurses, occupational therapists or social workers. Many required only minimal services/interventions to continue living independently. But rapid responses were vital to sustain self-confidence and a sense of independence. Effective outcomes resulted from good advice combined with opportunities to try out equipment.

4.43 Unqualified staff already offer advice on "simple" solutions under the guidance of qualified occupational therapists. Other staff could do this if appropriately trained in disability awareness, equipment and adaptation options, and sources of information, advice and demonstration.

4.44 The Strategy Forum is to draw up guidance on self-selection arrangements, and for training of staff, with the training itself co-ordinated by the proposed Centre for Older People (Chapter 3). Thereafter, **local agencies should put in place, by Autumn 2002 self-selection arrangements for "simple" solutions and training of staff by 2002/03**.

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Occupational Therapy Services

4.45 Proposals for joining up and improving equipment and adaptation services will inevitably impact on the work of occupational therapists. As demand for equipment and adaptations grows they are often seen as rationers of a limited resource. And inflexible organisational boundaries can mean both hospital-based and local authority occupational therapists being involved in one case. There are also questions about how the occupational therapy service should be organised, in the context of more joined-up health and social care services, to maximise the use of occupational therapy skills and enable other workers, qualified or otherwise, to play their part in providing equipment and adaptation services.

Using Occupational Therapists More Effectively

4.46 We recognise the need to change the role of occupational therapists so that they are not seen as the sole route to equipment and adaptations. Rather they should contribute to care solutions more generally by training and supporting others in managing “simple” solutions, developing complex packages of equipment and adaptations, and becoming more widely involved in intensive care management. They should have a pivotal and equal role in joint, co-ordinated hospital discharge arrangements; and be an integral part of intensive support services and multi-disciplinary community-based rehabilitation services (as indicated in Chapter 3).

4.47 Studies in Nottingham (McCloughry & Murphy 1998) show that 12 out of a sample of 21 people identified by social workers as requiring residential care were able to remain at home following occupational therapy intervention. And of 56 people receiving home care, half did not require the level of service being received when assessed by an occupational therapist (McCloughry & Lowe, quoted by DOH 1999).

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Kensington, Chelsea & Westminster Commissioning Agency and Westminster Social Services

Victoria Project: Community Occupational Therapy Rehabilitation Service

Grant from King's Fund to explore how health and social care can be purchased more effectively to meet older people's needs. Success based on combination of occupational therapy care management alongside rehabilitation, that resulted in significant reductions in care services.

Not all financial outcomes are available, especially on health care; but evidence shows a positive impact on reducing admissions and dependency, and on more appropriate use of health services. 92% of users showed significant functional improvement and health gain. Social care saved £65k through positive rehabilitation, rather than reacting to circumstances, and £14k on equipment and adaptations.

Organising Occupational Therapy Services

4.48 Current demarcations between 'health' and 'social care' occupational therapists are not helpful. There is a logical progression from accessing one another's services across organisational boundaries, to integrating certain services or parts of them (for example hospital discharge teams), and potentially to full service integration.

4.49 We recommend a staged approach. Firstly maximising co-ordination in community care services and then moving towards an integrated occupational therapy service within the wider context of the agenda for joined up and multidisciplinary health, housing and social care services.

4.50 Pointers to achieving these goals include commonality of boundaries, the right mix of specialist and generic skills, addressing issues related to pay and conditions and professional development and accountability, and consideration of the wider change agenda in community care.

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4.51 **We recommend:**

To target occupational therapy services more effectively, agencies need to modernise equipment and adaptation services, and to remove duplication between hospital and community based occupational therapy services wherever practical. For community based care services that reoganisation needs to begin as soon as possible, followed by the rest of health and social care within the context of the wider agenda for joined up health, housing and social care services.

