HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 5 December 2001
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE

30th Meeting 2001, Session 1

CONVENER

Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Nicola Sturgeon (Glasgow) (SNP)

*attended

WITNESSES

Mr Michael Buckley (Scottish Parliamentary and Health Service Ombudsman)
Professor Juliet Cheetham (Mental Welfare Commission for Scotland)
Danny Crawford (Scottish Association of Health Councils)
Dr James Dyer (Mental Welfare Commission for Scotland)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Graeme Elliott

LOCATION

Committee Room 1

Scottish Parliament

Health and Community Care Committee

Wednesday 5 December 2001

(*Morning*)

[THE DEPUTY CONVENER *opened the meeting at 09:33*]

Items in Private

The Deputy Convener (Margaret Jamieson): Good morning. Before we start our main item of business, I need to ask members whether they agree to discuss items 5 and 6—which are on the appointment of an adviser on organ donation for transplantation, and discussion of potential witnesses for the Tobacco Advertising and Promotion (Scotland) Bill—in private. Is that agreed?

Members *indicated agreement*.

Community Care and Health (Scotland) Bill: Stage 2

The Deputy Convener: No amendments to the Community Care and Health (Scotland) Bill have been lodged for stage 2. Motion S1M-2500 indicates the sections of the bill that are to be considered together.

I move,

That the Health and Community Care Committee consider the Community Care and Health (Scotland) Bill at Stage 2 in the following order: sections 8 and 9, sections 10 to 14, sections 15 to 18, sections 1 to 7, sections 19 to 22, the schedule, sections 23 and 24.

Is that agreed?

Members *indicated agreement*.

Scottish Public Sector Ombudsman Bill: Stage 1

The Deputy Convener: This morning we are taking evidence at stage 1 of the Scottish Public Sector Ombudsman Bill from Mr Michael Buckley, who is the Scottish parliamentary and health service ombudsman. Good morning and welcome to the Health and Community Care Committee. Do you wish to make a statement before members ask questions?

Mr Michael Buckley (Scottish Parliamentary and Health Service Ombudsman): I am very happy to do so if that would be of convenience to the committee.

I thank you for the opportunity to give evidence to the Health and Community Care Committee on the bill that will establish a public sector ombudsman in Scotland. The Scottish Public Sector Ombudsman Bill is the culmination of a long process, which started with the enactment in 1998 of the Scotland Bill. Section 91 of the Scotland Act 1998 states:

"The Parliament shall make provision for the investigation of relevant complaints"

of maladministration.

The Scottish Executive began a consultation process in October 2000, which culminated in the bill that is before us. Ombudsman arrangements south of the border have been the subject of a similar review, although that has not yet resulted in any firm legislative proposals; Scotland is showing the way. I welcome the Scottish Executive's early commitment to legislation, which will enact reforms that are designed to produce a user-friendly and effective ombudsman service for the Scottish public. I submitted evidence to both consultations jointly with my Scottish ombudsman colleagues. My staff have played a full part in a number of working parties with the other ombudsmen's staff and the Scottish Executive, on whose joint steering group they also serve.

Only by the creation of a single, unified ombudsman scheme can the difficulties that are faced by those who wish to pursue complaints against bodies that are in separate jurisdictions be removed. An obvious example is a complaint about discharge from an NHS trust into care that is provided by a local authority social work department or care service. It is right in these days of joined-up government and cross-department service delivery that citizens should be able to make complaints without needless and artificial restrictions. I therefore welcome the bill's provision of a new, unified public sector ombudsman.

Although many aspects of the bill are either policy matters—which are, properly, the concern of the Scottish Parliament—or detailed operational matters, I have concerns about three elements of the bill. I have outlined those concerns in the memorandum that I have supplied to the committee.

First, the bill almost exclusively emphasises investigation. The only functions of the new ombudsman that are mentioned in the bill are investigation and reporting. The bill is not flexible enough in that respect. It would have been preferable to draft the bill in more general terms, leaving as much as possible to the ombudsman's discretion. That would reflect the working methods that are employed by the existing ombudsmen and allow some flexibility in future as technological and social change occurs.

I understand that the local government ombudsman published only nine reports of formal investigations in 2000-01, compared with 210 complaints that were informally resolved. I expect that, increasingly, complaints that relate to matters that are now under my jurisdiction as the Scottish parliamentary ombudsman will be resolved informally. I recognise that certain types of complaint must be dealt with by formal investigation resulting in a statutory report. I am thinking particularly about the complex clinical complaints that I received as health service ombudsman. It is surely right that the principle of the ombudsman's resolving each complaint in the most appropriate manner—with the capacity that is necessary to resolve complaints speedily—should not be unnecessarily restricted under the bill.

Secondly, it is not clear to me whether the position of the existing staff of the three ombudsmen has been properly protected. The bill as introduced might not conform to the code of practice on staff transfers in the public sector. Although I recognise that detailed examination of the provisions relating to staffing and pensions are perhaps more properly a matter for stage 2 consideration, it is surely an important principle that equitable arrangements and adequate protection for employees should be enshrined in the proposed legislation.

Thirdly, I am afraid that the terms of the bill might give rise to incorrect impressions about the ombudsman's independence. As things stand, the determination of the pay, allowances and pensions of the ombudsman and of his or her deputies will be undertaken by the Scottish Parliamentary Corporate Body, which is currently within my jurisdiction as Scottish parliamentary ombudsman. It is proposed in the bill that the SPCB, or "Parliamentary corporation", be within the jurisdiction of the new ombudsman.

If the ombudsman is to function successfully, credibility in the eyes of the general public and of the administrators in the organisations that are subject to his jurisdiction will be essential. Clearly, the ombudsman must be impartial and independent of those bodies or organisations and must be seen to be so. It might pose a problem if his or her terms of service can be determined by a body that is within his or her jurisdiction.

Those are the three aspects of the bill about which I have some reservations. Nevertheless, I emphasise that I broadly welcome the bill as introduced, because it makes provision for an ombudsman service that is open, efficient, accountable and responsive to the needs of the public.

The Deputy Convener: Thank you. Members will now put questions to you. I start by asking whether sufficient consultation has taken place about the one-stop-shop element of the bill?

Mr Buckley: As far as I am concerned, sufficient consultation has taken place. The Executive consulted my office and me and we had the chance to input significantly. We sent memoranda on the first and second consultation documents. I have no criticism to make of the consultation process.

The Deputy Convener: Have the views that were expressed in the consultation process been taken into account in the bill?

Mr Buckley: I think that they have been. As I said, I have some reservations, in particular about the need to provide for a flexible method of working. We should not tie everything down to investigation and reporting; we made those points throughout the consultation process. As I said, I am not satisfied that the bill allows sufficient latitude in that respect.

The Deputy Convener: Will pulling together the various ombudsmen produce a lack of clarity? It might be that those who are drafting the bill are looking to one particular area and forgetting that things can be different in others, in particular in the health service.

Mr Buckley: There is probably a temptation to take the existing legislation and try to put it all together. The bill is successful in one of its main aims, which is to remove the barriers between the existing schemes. As I said in my opening statement, it is easy to imagine a complaint that involves a national health service trust and a local authority. At the moment, if someone is dissatisfied with those public sector services, they must make two separate complaints to two separate ombudsmen who will conduct two investigations—although they may exchange information—and produce two reports. At least we are getting rid of that. The tendency has been to

take the existing legislation and remove some of the worst problems rather than to start with a clean sheet of paper and ask, "What is the best way of achieving the result that we are trying to achieve?"

The Deputy Convener: During the consultation process, did you make the point about starting with a clean sheet of paper? If so, does the bill as drafted contain significant errors in respect of the proposed public sector complaints service?

Mr Buckley: The bill undoubtedly provides the basis for a better public sector complaints service. I stress that, in broad terms, I welcome the bill. However, I repeat that I am concerned about the pressure to push everything into investigation and reporting mode, which tends to be a cumbersome and long-drawn-out way of going about things. That said, in some circumstances, including in complex clinical complaints, it is inevitable that things have to be dealt with in that way.