Summary

4.52 This chapter sets out in some detail our proposals to improve joint working. They apply to all care groups. We have focused our attention on 3 important areas where improvement is clearly possible. The measures we propose are, as said elsewhere, of proven standing and testimony to those who have already addressed change. There will be organisational benefits for health, social work and housing services from more streamlined systems, more joint involvement and ownership of systems and, in the case of equipment services, a much needed joint approach to service organisation and delivery. But the ultimate goal is the positive effect on users of changes at the heart of community care. They should notice a real difference as a result of our proposals. Putting them in place must be a priority.

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CHAPTER 5

NEW FINANCIAL, PLANNING AND SERVICE MANAGEMENT FRAMEWORKS

5.1 This chapter introduces structural changes to underpin the service and operational recommendations in previous chapters on both rebalancing care for older people and on joint working. Some will apply nationally, some locally, and some to both. These planning, financial and service management frameworks all have one thing in common: they will contribute in their own way to improving outcomes for people who use services.

National and Local Financial and Planning Frameworks

5.2 As suggested in the Introduction and in Chapter 3, the financial and planning systems for community care have not necessarily helped the balance of care. Planning locally is increasingly joined up but resourcing less so; and nationally, priorities may not be linked formally to the allocation of resources. National and local planning and financing must be more integrated. The Strategic Issues Working Group has been considering a number of options for changing the funding of local government. We wish to apply some of their thinking, but to a wider pool of resources, across community care. We advocate a new approach of a partnership between the Scottish Executive and local agencies, focusing on all the new resources for community care – both capital and revenue - across social work, the NHS (including relevant acute services) and social housing; and deciding in partnership what to target these resources on and what outcomes to expect. That approach will bring a much needed and clearer link between resources and priorities.

5.3 A further critical issue is to underpin the new arrangements with stability of funding. The Minister for Finance announced the introduction of 3 year budgeting in his statement on 20 September 2000, starting in 2001.

National Programme Planning Group

5.4 We envisage this agenda being taken forwarded by a National Programme Planning Group. That group's role is not to develop policy. Rather, it will provide a strong lead and set targets for implementation of priorities that will ensure consistency and fairness across Scotland. The group will consist of key stakeholders including Ministers, elected and appointed members, senior managers and professionals from local authority, social work and housing departments, housing agencies and the NHS, and user representatives. It should:

- set development priorities and targets for local partners.

- monitor and assess local partnership agreements, and measure performance against such agreements.

- review financial arrangements at national and local level and ensure that they support integrated management of resources between partners. In particular, it should identify the relevant revenue and capital funding streams for acute and primary health care, residential and home based social care, and social housing;

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and advise on any reconfiguring to support the development of joint working and the achievement of priority service developments in community care.

- In a less formal way, we think it should also advise the Scottish Executive on ensuring that the legal and accountability arrangements for partners locally and nationally do not impede flexible partnership working, and on the extent to which national and local arrangements for performance measurement and management reflect and promote joint working. Lastly, it can disseminate good practice and reflect it in the development priorities and targets set.

5.5 We are very conscious that one alternative to our preferred approach would be more hypothecation of finance, and prescription of implementation mechanisms nationally. We clearly see that as second best. But to ensure that the Programme Planning Group can deliver, particularly on greater consistency across Scotland, it should have a degree of authority. It should, for example, be able to challenge local partnership agreements, and examine and advise on improving the existing financial, legal and performance frameworks for community care. Its precise ways of working can be developed more fully in the light of this report.

5.6 It may be asking too much to introduce these arrangements across the whole of community care. A staged approach seems appropriate. Services for older people take up the largest part of expenditure, offer considerable scope for changes of direction and are currently a priority. Early attention should therefore be directed to this care group, with others building on that progress.

Local Partnership Working

5.7 Moving from the national to a local perspective, Modernising Community Care proposed both more joint use of resources and more joint services locally. In their responses, agencies said they could do more within existing powers. There has been progress. Most people will be aware of the “Care Together” initiative in Perth and Kinross. And Glasgow has introduced joint management and joint resourcing of its learning disability services. The models are similar, as described briefly later.