Complainers come to the ombudsman with problems, for example they are not getting the right rates of benefit from the Benefits Agency or are council tenants whose roofs have not been repaired. Those complainers do not want a long investigation into why their problems have occurred; they want their problems sorted out. That aspect of the ombudsman's work should be acknowledged more in the bill.

There is a risk that the courts—by way of judicial review—or auditors will say to the public sector ombudsman, "Sorry, you are here to investigate and report. You are not here to sort things out by resolving complaints informally." If a high proportion of business is done informally, it would show common sense if the provisions of the bill reflected that fact.

Mr John McAllion (Dundee East) (Lab): I want to turn to the remit of the ombudsman. The proposed remit excludes some of the advisory non-departmental public bodies. Are you satisfied with the proposed remit? Should the remit be expanded in future?

Mr Buckley: The remit reflects the existing remits of all the ombudsmen, with a few additions. The remit is a matter for the Executive to propose and the Parliament to dispose. I take the view that it is not a matter for me to judge. The other ombudsmen share that view. It is for Parliament to decide on the appropriate remit and for me, as ombudsman, to carry it out as effectively as possible. I am sure that my colleagues and any future ombudsmen would do the same.

Some overseas ombudsmen have the police within their jurisdictions. Whether we should include the police within the jurisdiction of the new ombudsman seems to me to be entirely a political matter—for the Executive to propose and the Parliament to dispose. It would not be proper for an ombudsman to express a view.

09:45

Mr McAllion: In considering the remit, Parliament might find your views helpful. Should the police be included?

Mr Buckley: I know from colleagues from overseas that the police can be included, so it is not impossible. As to whether it should be done, I really do not think that it is for me to say.

Mr McAllion: I want to turn to the powers of enforcement over any authority that refuses to follow a recommendation or that fails to remedy an injustice. The policy memorandum says that there was general agreement that that should be left to Scottish ministers. Do you agree with that? If so, why?

Mr Buckley: I agree that findings, conclusions and recommendations of the ombudsman should not be legally binding. I have two main reasons for saying that. First, if they were, one would have to consider article 6 of the European convention on human rights, because the ombudsman would be determining rights and obligations. That would lead to pressure to adopt a more court-like procedure, which would be a great pity.

Secondly, I am always conscious that I, as an ombudsman, am an unelected office holder. I have no democratic mandate and it is right that decisions on important policy matters, or decisions that involve substantial public expenditure, should be decided within the democratic process, or—if they follow from a court action—in accordance with the law. I do not think that it is right that ombudsmen should be able to dictate to the elected representatives of the people or to those who are accountable to those representatives.

Clearly, I would be unhappy if recommendations were frequently ignored. An ombudsman's recommendations should not be binding in law, but they should be taken seriously. If they are not accepted, whoever does not accept them should be required to justify their refusal to do so; that can be done through the democratic process.

Mr McAllion: I understand your point that, unlike you, ministers are elected and have democratic authority, but what happens if ministers ignore the fact that various authorities are refusing to remedy injustices? Is there some way in which Parliament can be involved?

Mr Buckley: There is. It would certainly be possible to have an understanding that, if ministers in the Executive rejected findings and recommendations of the ombudsman, they should be required in some way or other to secure the endorsement of the Parliament for that rejection. I am sure that that could be done but—again—

whether it should be done is a matter for Parliament.

Mr McAllion: I am sure that the whips would ensure that the Executive got the necessary support.

Mr Buckley: Yes, but I am talking about the constitutional theory.

Mr McAllion: On a number of occasions, you have spoken about artificial restrictions that, under the present system, interfere with people's right to make a complaint against an authority. Can you give us a couple of examples of that, and explain the way in which a one-stop shop would remedy the problem?

Mr Buckley: The example that I use is deliberately drawn from the health sphere, because that is the one with which I am most familiar. We know of a case in which there was discontent about the way in which a health trust discharged a patient into the community. There were problems with liaison between the health trust and the local authority and problems with the care for which the local authority was ultimately responsible. As far as the patient was concerned—or as far as anyone who might have complained on his or her behalf was concerned—there was just one episode of care. It is pretty unreasonable to say that a person must find out exactly for what the trust was responsible and for what the local authority was responsible. One must remember that people are frequently inarticulate and that, perhaps as a result of such an episode, they might have considerable problems on their hands. People should have to make only one complaint.

I will give an example from south of the border, because similar problems arise there. A complaint was made about a trust's treatment of a patient, which was followed by the patient's being discharged into a nursing home, in which the health authority—the equivalent of a health board in Scotland—was responsible for supervision. However, the local authority paid for the care. Complaints were made against three bodies. The first complaint was dealt with under the NHS complaints procedure, but because the second was about a health authority and was within the jurisdiction of the health ombudsman, I had to investigate it. The remaining local authority complaint had to be considered by one of the English local government ombudsmen. Two separate reports appeared at different times, which had to be put together. From the point of view of the complainer, the situation was totally unsatisfactory.

Mr McAllion: The bill seeks to ensure improved consultation between the ombudsman and other statutory ombudsmen and commissioners. Will you explain how that will work in practice, and say what inconsistencies arise currently because of the lack of consultation?

Mr Buckley: To an extent, the bill aims to preserve the current position rather than to change it. There exists the potential for frequent complaints about freedom of information. Complaints from people who cannot secure access to official information or information that is held by a public body are often part of complaints about maladministration or poor service. People are not happy and cannot get the information that they need to pursue complaints. One certainly does not want to put complainers to the trouble of having to make one complaint to the ombudsman and another to the Scottish information commissioner.

We suggested and managed to secure in the Freedom of Information Act 2000 the ability for ombudsmen to consult each other and exchange information. I hope that the legislation in Scotland will allow the new ombudsman to tackle freedom of information complaints in consultation with the information commissioner. There will be no statutory barrier to exchanging information and consultation. Complaints will be handled through one investigation, rather than through two separate investigations. The measure is intended to ensure that we do not have trouble in the future, rather than to cure present troubles.

Mary Scanlon (Highlands and Islands) (Con): Two of the three concerns in your memorandum are about the protection of your staff, and who determines the ombudsman's pay, allowances and pension. The third concern implies that the current system is better and less likely to be challenged. My impression is that you do not much like the bill. Will you enlarge on what you believe to be the potential problems?

Mr Buckley: I see three problems, but I do not want to suggest that my unhappiness extends to most of the bill. On the contrary; in general terms, I support the bill.

I have discussed the first problem, which is the exclusive emphasis on investigation and reporting. I will deal with the other problems in reverse order. I am concerned that it will appear as if the parliamentary corporation can put pressure on the ombudsman because it has the right to determine his or her terms of service. Therefore, it might be said that it is difficult for the ombudsman to investigate complaints against the corporation or that there is some inhibition. I am sure that that is unlikely, but it is important that the ombudsman is independent and is seen to be independent.

The second concern that Mary Scanlon mentioned is about staff terms and conditions. As the issue is technical, I am happy to submit a note

to the committee, but I will outline the matter briefly. Transfers of undertakings are, as the committee knows, governed by the Transfer of Undertakings (Protection of Employment) Regulations—which are referred to as TUPE. The effect of that is to impose a statutory novation of the contract of employment of one employer for another. Thus, the employee can look to the transferee to perform those obligations, which he or she could otherwise have enforced against the transferring body. In other words, there should be no change in contract terms as a result of a transfer.

I am advised that in law, TUPE does not apply to transfers within public administration. The Cabinet Office made a statement of guidance for good practice on transfers in the public sector. As far as I know, that is accepted north of the border as well. The guidance states:

"Departments must therefore ensure that legislation effecting transfers of functions between public sector bodies makes provision for staff to transfer and on a basis that follows the principles of TUPE along with appropriate arrangements to protect occupational pensions, redundancy and severance terms".

I am concerned that the wording of the bill does not give that guarantee. Subparagraph 2(2) of schedule 6 to the bill states:

"The terms and conditions of appointment … taken as a whole, must not be less favourable … than the terms on which that person was employed immediately before the transfer".

That implies that there may be changes that cancel each other out so that, as a whole, the terms are no less favourable. That is not a valid approach under TUPE and under the Cabinet Office's guidance. That is my concern.

Mary Scanlon: I return to the important point that you made about the bill's proposal that the Parliamentary corporation should determine the ombudsman's pay and allowances. Do you feel that there will be a conflict of interest, that there will be undue pressure on you and that you will not be able to be independent in your role as ombudsman if the Parliamentary corporation pays you?

Mr Buckley: It is possible that that impression will gain currency. I will put that more strongly. No one would dream of allowing the Executive to determine the pay and pension of the ombudsman—everyone would say that that must be wrong. The Executive could reduce the salary, it could make the salary far too small and it could apply pressure on the ombudsman.

The Parliamentary corporation is not a body about which one expects to receive a large number of complaints. In practice, I accept that the position causes less concern. Nevertheless, it is wrong in principle for a body that is within the jurisdiction of an ombudsman to be able to determine the ombudsman's terms of service. There is, in that, the appearance of a conflict of interest. There is the appearance that the Parliamentary corporation could bring pressure to bear on an ombudsman to do one thing rather than another because, in a certain sense, the corporation has the role of an employer, in that it can determine pay and pensions.

Mary Scanlon: You have covered the staffing issues quite extensively. I pick up on John McAllion's question on the scrutiny of cross-cutting areas; for example community care. Will the bill make that scrutiny easier to perform? Will it make it easier to scrutinise local government, health authorities or—depending upon who provides the services—the independent sector? I draw your attention to a point that the Mental Welfare Commission for Scotland made. It stated:

"They will mean that the decisions and actions of professionals who do not operate clinical judgment, but who do use other forms of professional judgment, will not be open to the same scrutiny as those of their colleagues within the health service".

Is that what you were getting at when you responded to John McAllion's point about local government?

Mr Buckley: There are two points. The first is that, because the new ombudsman will be able to examine complaints across the public sector, in particular complaints about cross-cutting issues, he or she will be better able to get a view of standards of service and problems, and to produce advice on those issues. The ombudsman will be able to address those issues in annual or special reports. The bill should enable the ombudsman to get a better overview of standards in the public sector than is possible now.

Secondly, the issue of professional and clinical judgment is somewhat vexed. The bill preserves the existing position that ombudsmen cannot question the merits of discretionary decisions. It also says that that does not apply to discretionary decisions that are taken in clinical judgment.

Arguably, the bill should go further by stating that the ombudsman cannot question the merits of other kinds of professional judgment. It is important to make it clear that no one is suggesting that the ombudsman should second-guess engineers on the design of a bridge, for example. However, if the engineers had not bothered to do calculations or had done something that the majority of their profession thought was foolish then that, on principle, should be a matter for the ombudsman.

10:00

Mary Scanlon: I am not familiar with engineers and bridges. Can you put your point in the context

of care in the community? You mentioned when John McAllion was questioning you that the complainer is concerned only with being heard, investigation fairness, equity and judgment. What point are you making about a person being discharged from hospital into the community?

I do not understand your point about discretionary decisions that are taken in clinical judgment. Are you saying that someone who is employed under the remit of the health service is under greater scrutiny than is, say, a social worker, home-care worker, or council worker? I want to be sure that the patient's journey comes under your jurisdiction at all points.

Mr Buckley: I understand your point. Perhaps the committee should also put that point to the local government ombudsman, if it takes evidence from him. As far as I am concerned, I, as the health service ombudsman, can consider the reasonableness of the clinical judgment of a range of professionals, such as doctors, nurses, physiotherapists and community psychiatric nurses. Social workers would not normally come under my jurisdiction because local authorities employ them.

My understanding of the law is that social workers are not regarded as exercising a clinical judgment, so it could be that their decisions cannot be questioned unless they have obviously failed to look at case notes or take a history. However, I stress that members should discuss that point with the local government ombudsman.

Mary Scanlon: Are you saying that the Scottish Public Sector Ombudsman Bill does not allow a social worker's judgment, under the new proposal for a one-stop shop, to be questioned?

Mr Buckley: I think that that may well be the case. If so, that would just preserve the existing situation, which is that I, as health service ombudsman, can question the reasonableness of the judgment of any professional in the health service. My understanding is that that is not the situation in the local authority sphere, but members should get an authoritative answer on that point from my colleague the local government ombudsman.

The Deputy Convener: We will raise that with the Local Government Committee, as it will probably deal with the matter rather than the Health and Community Care Committee.

Shona Robison (North-East Scotland) (SNP): When the bill was being developed, the Executive examined the ombudsman arrangements in other countries. Has the model that the bill proposes proved successful in other countries?

Mr Buckley: The majority of countries and—I think—all countries whose population is comparable to Scotland have a single ombudsman for the public sector. Ombudsmen's jurisdictions vary, as some cover police, but others do not, and some cover prisons, but others do not. However, there is generally a single ombudsman for the public sector. The United Kingdom is unusual in having separate ombudsmen for the public sector. That is historical, going back to 1967.

The overwhelming majority of countries—perhaps all countries—with a population similar to Scotland's that have an ombudsman system have a single ombudsman for the public sector.

Shona Robison: Can you describe any additional proposals that you would like to be included in the bill?

Mr Buckley: I have touched on the main suggestions that I would like to make. The most important is on the overemphasis in the bill on investigation and reporting which, rather than being the rule, is becoming increasingly an exceptional way for ombudsmen to deal with complaints. More and more, ombudsmen use what they call intervention modes rather than investigation and reporting, which consumes a lot of time and resources and tends to be drawn out.

Dorothy-Grace Elder (Glasgow) (SNP): I return to the word "investigation". I know that your concern centres on the fact that very often you can settle matters informally. However, is it an area of concern that members of the public—after receiving a letter from an ombudsman that says that the matter is being investigated—subsequently find out that there has been just one letter and one phone call? Such cases have come to me. That practice is perhaps unintentionally deceptive to the public, who think that a full investigation has taken place. If "investigation" is to remain as a primary concern in the bill, we must spell out exactly what an ombudsman has done.

Mr Buckley: That is a fair point. My office does not use "investigation" or "investigate" unless it has at least initiated a statutory investigation. We might say, "We have looked into it," or "We have made inquiries," and indicate what we consider as a result, but we do not use the word "investigate". It might be right to insist that the new ombudsman exhibit greater clarity about what has been done.

If a complainer produced something that seemed to need looking into, I do not think that most ombudsmen would simply write a letter to the body complained against, get a bland reassuring reply and then drop the matter—it would be looked into. How far it was looked into would depend on the circumstances of the case.

The Deputy Convener: Thank you very much for your evidence.

Mr Crawford is acting director of the Scottish

Association of Health Councils. Do you wish to make an opening statement in support of the written evidence that you have provided?

Danny Crawford (Scottish Association of Health Councils): Yes, please. If my voice goes, it is not stress, but a head cold.

I thank the committee for inviting the Scottish Association of Health Councils to give evidence today. We had an opportunity to submit evidence—our response to the consultation documents of 12 months ago. The health council movement in Scotland is broadly supportive of the bill. We support the policy objective of having a one-stop shop for public sector ombudsmen, which makes sense with the joint future proposals that are being advanced.

The proposal that the ombudsman should take over the Mental Welfare Commission's function of investigating and handling complaints relating to mental health is relevant to the health councils and particularly to vulnerable patients who suffer from mental health problems. When responding to the earlier consultation, the Scottish Association of Health Councils stated that it felt that that was necessary, as there was a lack of clarity between the role of the Mental Welfare Commission and that of the ombudsman in handling complaints. That was evidenced by the fact that a concordat was drawn up between the two bodies to clarify the situation. It is still not clear to many complainants who does what and when.