5.8 These initiatives are very significant, but somewhat isolated. We know that some agencies still have doubts – at the margin at least – about their ability legally to have fully fledged pooled budgets. We also acknowledge the practical issues that creates. But like many of those at the seminars, we do not wish these doubts to get in the way of progress. We believe that a new lead is required, not just on bringing together agencies’ resources, but also on the management of services.

5.9 We are looking for an approach which reduces barriers, is practicable and deliverable, and provides better results for users. We believe jointly resourced and jointly managed community care services, either in the round or for each care group, achieves that. In future, that should be the norm. These arrangements give members the opportunity to take joint decisions on a bigger pool of resources, and opportunities to break down negative cultures, for mutual learning and, most importantly, to organise and deliver services in a more concerted way to the benefit of the person using the service.

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5.10 To explain what we mean, joint resourcing is about the resources at agencies' disposal – their staff, their buildings and their money, and how they use these resources jointly. As in other settings, we envisage relevant parts of health, social care and housing forming the nucleus of the local joint resource. The jointness is mainly in the use of these resources. As the models illustrate, decisions are taken by a joint body/single manager as appropriate. This approach is therefore not as advanced as pooled budgeting, but is more practicable at this point in time. And it is deliverable reasonably quickly. It is beginning to happen now. Pooled budgeting, in which resources are freely interchangeable in the pool and accountability joint may, however, be the Executive's longer-term aim.

5.11 Joint resourcing and joint management of services go together. Joint management brings health, social and housing services, as appropriate, under a single manager – of either community care services in the round, or of individual care groups. The manager can come from either a health or social care background. At the outset social and health care services, together with relevant elements of housing, may be separate entities under a common manager, but over time we expect progress towards joint services, facilitated in part by the growing use of joint teams and generic workers. As indicated earlier, there are existing models of joint resourcing and joint service management.

Glasgow: Joint Learning Disability Service

The joint learning disability service operates under a joint sub-committee of the Health Board, Council and NHS Trust, with member/officers drawn from each agency. The sub-committee has delegated authority to plan and manage services and, in turn, delegates that to an executive group of senior officials. They oversee a joint general manager who has responsibility for joint commissioning and joint management of learning disability services. This is a single, joint commissioning team which pools the collective resources and commissions all health and social care from the one 'pot'. At the moment it does not include a housing component.

On service management, Glasgow is about to move to integrated area learning disability teams with integrated single management, integrated care management, shared assessments, shared resources, and shared premises. Health staff will remain employed by the NHS Trust and social care staff by the Council. Individual team managers – of whatever discipline - will remain employed by their present employer but will have joint management responsibility for the whole team. The teams will have shared budgets.

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Perth and Kinross: Community Care Services

The Board, Trust and Council's model for joint organisation and delivery of care revolves around a "joint board" comprising members and officers of the 3 bodies. The joint board will have delegated powers and resources, and will operate within the current legal responsibilities of the respective organisations, but without the administrative barriers. The joint board will appoint a general manager, and has operated in shadow form from 1 October 2000. Staff will be officers of the joint board but will retain their existing pay and conditions.

The joint board's responsibilities will cover the resourcing and management of all relevant social and health care services for adult community care clients. That includes the Trust's secondary and intermediate care services but for the moment that covers only community services in the Local Health Care Co-operative. General Medical Services are not at present included.

Local Partnership Agreements

5.12 To consolidate this joint approach, we believe local agencies should draw up "local partnerships agreements". In due course, they will have regard to the lead and targets given by the National Programme Planning Group. The agreements will both inform communities about proposed service developments and allow scrutiny by the National Programme Planning Group. It is important to stress again that we do not see local partnership agreements as new policy statements, and thus a new layer of planning. Rather, they are action plans distilled from existing policy expressed in community plans, community care plans, HIPs and TIPs and housing plans. A local partnership agreement should include:

- the joint development priorities and targets for a 3 year period, covering the key community care client groups and carers, in the light of the lead from the National Programme Planning Group;

- developments in joint service management and joint resourcing proposed to support the stated development priorities and targets;

- the performance management framework to be used to monitor progress, evaluate impact, and guide corrective action if necessary. (This is likely to include local performance indicators, timetabled targets, user and carer feedback, service level pledges, etc. It should also include proposals for assessing outcomes.)

- the governance and accountability framework for the partnership agreement, straddling a number of local agencies. This could be a joint board, or joint programme commitments, or joint management arrangements with clear empowerment and reporting lines to parent agencies. (We would not wish to be prescriptive at the outset but the National Programme Planning Group will analyse proposals and ensure that robust frameworks for governance and accountability are in place.)

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5.13 We envisage partnership agreements being updated annually in the light of performance, feedback and financial circumstances. They should be part of existing plans (eg community care, HIPs etc).

5.14 Local partnership agreements will therefore set out the arrangements for setting up joint resourcing and joint management of services across the board. But in concert with our thinking elsewhere in the report, we believe it is important to make an early start on services for older people, with full implementation from 2002. Local partners who believe they can move faster on either older people or any of the other groups are encouraged to do so.

5.15 **To improve financial planning nationally and the financing and management of services locally, we therefore recommend:**

The Scottish Executive should set up a programme planning and financial framework, beginning with services for older people in 2001.

Local authorities (that is social work and housing), health boards and NHS trusts, and Scottish Homes should draw up local partnership agreements, to include a clear programme for local joint resourcing and joint management of community care services collectively or for each care user group individually.

As a step towards that, and recognising current progress on the ground, every area should introduce joint resourcing and joint management of services for older people from April 2002, and in preparation for that introduce shadow arrangements in the course of 2001-02.

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CHAPTER 6

HUMAN RESOURCES ISSUES

6.1 We have identified a mix of organisational, structural and practical measures to rebalance care and to improve joint working. But we acknowledge that people, not just structures, create and support change. We need to help staff across agencies overcome barriers to change. We commissioned a helpful presentation from Human Resources/Personnel Managers from local authority and health settings.

6.2 As services move closer to the user and at the same time social care and health services become more joined up, added importance attaches to breaking down traditional cultures, the more rigid employment practices, differing terms and conditions, etc. in both health and social care. This calls for strong leadership locally and greater emphasis on joint training and development, within a partnership framework which gives staff appropriate security through involvement and support, and at the same time enables them to address change positively. We recognise that a more structured approach to human resources issues generally will pay dividends in terms of improved joint working, determining joint visions and reducing divisions between staff groups and between their employers.

6.3 The presentation identified, amongst other things, a number of recommendations which could form the agenda for a national network group on human resource issues across the community care spectrum, as follows:

- joint service provision requires to be more systematically supported by organisational development programmes, which help form strategic alliances and partnerships;

- the competencies required for leaders in the NHS and local authorities require to be integrated, based on personal development planning;

- a more structured approach to secondments of senior staff between health and social work would increase understanding of differing cultures and working arrangements;

- discussion with education providers is needed to ensure that professional training reflects the need for joint provision of services centred around individuals and based on effective teamworking;

- joint training requires a systematic approach and commitment at a strategic level to support joint community care plans;

- a staffing framework should be agreed by the NHS, local authorities, the trade unions, and the voluntary and private sectors ;

- opportunities should be sought to achieve where possible alignment of the varying terms and conditions and pension arrangements;

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- regulatory bodies need to be sufficiently flexible to accept dual registration or to accept transfer between regulatory bodies, and recognise the continuing professional development requirements of other bodies.

6.4 We endorsed these vital issues but recognised that addressing them was both outside our direct remit and our tight timetable. We resolved therefore to refer them to the NHS Human Resources Directorate in the Health Department. It, in turn, is setting up a network group, comprising a wide range of trade union, professional and management interests across health and social care to take forward these issues, within the wider modernisation/partnership agenda more generally.

6.5 Our recommendations throughout our report hinge on the quality, training and flexibility of, particularly, front line staff. Selecting, training and retaining staff to deliver the desired outcomes in a changing environment will undoubtedly be one of the challenges for the future. Joint training - of managers, professionals and front line unqualified staff - has to be a prerequisite.