We welcome the proposal that the Scottish public sector ombudsman will deal with complaints relating to mental health issues. However, we hope that the focus given by the Mental Welfare Commission in its annual report on mental health problems is not lost when the issue is taken on by the public sector ombudsman.

The proposal is consistent with what was outlined in the Millan report. It is important that the Mental Welfare Commission as the regulator and promoter of the principles of the Mental Health (Scotland) Act 1984 should not be seen as an independent investigative body dealing with complaints. Those functions should be kept separate.

In certain quarters, there is a perception that the Mental Welfare Commission is rather bureaucratic and too close to psychiatry. In the recent Docherty case, it was claimed that the Mental Welfare Commission was not only too close to the psychiatric profession but very secretive in its operation. The ombudsman is not subject to such criticism, although we have concerns about some aspects of the ombudsman's operation. I had an opportunity to discuss that with Mr Buckley earlier and I do not think that he disagrees with our points. Although we think that in the past the NHS ombudsman has been rigorous and that his reports have been detailed and worth while, the number of complaints that he has dealt with is relatively low. Those investigations have taken considerable time and have been expensive. There may well be a resource issue if the public sector ombudsman is to deal with more complaints and the public might expect complaints to be dealt with more timeously.

There is already a problem in the NHS in dealing with complaints within the time limits. Last year, the NHS ombudsman referred 224 cases, accepted 34 and reported on 24. The ombudsman agrees that he has to review the practices in an effort to reduce the time that is taken to deal with complaints. The annual report states that the average time taken to deal with a complaint has dropped from 45 weeks to 42 weeks. We think that the public expect reports to be concluded more quickly than that. Often, by the time complaints reach the ombudsman, a complainant has already waited a considerable time.

We are concerned that the time limit for submitting a complaint is still one year. We accept that there should be a time limit, but there is an issue about flexibility, given the time taken to deal with complaints within the health service. We must state that very strongly. Many people who have complaints have already been through the NHS procedure, which might take a year—we have had cases that took more than a year before they got to the ombudsman. Many of the complainants have been bereaved or are ill themselves. In those circumstances, a very flexible approach to the time scale of complaints should be taken.

We welcome several aspects of the bill. We understand that paragraph 6 of part 1 of schedule 2 indicates that complaints in respect of services provided by private hospitals that deal with NHS patients who have been referred to them, or in respect of companies providing services under the private finance initiative, will be liable to investigation. That is essential. We also welcome the fact that the bill closes the current loophole by allowing the new ombudsman to investigate complaints about family health service practitioners or independent providers who have retired or otherwise ceased to provide a service. We welcome the removal of the MSP filter, allowing the public to address complaints directly to the ombudsman. We welcome what should be greater scrutiny of the work of the ombudsman by the relevant committee of the Scottish Parliament.

The change presents a great opportunity to relaunch the service provided by the ombudsman and publicise that important work. We hope that the promotional and communications material will advertise other sources of information and support available to the public, such as local health

councils and citizens advice bureaux.

The public sector ombudsman should institute clear appeals and complaints arrangements for his office. We know that there is a degree of dissatisfaction on the part of many people whose cases have not been accepted and reported on. Those people feel that the reply that they received is far from satisfactory. Dorothy-Grace Elder made that point.

We agree that the bill should aim to maintain the ombudsman's independence from the bodies that he or she investigates. We might be wrong about this, but we believe that there is a problem with the wording of subsections (1) and (2) of section 2, on "Power of investigation". Section 2(2) states:

"The Ombudsman may investigate any matter, whenever arising, if—

(a) paragraphs (a) and (b) of subsection (1) are satisfied, and

(b) the person liable to investigation has requested the Ombudsman to investigate the matter."

That could be interpreted to mean that the body being complained about had a veto on investigations by the ombudsman. Clearly, that is not the intention of the bill, but to our untutored eyes it looks as if "and" at the end of line 3 on page 2 of the bill should read "or", which would solve the problem. However, we are not used to drafting parliamentary bills and perhaps the word "and" has to be used. The guidance makes clear the intention of the bill, but we would not want people to feel that the body being investigated had a veto on investigations.

10:15

The Deputy Convener: Thank you very much. MSPs welcome the removal of the filter that means that everything must come to us before being referred to the ombudsman. Do you think that health councils could be involved in dealing with complaints at a much earlier stage, or should the bill remain as it is?

Danny Crawford: I have heard mentioned a change in the role of health councils in the handling of complaints. In some quarters, it has been suggested that health councils should be involved in investigating complaints. The health council movement has not discussed that possibility. If health councils were involved in investigating complaints, that would change their role fundamentally. Health councils exist to represent patients and the public, rather than to act as arbiters. Quite rightly, staff in the health service see our role as being to represent patients, rather than to act as independent investigators of complaints. It is right that our role should be to support patients and the public, as that is consistent with other aspects of our work.

We have concerns about the time that it takes in the NHS to deal with more complex complaints. Target times for dealing with complaints are rarely met by trusts, boards or the ombudsman. Perhaps those targets are unrealistic. The complaints system is being reviewed and we await guidance from the Scottish Executive on how it should change. A representative from the Scottish Association of Health Councils has been involved in the discussions that have taken place in the relevant working party, but we have not seen the party's final paper.

The Deputy Convener: The vast majority of cases in which MSPs have been involved have related to communication. Individual health professionals seem to lack skill in communicating with their patients, which leads to complaints. As a representative of health councils, do you believe that there has been sufficient consultation with patients groups, in particular, on the bill?

Danny Crawford: We had an opportunity to submit comments on the original consultation document, but I do not recall how much time we were given to do that. The Scottish Association of Health Councils and similar organisations are inundated with consultation documents. Often, the time scales within which we have to reply to them do not allow us to carry out proper consultation with the interested parties—voluntary organisations, community groups and patients groups—with which we have contact. However, that is outwith our control.

On the drafting of the bill, my understanding is that the bill was published only a couple of weeks ago; there has not been much time to examine it. I have contacted a couple of organisations, such as the Scottish Association for Mental Health, to ask for their views on the bill. They felt that they had not had time to digest it. Perhaps the nature of politics is that decisions have to be made quickly, but I suspect that to have more time to respond would be helpful for a number of interested bodies.

Nicola Sturgeon (Glasgow) (SNP): One of our general functions in deciding whether we agree with the bill's general principles is to determine how adequate consultation has been. You have said a bit about how widely you felt that the Executive has consulted—or has not in the case of the time scale for the bill. I will consider consultation from the other direction. Have you consulted widely in your organisation? Have you consulted individual health councils on their opinions on the bill before coming to the committee?

Danny Crawford: All health councils were e-mailed and given details of where on the internet to find the bill early last week. A number have responded. I suspect that the chief officers did not in the main have an opportunity to take the matter

to a full committee of each health council. In that sense, the consultation process has not been ideal. However, the bill was published only a fortnight ago. All health councils have had an opportunity to have input and all have seen the draft submission that was prepared. A number commented on that draft. It has been changed to take into account some of the comments that were received.

Mr McAllion: I accept everything that you say about the problems of the bill being printed only two weeks ago and about the difficulties of getting the views of all the health councils in that time scale.

Do you think that the bill meets the principle that it claims for itself: the establishment of an open, easily accessible and accountable public sector complaints service?

Danny Crawford: The principle of a public sector ombudsman bill is good. Perhaps time alone will tell whether it will operate in the way in which the public would like it to operate. There are issues of concern to health councils, such as the one-year time limit on complaints, which the bill implies should be treated with some flexibility. We think that the present situation, whereby the Mental Welfare Commission investigates complaints related to mental health, should be changed. We welcome aspects of the bill.