6.6 Although we did not make a formal recommendation on human resources issues, that does not diminish the importance we attach to them. As this chapter makes clear, human resources will be central to the progressive development of community care. People's ability to move from one employment field to another, across agencies and across sectors, and to have joint training with colleagues are important examples of our vision for the future. But a more systematic and holistic approach to the range of human resources issues is required to achieve that.

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CHAPTER 7

CHARGING FOR HOME CARE SERVICES

7.1 We were invited to offer advice on charging for home care services. Local authorities have considerable discretion on what charges, if any, they make and on how they set these charges.

7.2 The task had two elements. The first was to consider steps to reduce the inconsistency in charging for home care services between areas of Scotland. Our proposals are set out below in paragraphs 7.3 to 7.5. The second was to consider any new policy on charging in the light of, amongst other things, the Royal Commission on Long Term Care's[8] recommendations on free personal care. While recognising the principles which underpinned the Royal Commission's recommendations, we preferred approaches to charging that not only helped older people financially, but also supported community care more directly. Our proposals are set out below from paragraph 7.6 onwards.

Improving Consistency

7.3 Charging for services is an integral part of the funding of social care. Practice has evolved often as a consequence of financial pressures. As a result, the levels of charge and charge construction vary considerably from authority to authority. Greater consistency is clearly required. The Convention of Scottish Local Authorities (COSLA) has been looking at this since before the JFG was set up. We support their initiative.

7.4 **We recommend therefore:**

COSLA should develop guidance on charging policies to reduce the inconsistencies in home care charging.

7.5 COSLA is now consulting on a number of approaches authorities might adopt to improve consistency. These include setting common income thresholds above which charges would apply; an agreed minimum for the treatment of capital, with no maximum; housing, mortgage and council tax payments to be disregarded; and a standard disregard for dependent children. The objective is that local authorities should take a more strategic view of charging policy and its relationship to overall plans and objectives. The desired effect is greater consistency in charge construction, and users of services being left with sufficient money to have a reasonable quality of life. The role of benefits is obviously pivotal. COSLA's proposals include a benefits check as part of any proposal to charge and, secondly, that an individual's resources left after any charge should exceed the level of Income Support and any premiums.

Charging Policy

[8] Royal Commission on Long Term Care (1999) *With Respects to Old Age*

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7.6 Our starting point was to consider whether home care services should be provided free of charge. We concluded that providing free home care services as a whole would be unaffordable, would give rise to inconsistencies with the benefits system and would do nothing to develop better community care services. We explored a number of options and focused on two:

- free home care for older people for up to the first 4 weeks after hospitalisation; and

- free personal care for those older people receiving most care, who might otherwise be in residential, nursing home or hospital care. (For reference purposes, this group of people are described as requiring "extended home care").

Up to 4 Weeks Post Hospital Care for Older People

7.7 Our proposals aim to facilitate an individual's discharge/ resettlement and to benefit them financially, for a limited period. They also support both rehabilitation and the initiatives to speed up discharge. We want older people to receive care at a critical time, possibly more intensively than needed for the longer term, and get back on their feet without worrying about the cost of their care.

7.8 For these purposes we define older people, as men over 65 and women over 60. The extension would follow discharge from in-patient acute hospital care. It should be limited to a maximum of 4 weeks in each case. For these purposes home care means personal care or other social work services, including equipment, provided in the home within the maximum 4 week period.

7.9 Local authorities will therefore have to decide, just as they do at present, how long a person needs support following discharge. Four weeks is not a norm. It is a maximum, only for charging. We recognise some people will not need 4 weeks, but others may need more. The limit will cover the vast majority of cases. Setting a time limit gives a clear message about duration, and reduces incentives to prolong the initial level of care unnecessarily.

7.10 We also considered - but rejected on practical grounds - offering relief from charges to stop people going into hospital in the first place. It has been suggested that under our proposals professionals and users could collude to engineer a stay in hospital so as to secure free post hospital care. But we do not believe that is realistic.

7.11 Some councils already operate "home from hospital" schemes. Some charge, some do not. Our proposals would mean that all older people would get a free service for up to 4 weeks.

7.12 **We recommend therefore:**

free home care for older people for up to 4 weeks after leaving hospital.

Extended Home Care

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7.13 We recognise that a small number of home care users receive very high levels of home care, usually provided by both health and social care services to sustain them at home. Without that level of help, these people would almost certainly be in residential, nursing home or even hospital care. This is therefore effective community care.

7.14 Charging for these services is a recognised part of the financing of local authority services. Moreover, the benefit system provides resources, with a dependency differential, to help individuals meet the added cost of frailty or disability, including paying for care.

7.15 We believe that people who need substantial levels of care should not have to pay a premium, just because they are more infirm than others. In hospital, they would not pay at all, and in residential or nursing home care their care costs would be met wholly by the state if they had limited resources; partly by the state if they had modest resources; and if they were better off they would have to pay the whole cost themselves. Because of local authorities' discretion, people paying for home care are currently treated differently from area to area, though only a few pay the full costs. Nevertheless this can, depending on the levels of local disregards, make care at home financially unattractive.

7.16 We are told that charging for social care can be an impediment to developing joint packages of care, especially where agencies are working towards or already have generic workers or other blurring of professional roles. We would want charging to support joint working wherever possible.

7.17 Our approach aims to support joint working, and the home care policy generally. It also recognises the contribution which benefits can make to an individual's ability to pay for care. Moreover we believe that people who use services will understand that getting greater levels of care should not necessarily result in a greater charge.

7.18 We propose to provide relief for the additional cost of care of those people who receive 'extended home care'. 'Extended home care' means a range of specific tasks to be defined, provided by both health and social care staff. The crux, however, is their intensity. To secure relief from the charge would require at least 4 such interventions a day. To maintain a link with the benefits system, the person would, however, continue to pay for 'ordinary' home care or other services. How to measure both 'extended home care' and 'ordinary' services will be discussed with COSLA.

7.19 **We recommend therefore:**

Free home care for older people receiving "extended home care", (though they would still pay for 'ordinary' services).

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CHAPTER 8

GOOD PRACTICE

8.1 Our task is to set a new direction for identifying and sharing good practice. As this report makes clear, much of our work is founded in good or innovative practice. We were struck both by the number of good practice examples in Scotland and the growing number of "players" in the development and dissemination of good practice.

8.2 We attribute that increasing interest to a combination of factors: the Government's greater emphasis on service quality, Best Value, organisational learning and standard setting, as well as broader social trends such as life-long learning, advances in information technology and the growing involvement of service users and their carers.

8.3 In considering options for the collection and dissemination of good practice, we want to minimise 're-inventing the wheel' locally, with all the effort and wasted opportunity that can generate.

The Current Picture

8.4 Our analysis of the current arrangements for sharing good practice identified 3 broad categories of activity. The first comprises organisations whose role is to drive, gather, evaluate and disseminate good practice as a core function. In Scotland, this includes the Nuffield Community Care Database, the Designed Healthcare Initiative, the COSLA Website to showcase good practice (under development) and the Scottish Inter Collegiate Guidelines Network (SIGN). Bodies in England include the Idea and Development Agency, Evidence Base 2000 and the NHS Learning Network (to be subsumed into a Modernisation Agency). In addition to their common focus, this group of bodies is distinctive because of the interactive methods used to share good practice, such as networking and interactive databases.

8.5 The second category focuses on those organisations associated with the development, dissemination and monitoring of standards. They identify good practice as a by-product of standard setting, review or inspection. Examples in Scotland include the Clinical Standards Board, Scottish Homes, Best Value Groups, Audit Scotland, Social Work Services Inspectorate, the Scottish Health Advisory Service and the forthcoming Commission for the Regulation of Care.