We have one major concern, which I failed to mention earlier. When we submitted our original comments for the consultation on the draft bill 12 months ago, we took the view that, although a one-stop shop was acceptable, it would be appropriate for the public sector ombudsman in Scotland to have support from a specialist health team. It is now of concern to us that, according to the bill, there will be no deputy ombudsman designated as being responsible for health. We note that the policy memorandum states:

"The Ombudsman will allocate responsibilities to the Deputies as he or she sees fit according to variations in workload and business priorities at any particular time."

The view of the health councils is that the complexities of many health complaints are such that they are often time consuming and require a degree of specialist knowledge. We are concerned that the bill appears to allow for a generic deputy ombudsman to deal with health, local government and various other public sector services. We feel that the nature of the health service and of health complaints is such that to have a deputy ombudsman designated as being responsible for health would be a good idea.

Mr McAllion: During the consultation period, two alternative models for a one-stop shop were discussed. One was a kind of college of ombudsmen who shared the same building and support staff but retained their own specialisms, for example, in the health service. The other was the all-encompassing ombudsman service with deputies, which you have touched upon. Are you suggesting that the second model is the one that health councils prefer, but that within that, you want the roles of the deputies to be set in statute rather than left to the discretion of the ombudsman?

Danny Crawford: Basically, yes. We saw advantages in having one public sector ombudsman but we felt that, under the umbrella of that office, there should be someone with a designated responsibility to deal with health issues.

Mr McAllion: Do you mean that the bill should designate the deputies?

Danny Crawford: The guidance suggests that there will be a generic deputy. In practice, the public sector ombudsman may decide that. However, we think that that is so important that it should be in the bill.

Mr McAllion: One of the issues that arose in the consultation was the extent to which detailed provision for the procedure of investigation by the ombudsman should be set out in the bill or left to the discretion of the ombudsman. This morning, we heard that the health service ombudsman thinks that more discretion should have been allowed to the ombudsman and that less detail should have been set out in the bill. Do you agree with him, or do you think that the way in which investigations should be carried out should be set out in the bill?

Danny Crawford: That is not a question to which the health councils have responded. We have not taken a position on that.

Dorothy-Grace Elder: Let us turn to the remit of the ombudsman, about which we questioned the previous witness. The remit excludes certain types of organisations, such as some health-related advisory bodies. Are you satisfied with the proposed remit of the ombudsman? Would health councils wish that remit to be expanded in future, in any particular way?

Danny Crawford: In its original submission, which it made 12 months ago, the Scottish Association of Health Councils stated that it was focusing on the health aspect of the ombudsman's remit and did not want to suggest which other public bodies should be included or excluded from that. We felt that that would be, in a sense, outwith our remit. We have not responded specifically on that issue.

Dorothy-Grace Elder: The process has been rather speedy, with the bill being introduced just a couple of weeks ago. None of the existing public

sector ombudsmen has powers to enforce recommendations or impose sanctions. The Executive has decided that it should be left to Scottish ministers to take whatever enforcement action is considered necessary. Do you agree that the powers of enforcement should be left to the discretion of the Scottish ministers or the Parliament?

Danny Crawford: That is a difficult issue. I understand that, within certain bodies, it was the convention that, if the ombudsman made a recommendation, that recommendation would be accepted. Over a number of years, that has become less of a convention, and it is not exceptional for a body to disagree with the ombudsman. That is unfortunate. The public expect that, if the ombudsman upholds a complaint, a public body should accept that decision and adhere to it. The public feel that the ombudsman's role is judicial and that he or she should, therefore, have the power to ensure that the recommendations are enforced.

I read the ombudsman's annual report. He makes the point that victim blaming is wrong and that, when complaints arise, they are normally due to faults in the system or financial problems. I can imagine a situation arising, perhaps in the NHS, in which, although a complaint has been upheld that could have significant financial implications, the ombudsman's recommendations are not acted on because doing so could create a precedent that would incur significant expense. Nonetheless, the public would expect public bodies—including those in the health service—to adhere to the recommendations of the ombudsman. I am not sure whether that would mean that they would have to be legally enforced.

Dorothy-Grace Elder: Or go before Parliament.

Danny Crawford: Yes. I think that cases in which the ombudsman's decision is not upheld should go before Parliament.

Dorothy-Grace Elder: Should they go before Parliament rather than the Scottish ministers? Or should they be dealt with by a minister first?

Danny Crawford: In some cases, a health board might argue that implementing the ombudsman's decision would set a precedent that would incur enormous costs that it could not afford. In such cases, it might be appropriate for the matter to be reconsidered by the Parliament or the Health and Community Care Committee. I presume that the committee would be able to call the ombudsman and the public bodies in the health service before it, to ask why those bodies had not acted on the recommendations.

Dorothy-Grace Elder: There is a proposal in the bill that, as an option of last resort, organisations should have the power to request that an investigation should be undertaken where there has been public criticism but no direct complaint to the ombudsman. That could lead to a considerable expansion in the work load of the new ombudsman. Do you think that that would be appropriate?

10:30

Danny Crawford: It could be appropriate. I can imagine there being public concern about a situation, even though a vulnerable patient was not in a position to raise a complaint. It would not be inappropriate for the ombudsman to carry out investigations in such exceptional cases. However, I am sure that the ombudsman would not want his investigations to be dictated by every newspaper headline.

Dorothy-Grace Elder: Can you think of examples of such exceptional cases?

Danny Crawford: A lot of work has been done recently on the administration of electroconvulsive therapy. The health service is putting its house in order with regard to ECT, but it could have been an issue on which a formal complaint might not have been raised by a patient or a patient's relative but about which a bona fide body might have been concerned.

Dorothy-Grace Elder: From my knowledge of the health councils, I get the impression that, although you are generally satisfied with the situation, aside from issues such as the 42 weeks or so to answer a letter and the fact that only a third of cases are properly taken up—I point out that I have seen smaller proportions taken up by other ombudsmen—the bricks and mortar of the implementation and funding of the proposals in the bill concern you? Among the public, there is a great belief in the ombudsman system but, until now, only the tiniest minority of cases have been seen through.

Danny Crawford: That is true. We are concerned about how the legislation might work in practice. I should point out that it does not take the ombudsman 42 weeks to reply to a letter. More than 80 per cent of letters are replied to within the target of 18 days.

Dorothy-Grace Elder: I am sorry, I meant 42 weeks to close the case.

Danny Crawford: On average, the ombudsman takes 42 weeks to carry out an investigation and produce a report. Some cases take a lot longer than that. As the public's attitude to services changes, there will be more and more complaints, which raises a resource issue for the new service. The service is likely to get busier and busier and, if it is relaunched and highly publicised, it will have to be equipped to meet the demands on it.

Janis Hughes (Glasgow Rutherglen) (Lab): The policy memorandum states that the new one-stop shop should resolve problems of co-operation between various ombudsman services in Scotland. In light of new legislation with regard to joint working, which we have already mentioned this morning, that is more pertinent than ever.

Do you have any experience of a lack of co-operation between ombudsman services leading to difficulties?

Danny Crawford: We have tended to deal only with complaints that relate to the health service, so the situation has been relatively straightforward. We are aware of confusion about the role of the ombudsman in relation to the Mental Welfare Commission.

I have not been involved in a community care case that has gone to the ombudsman that has affected both the health service and local government, although I have been involved in a few cases in which the tensions between the two bodies involved in an issue has created problems for the client or the patient. One such case might be about to go to the ombudsman, but I do not know of any community care cases that have done so. The proposals should resolve any conflict or confusion that could arise under joint future or through community care.

Mary Scanlon: The process of bringing complaints against the health service is currently under review. Do you expect any changes to the ombudsman's role following the review, in light of the fact that health councils in England have been abolished?

Danny Crawford: I have not been party to discussions concerning the review, but I hope that it will make more fundamental recommendations than simply saying that the time scale for handling complaints should be changed. Complainants find the current system time consuming and bureaucratic; many of them just want the complaint to be investigated timeously and to receive an apology and an assurance that lessons have been learned. The current system is not very good at doing those things. As people can be very defensive, there is a lack of openness and honesty towards complainants. However, as I have not seen the new proposals, I am not sure whether they will resolve those dilemmas.

As for the changes in England, I note that where one organisation represented the public and patients, it appears that four or five organisations will now take on that role. There is concern down south about the independence of some of those bodies, many of which might be too close to the health authorities and might not be independent enough advocates for patients.

Mary Scanlon: You have been quite critical of the Mental Welfare Commission this morning. You said that the commission was too secretive and too close to the psychiatric profession. Do you agree with the commission's statement in its submission that

"the actions and decisions based on judgement of professionals outside the health service is not open to scrutiny of the Public Sector Ombudsman"?

Danny Crawford: I heard that issue being discussed with the ombudsman earlier. Although a significant change some years ago meant that the health service ombudsman could investigate clinical matters, many complainants were greatly frustrated when the ability to do so was not included within the ombudsman's remit. As far as I am aware, now that it is part of that remit, it has not caused huge problems for the medical profession.

Mary Scanlon: Given the increased emphasis on care in the community, are you concerned that professional judgments and judgments made by people who are not NHS staff are not given the same weighting in the system as clinical judgments?

Danny Crawford: I was just about to say that the change that took place in the health service in that respect was right and proper and it is appropriate to take that step within local government. Professional judgments should also be taken into account. If members of the public feel that they are getting a raw deal, they will not differentiate between a managerial or administrative decision and a professional decision.

Mary Scanlon: So you are saying that any decision on a patient's journey—whether in the acute primary care context or the community care context—should be brought under the rigorous scrutiny of the public sector ombudsman.

Danny Crawford: That is right.

Mr McAllion: I want to be absolutely clear on this matter. If a psychiatrist sections a patient, should the patient have the right to complain to the ombudsman about that decision?

Danny Crawford: The standard practice is that the ombudsman will investigate a complaint only after it has been investigated under the NHS complaints procedure. As a result, a complaint about sectioning would not automatically go to the ombudsman. The Mental Welfare Commission would still have a role in supervising aspects of the care of mentally ill patients.

Mr McAllion: I am not clear on this matter. Should clinical decisions taken by psychiatrists about the mental well-being of patients be open to challenge by the ombudsman service?

Danny Crawford: Yes, but only after the complaint has been dealt with under the NHS complaints procedure. If the complainant feels that the complaint has not been adequately dealt with under that procedure, they should have recourse to the ombudsman. However, it is for the ombudsman to decide whether to take up the case.

Mr McAllion: But how is the ombudsman qualified to make a judgment on a psychiatrist's clinical decision?

Danny Crawford: As I understand it, the ombudsman will consider the complaint and decide whether the appropriate procedure has been followed.

Mr McAllion: So the focus is on the procedure, not the actual clinical judgment.

Danny Crawford: That is my understanding.

The Deputy Convener: I thank Mr Crawford for his evidence. We now have a little difficulty, as the next witnesses have not yet arrived. I suggest that we have a short adjournment.

10:40

Meeting adjourned.

10:48

On resuming—

Petitions

Organ Retention (PE283 and PE370)

Post-mortem Organ Removal (PE406)

The Deputy Convener: The witnesses from the Mental Welfare Commission have not yet arrived and we have not been told why. With members' agreement, we will now take agenda item 4—petitions PE283, PE370 and PE406. We will return to item 3 when the witnesses arrive. Is that agreeable?

Members *indicated agreement*.

The Deputy Convener: Members have received copies of Sheila McLean's report on organ transplantation and retention and copies of the Executive's letter, which is dated 23 November. The Executive is consulting us and organisations on several issues and the deadline for responses is 31 March 2002.

Members received the report and the letter only last week. I have certainly had difficulty in finding sufficient time to examine the report in detail. The document is pretty heavy and we will need to revisit it individually. Do members have views on the matter?

Mary Scanlon: I note that the Scottish Organisation Relating to the Retention of Organs was very complimentary about the report. As the deputy convener said, it takes some time to digest. The consultation must be responded to by 31 March 2002. We cannot complain about the length of the consultation, which is excellent too. Lydia Reid was not quite as happy as SORRO and I hope that she will use the consultation to state her concerns.

We should note the consultation and the excellent report by Sheila McLean. SORRO says that it is perfectly satisfied and does not seem to be calling for the public inquiry for which its original petition asked. I suggest we note no change to our position and await the end of the consultation process.

Mr McAllion: I would like to clarify one point about petition PE406, which is from Margaret Doig. She read the *Official Report* of the meeting at which the Public Petitions Committee dealt with her petition and told us that the committee had not quite understood the point that she wanted to make. Her point concerns the removal of organs from deceased people who have no relatives. She wants clarification on the role of executors and on whether executors would be consulted. Many

references are made to consulting relatives and next of kin, but no references are made to consulting executors of wills, yet they might know the deceased's views.

The Deputy Convener: We could pass that comment to the Executive as part of the consultation.

Mary Scanlon: I agree that that comment should be passed on as part of the consultation. Lydia Reid and SORRO asked for a full public inquiry. The report is extensive. If they feel that something is missing from the report, I hope that they will take advantage of the process to address that between now and March 2002. The same goes for Margaret Doig.

The Deputy Convener: Do members agree with Mary Scanlon's proposal to await the end of the consultation?

Members *indicated agreement*.

The Deputy Convener: I have two options for committee members. We have two agenda items to take in private. If we considered them now, they might last until 11:15. Otherwise, we could adjourn again. The decision is in the committee's hands. Do members want to go into private session? [*Interruption.*]

I retract that proposal, as the witnesses have arrived. We will give them a few moments to settle.

Scottish Public Sector Ombudsman Bill: Stage 1

The Deputy Convener: I say good morning to Dr Dyer and Professor Cheetham. We were just about to go into private session but, as you have arrived, we have changed our minds.

We return to taking evidence on the Scottish Public Sector Ombudsman Bill. Do you wish to provide a statement before members ask questions?

Dr James Dyer (Mental Welfare Commission for Scotland): It might be helpful if I make a short statement. We have also submitted a paper to the committee.

For those who are not familiar with the Mental Welfare Commission for Scotland, it may be helpful to explain what it is and why we have an interest in the bill. The commission is an independent statutory body set up under the Mental Health (Scotland) Acts 1960 and 1984. It now has duties under the Adults with Incapacity (Scotland) Act 2000.

The commission has a wide remit to protect people who might be vulnerable through mental disorder. That remit gives us duties in relation to health and social care services. We have specific duties to investigate where there might be deficiency in care or ill treatment of people who might be vulnerable through mental disorder. That has opened us to receiving complaints.

It is important to understand that the Health Service Commissioners Act 1993 prevented the ombudsman from investigating matters that were within the remit of the commission. To date therefore, the Mental Welfare Commission for Scotland has carried out an ombudsman-like role on complaints relating to mental disorder. The exception is that the commission could extend beyond the health service—in hospital, in the community or being provided with a service for their mental health problems from health or social work departments. The commission can take an interest in such people and that gives rise to issues that are mentioned in our submission.

We are happy to support the proposal in the bill that, in future, all complaints should be dealt with in the same way and that people who have a complaint relating to a mental disorder should be in the same boat as people with a complaint relating to a physical disorder. It makes sense that there should not be discrimination against people with mental disorder.

The new public sector ombudsman will have clearer powers and protections compared to those of the commission. Removing complaints from the

commission's remit will leave us free to concentrate on our protective duties and to carry out investigations into deficiency in care. We therefore support that idea.

The Deputy Convener: Do you think that the Executive consulted sufficiently on the proposals in the bill?