8.6 The third category is characterised by more focused activity such as centres of expertise, professional bodies/development units and those engaged in academic activity or consultancy. The Scottish Development Centre for Mental Health and the Scottish Dementia Services Development Centre are centres of expertise driving change in a specific client group. And professional bodies such as the Royal College of Nursing, the British Association of Social Workers, the College of Occupational Therapy, and the Chartered Institute of Housing all engage with their membership on issues of professional good practice. Academic activity and research is sponsored in part by the statutory sector and includes the Nuffield Centres, the NHS Research and Development Fund and the work of the Scottish Executive Central Research Unit.

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8.7 We concluded that the links within and between these categories of organisation are incomplete. As a result good practice is not spread on the widest possible basis. The existing knowledge base is not being maximised. We want to develop a culture of inter agency knowledge management and learning. We also considered recent research by the Office for Public Management[9] into the dissemination and uptake of good practice. A variety of approaches will be necessary to achieve our aim, to cover different types of knowledge, the range of bodies and the geography of Scotland. We need to harness information technology, but recognise that while technology makes sharing more practicable, it does not of itself make it happen.

The Way Ahead

8.8 As a result of our analysis we recognised the need to:

- encourage those who develop good practice to disseminate it more widely;
- encourage more face to face exchange of more complex good practice through multi-agency networking;
- linking as many as possible of the bodies to maximise the information available and the number of recipients in community care; and
- make better use of information technology, particularly the use of interactive databases.

8.9 We looked at 2 approaches. The first would involve central co-ordination of good practice activity under the auspices of a Scottish centre, linked to the range of bodies above and with a specific role to lead and develop good practice in Scotland. The second would encourage the linking of current bodies into a network without disturbing their separate identities, using the advances of information technology. This will bring greater cohesion and maximise the considerable public resource already invested in many of their activities. We concluded that greater benefit would lie in linking existing players to achieve better co-ordinated activity and to develop effective systems to co-ordinate and disseminate their outputs.

8.10 Improving good practice is a longer term objective. But work to set in train the desired outcomes needs to begin shortly.

8.11 **We therefore recommend that**:

The Scottish Executive should, by mid 2001-02, identify measures to improve the collection and dissemination of good practice by linking together the bodies in the field in a more cohesive structure, using the benefits of networking and information technology.

[9] The Office of Public Management (2000): The Effectiveness of Different Mechanisms for Spreading Best Practice.

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CHAPTER 9

IMPLEMENTATION

9.1 The Group reports formally to Susan Deacon, Minister for Health and Community Care. It will be for Ministers to decide to accept the report, in whole or part. We envisage, however, a short period of consultation with interested parties. This would include referral to the Health and Community Care Committee which is nearing the end of its Community Care Inquiry.

9.2 In proposing change, we have not had to be radical. Much of what we recommend is already there, in part at least. Our proposals will, however, build key measures into the fabric of community care, across the board.

9.3 The changes we recommend should not be optional. We believe that agencies, their management, professionals, and indeed users and carers all realise that implementing these changes, quickly, is essential if community care in Scotland is to be more effective. Ministers will decide how to do that.

9.4 We recognise in our recommendations the need for closer links between resources - especially new resources made available nationally - and delivery of outcomes against them. Possibilities to achieve that might include:

- working under the financial proposals set out in Chapter 5, if they are introduced quickly;

- agencies submitting joint proposals to achieve our goals against new resources. This might be termed a change fund approach; and

- directing agencies.

9.5 The consultation seminars suggested a willingness on the part of agencies to implement our proposals. A number did however express concern that a directive/prescriptive approach might not sit well with the partnership approach being advocated in at least some of our recommendations. The Executive's statement on older people proposed discussions with the Convention of Scottish Local Authorities on how to achieve the desired outcomes, and we welcome that.

9.6 We have produced a strong set of recommendations at a time when a new lead is required. This is a great opportunity for Ministers, for all the agencies involved in community care and their staff to accept and run with the challenge we present. We believe there is a strong will to do that. It is now down to all concerned to make that happen. We look forward to our recommendations being acted upon, both locally and nationally, in a sense of partnership.

<u>Resources</u>

9.7 We recognise that some of our recommendations will have resource implications. On the other hand, some will result in better use of existing resources

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and better service outcomes. Agencies need to look very carefully at the way they resource existing services and systems, and identify the scope for their better use.