Dr Dyer: I would say that it did. There were two phases of consultation, both of which we contributed to. We were happy to be consulted in that way and feel that we had ample opportunity to put our views.

Professor Juliet Cheetham (Mental Welfare Commission for Scotland): I thought it was a model consultation and that both sets of papers that were produced were clear and helpful.

The Deputy Convener: Are you satisfied that the points that you raised have been taken on board?

Professor Cheetham: One or two points that we raised have not been taken on board. One of those was pointed out in our submission. That is the significant anomaly whereby complaints to do with health services that affect clinical judgment can be investigated in total by the new public sector ombudsman but, for complaints arising in other quarters—for example, concerning local authority services—the new ombudsman will be confined to considering maladministration and not the substance of the decision or action.

That is a continuation of the current position, but we have always found that to be an anomaly. In our submission, we have pointed out how the process could work in a strange way: when someone makes a complaint against an NHS-based mental health service, the judgment of the staff will be examined and investigated but, when that complaint extends into local authority services, the investigation will be narrower. That is a significant anomaly, which, as far as complainants are concerned, seems to indicate a degree of unfairness. However, in the paper setting out the responses to the consultation process, we read recently that only a few people and organisations supported the extension of the ombudsman's powers to investigate the judgment and decisions of professionals other than those in the health service.

11:00

Dr Dyer: The joint future approach is that health and social care should be integrated as far as possible. Given that approach, if someone receives a service from a community mental health team, which might be jointly funded and managed by health and social work departments, how is the ombudsman to deal with that complaint? He will be able to investigate the substance of the health aspect of the complaint, but only the administration element of the social work aspect. That seems an anomalous division.

The Deputy Convener: Will that create difficulties for members of the public who wish to make complaints? Will they be unaware of such restrictions?

Dr Dyer: It will be hard for them to understand why part of their complaint can be investigated fully, as they might wish, and another part can be investigated only in terms of administration.

Professor Cheetham: In the health service, a significant proportion of complaints are about mental health services. Last night, I looked at the figures for complaints that were made to the Mental Welfare Commission and those that went to the health service commissioner. In the past two years, around a third of complaints concerned mental health services—those were the complaints that came to us.

At present, most of those complaints do not affect local authority services. However, as Dr Dyer said, services will become more community based and there will be more joint working. That means that the system will confuse a fair number of people, although it could be argued that some people would be unfairly dealt with if two systems were to co-exist.

Mr McAllion: Will the ombudsman service that is proposed in the bill be open, easily accessible and accountable, as the Executive claims? You have given us one example where elements of what is proposed will act against those principles. Can you give us others?

Professor Cheetham: I am sorry, but I did not catch the first bit of Mr McAllion's question.

Mr McAllion: The Executive claims that its proposed ombudsman service will be open, accountable and easily accessible. Do you agree that that will be the case or are some of the proposals flawed?

Professor Cheetham: The proposals on openness are good, as are the proposals on the range of ways in which complaints can be received. For example, evidence can be received orally from people who have communication difficulties and complaints do not have to be filtered through an MSP. In my view, which is shared by the commission, the suggested arrangements will promote openness and easy access.

Making a complaint is intimidating. It is a long and weary process, as we know from talking to the people with whom we have worked. To a substantial extent, the openness and accessibility to the ombudsman will depend on the quality of

information that people get at the primary complaint stage about the right that they have to take their complaint further. In our experience, the clarity and efficiency with which health authorities and local authorities impart that information is a bit variable. The information would need to contain more than a sentence saying, "You can go to the ombudsman." If the objectives of openness and ease of access are to be achieved, the process needs to be explained further.

Dr Dyer: We are attracted by the one-stop shop idea, which we think will improve accessibility to the public. We thought that, paradoxically, there might be too much accessibility in the proposal that bodies should be able to request an investigation by the public sector ombudsman. The commission was not absolutely unanimous on that, but we had doubts about whether it is wise to allow bodies, of which there may be criticism, to ask the ombudsman to investigate them. We are inclined to think that the ombudsman is there for the punter with a grievance and not for an organisation to seek some sort of rubber-stamping. If there was subsequently a complaint from a member of the public against that organisation, the ombudsman's independence might be prejudiced. We urge that some thought be given to that.

Mr McAllion: During the consultation, consideration was given to two models of one-stop shop. One was a kind of college of ombudsmen, where they share the same building and support staff but keep their own specialisms, so that there would be a health service ombudsman, for example. The other model was an all-encompassing public sector ombudsman, with deputies with specific responsibilities. Which of those models do you prefer and why?

Dr Dyer: We did not have strong views about that. We were happy to accept the model proposed in the bill, where there is an overall public sector ombudsman to cover all the functions and deputies to whom the various functions are divided out.

Mr McAllion: We have heard some concern this morning that the remit of the deputy ombudsmen has been left to the discretion of the ombudsman. Some people would like it to be set down in legislation that, for example, one of the deputy ombudsmen should be responsible for the health service and should retain that specialism. What is your view?

Dr Dyer: We assumed that one of the deputy ombudsmen would have a health function. We would be concerned if there was doubt about that, as there is clearly a substantial role for a health ombudsman.

Mr McAllion: Are you concerned that it is being left to the discretion of the ombudsman to detail what his deputy should be doing? Should that be in the bill or issued in guidance from ministers?

Dr Dyer: We are not too concerned about that. We assume that appropriate decisions will be made about the division of functions. The policy memorandum indicates that one of the deputy ombudsmen is likely to have the health function, so we are fairly confident that that would be so.

Mr McAllion: Five sections of the bill give detailed provision for investigation procedures by the ombudsman. Is that too restrictive? Should more be left to the discretion of the ombudsman about how to conduct his business or is the balance in the bill about right?

Dr Dyer: The bill is not too prescriptive. It leaves a lot of the nitty-gritty of how investigations are carried out to the ombudsman.

Professor Cheetham: That is right. Our experience from our connections with the health service commissioner show that, over time, procedures are evolved to make investigations more open. Moreover—this is significant in the most recent health service commissioner reports—not all complaints are appropriately dealt with by a full investigation. In many cases, it is appropriate and sufficient to make inquiries of the relevant authorities, to suggest remedies, perhaps to meet the complainant and to write a report on that basis. Most of our detailed work on mental health complaints is not based on a full and formal investigation of everything that happened during the incident. Increasingly, the health service commissioner operates in that way and it seems to me absolutely right that the ombudsman should have discretion to make those decisions.

Mr McAllion: In your view, does the bill allow the ombudsman that discretion, or should it contain a specific additional right giving the ombudsman that discretion?

Professor Cheetham: I think that the provision is sufficient as it is, but I have not spent a lot of time focusing on the precise procedures for the ombudsman.

Mr McAllion: You are saying that the bill should allow for such discretion.

Professor Cheetham: The policy memorandum is clear about not being prescriptive about procedures. If an act stipulates procedures, the procedures will be out of date before the act is out of date. I would be against that.

Mr McAllion: Policy memorandums are less binding than legislation.

Professor Cheetham: Yes, they are.

Dorothy-Grace Elder: I want to turn to the remit of the ombudsman. To what extent should the

ombudsman consult the Mental Welfare Commission on complaints about mental health services?

Professor Cheetham: As members will know, the Millan committee, of which Dr Dyer was a member, made that proposal. The second consultation paper suggested in fairly prescriptive ways that the public sector ombudsman should consult the commission on mental health complaints. We responded to the consultation document by saying that we did not think that Millan intended that or that it would be appropriate for the new ombudsman to consult us on every mental health complaint. That could lead to a parallel system of investigation, which would rather defeat the objective of the one-stop shop.

We made an alternative proposal for a memorandum of agreement in which we would try to define significant complaints, such as complaints concerning detention, where the health service ombudsman should consult the commission to seek advice on specific matters. We proposed to deal with that through a panel within the commission. In other words, we were saying that we did not think that the ombudsman should consult the commission on all occasions. The bill does not oblige the public sector ombudsman to consult us.