Conclusion

9.8 This is the beginning, not the end. Individual agencies have very different starting points, but we hope our recommendations will bring to the vast majority of people using community care services better quality services, better systems and as a result better outcomes available more consistently across Scotland. We expect the Scottish Executive to look for demonstrable progress by agencies on delivering our recommend-ations.

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APPENDIX 1

HOW WE WENT ABOUT OUR WORK

1. Susan Deacon, the Minister for Health and Community Care, announced the setting up of the Group at the end of December 1999. We met first in February, and then on 5 subsequent occasions.

2. We drew on the knowledge and understanding of individuals within the Group and on advice from officials in the Scottish Executive. We also received presentations from the then Invest to Save Project Team in Perth and Kinross, now known as 'Care Together'; Directors of Human Resources and Personnel in local authorities and the NHS; and the Nuffield Centre for Community Care Studies on its good practice study. We are grateful for the quality and concise nature of these presentations.

3. Towards the end of September we held 4 regional consultation seminars to bring the general thrust of our proposals to the attention of leaders of councils, health boards and NHS trusts, their senior management, and representatives of providers and users and carers. These seminars endorsed our general direction of travel; but we received many requests for additional information or clarification, which we hope this report now provides.

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APPENDIX 2

JOINT FUTURE GROUP

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1. The main aim of the Group is to find ways to improve joint working in order to deliver modern and effective person-centred services.

2. Its primary task is to agree a list of joint measures which all local authorities, health boards and trusts should have in place to deliver effective services, and to set deadlines by which this must be done. It will also act as a Steering Group for a short series of regional seminars to take forward the themes from the 5 November 1999 seminar at a more local level.

3. The Group will advise on:

- the balance between residential and home based care; having regard to the opportunities for flexible home care services, smart technology etc;

- options for dealing with charging for personal care delivered at home (including the relevance of the Royal Commission's recommendations);

- how to identify and share good practice.

4. Within these broad parameters, the Group will have extensive scope. Its aim is to produce sound practical proposals which can make a real difference, some hopefully with early effect. It must, however, have regard to costs of and speed of implementation, and recognise that some proposals could ultimately require legislation.

5. The Group should report formally on the balance of care and charging issues by the end of June, and on the other matters by the end of September. It may, however, announce milestones as its work progresses.

6. In managing its business, the Group may co-opt or invite others to participate in meetings; can commission work; and would want particularly to recognise the interface with users and carers, housing, and the voluntary and private sectors.

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APPENDIX 3

JOINT FUTURE GROUP: MEMBERSHIP

Iain Gray, Deputy Minister for Community Care (Chair)

Oonagh Aitken, Chief Executive, COSLA
Tim Davison, Chief Executive, Greater Glasgow Primary Care NHS Trust
Colin Mair, Scottish Local Authority Management Centre
Councillor Rita Miller, South Ayrshire Council
Dr Linda Pollock, Director of Nursing, Lothian Primary Care NHS Trust
Jacquie Roberts, Director of Social Work, Dundee City Council (as from 2 June)
Heather Sheerin, Chairman, Highland Primary Care Trust
Margaret Wells, Director of Housing & Social Work, Aberdeenshire Council
Jenny McNeill, Scottish Executive, Joint Future Unit (Secretary)

Scottish Executive Officials in Attendance

Rosemary Bland, Community Care Team, Social Work Services Inspectorate (to 28 August)
Stephen Gallagher, Joint Future Unit
Liz Lewis, Community Care Division (to 28 August)
David Meikle, Joint Future Unit
Gill Ottley, Assistant Chief Inspector, Community Care Team, Social Work Services Inspectorate (to 28 August)
Susan Scott, Community Care Team, Social Work Services Inspectorate
David Pia, Assistant Chief Inspector, Social Work Services Inspectorate (as from 2 October)
Thea Teale, Community Care Division (as from 28 August)
Dr Kevin Woods, NHS Management Executive (to 26 June)

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