Dorothy-Grace Elder: Do you think that it should?

Professor Cheetham: No. Broadly, we are content with the situation. It would be hard to frame a provision that said that in some cases the ombudsman should consult the Mental Welfare Commission. We have suggested a provision that says that the public sector ombudsman should consult bodies where there are shared interests in particular circumstances or complainants. Such a provision would allow bodies such as the Mental Welfare Commission to prepare a memorandum of agreement with the ombudsman whereby he or she could consult us in specific instances. I suspect that we could establish such an arrangement as a matter of good will, if the ombudsman thought it important. However, if the committee wanted to ensure that approach, a provision that gave the ombudsman a power to establish such arrangements might be appropriate.

Outwith our remit, another organisation with which the ombudsman might want to have such an agreement would be the Scottish Commission for the Regulation of Care, which will have a large complaints function. How that would be dealt with could be covered by a memorandum of agreement.

Dorothy-Grace Elder: In both cases you would wish memorandums of agreement rather than something more solid that was enshrined in the bill. I am assuming that you are referring to issues or individual cases that raise what you consider to be national issues.

Professor Cheetham: The provision could apply to issues and individual cases where the ombudsman thought that there was some matter about which we would have particular expertise, such as a complaint involving inappropriate detention.

Dorothy-Grace Elder: As you know, none of the currently established public sector ombudsmen has powers to enforce their recommendations or to impose sanctions of any kind on an authority or body that fails to remedy an injustice. The Scottish Executive considered whether the ombudsman should be given enforcement powers, but the policy memorandum says that there was general agreement following consultation that

"it should be left to the Scottish Ministers to take whatever enforcement action is considered necessary in any particular case, or the Parliament where it is not satisfied with the action taken by the Ministers."

Do you agree that the powers of enforcement should be left to the discretion of the Scottish ministers or Parliament?

Dr Dyer: Yes, we are content with that. We have experience of a similar issue. Although people sometimes say that the Mental Welfare Commission should have stronger powers, so that we could enforce our recommendations and reports of inquiries, we believe that we should not. Our duty is to investigate, to reach conclusions and to make recommendations; others have executive power and responsibilities to ensure that our recommendations are carried out. That is the correct division of functions. The ombudsman will be able to make his report, but it will be up to others—including ministers and the Parliament—to ensure that the recommendations of those reports are carried out.

11:15

Dorothy-Grace Elder: Is it satisfactory that the bill leaves enforcement to the discretion of Scottish ministers or Parliament?

Dr Dyer: Yes. The ombudsman's role is predominantly to investigate and make recommendations. To give the ombudsman executive power to enforce recommendations would be to alter that role.

Dorothy-Grace Elder: An earlier witness rather objected to the bill's use of the word "investigation" because, as you have indicated, these matters can often be solved informally. I, too, have doubts about the use of that word; a constituent received

a piece of documentation, which referred to an "investigation" that consisted only of a letter and a phone call. We may be deluding the public, who will think that there will be a thorough investigation every time.

Dr Dyer: There is also strength in allowing for an early attempt at conciliation without a full investigation. However, there must be the possibility of a full and rigorous investigation if that fails.

Professor Cheetham: We found it extremely useful to meet complainants to find out their desired outcome of the complaint. By the time that they get to the ombudsman stage, their views about what would be a good outcome may be very different from what their views were at the beginning of the process. Earlier, we talked about how prescriptive we should be on the new ombudsman's function. We do not think that there should be too much prescription, but meeting complainants has proved useful for us. It takes up time but it allows for the early resolution that Dr Dyer mentioned. Perhaps the new ombudsman will consider doing that in certain circumstances. That is an example of the need for flexibility.

Dorothy-Grace Elder: My final question concerns the bill's power on the option of last resort, under which it is proposed that organisations should have the power to request that an investigation be undertaken where there has been public criticism but no direct complaint to the ombudsman. Do you agree with that? Would your organisation wish to exercise such an option?

Dr Dyer: As I said, we have strong doubts about that power. It seems to us that the ombudsman will exist for the individual who has a grievance against a listed body. If, in the face of criticism, a listed body can request an investigation by the ombudsman, that might prejudice further complaints against that body, which will already have been investigated and perhaps given a clean bill of health by the ombudsman. That might put into question the independence of any further investigation into that body by the ombudsman. We believe that the ombudsman should be reserved for individuals. We have strong doubts about organisations being able to request investigations.

Shona Robison: The policy memorandum says that the one-stop shop should help to resolve problems of co-operation between the existing ombudsman services in Scotland. Can you provide examples of problems with co-operation? What implications do those problems have for the current service?

Professor Cheetham: As a quasi-ombudsman body, we have not been aware of co-operation difficulties in our relationships with the health service commissioner and the commissioner for local administration, who are the two ombudsmen with whom we have had contact. The relationships have been easy, friendly, constructive and helpful, and we have had regular meetings.

On the scope of investigatory powers of the different ombudsmen, there has been a difficulty for complainants who have made a complaint about a mental health service in a local authority. They have found that the commissioner for local administration could investigate not the substance of the complaint—the decision that had been made by a social worker or mental health officer—but only the way in which the complaint had been handled and other matters of maladministration. We, on the other hand, could investigate the whole case, which is what the complainants wanted. We were in a rather anomalous situation in which the commissioner did one thing and we did another and we had to tie that up rather closely.

That is a good example of the difficulties that we described earlier. Dr Dyer is a psychiatrist and I am a social worker. Somebody could complain about the services that we had offered jointly. Everything that Dr Dyer had done—the treatment, the decisions that he had made, the medication that he had prescribed and the regime that he had recommended—could be the subject of a complaint and an investigation. All that could be investigated in my case is whether I had followed the correct procedures in making an assessment—for example, the right processes in arranging for a service to be provided. That is unfair, as it lets me off the hook and I do not think that I should be off the hook.

Shona Robison: Let us pursue that a bit further. The bill seeks to ensure improved consultation and co-operation between the new ombudsman and the other statutory ombudsmen and commissioners. How do you think that that will work in practice? Do you think that it will help to resolve the difficulties that you have just highlighted?

Dr Dyer: I guess that having a one-stop shop will help. If one is just down the corridor from somebody, it is a lot easier to have frequent communication. If the public sector ombudsman and related commissioners are in the same building—which would be possible—that should encourage a collaborative approach, which is desirable.

Shona Robison: The policy memorandum states that establishing a one-stop shop should help co-operation with similar bodies in England and Wales and with the Auditor General for Scotland. To what extent, if at all, is co-operation with those organisations a problem at present?

Professor Cheetham: Our former chairman, Sir William Reid, had been the ombudsman for England and Wales, so we had some useful informal contacts with the ombudsmen and associated organisations in England and Wales. However, we have not needed to have much contact with them. If we had wanted it, we would have had it. We read one another's reports. It is important that, in the evolution of the investigation of complaints—for example, whether individuals should be named, which is what the health service commissioner decided might happen if general practitioners remained obstructive and did not co-operate during investigations—we read those reports and, if necessary, talk about matters of common interest. However, we have not had to do much of that, although I do not think that it would have been a problem if we had sought such co-operation.

Mary Scanlon: I found your submission thorough and helpful to our purposes. If you have a bee in your bonnet today, it is probably about the local authorities needing equal scrutiny. Given that the Millan report mentioned that there was no arrangement for complaints by mental health service users against local authorities, are you satisfied by the transfer of the responsibility of the commissioner for local administration to the new ombudsman? Are you satisfied that complaints about local authority mental health teams will be scrutinised equally?

Dr Dyer: Yes, but those complaints will be restricted. The ombudsman will be able to look only at the process, not the substance, of the complaints. In other words, the ombudsman will be able to look only at complaints of maladministration. However, if the complaint had been about the health service, he or she would have been able to deal with the whole substance of the complaint. That is the essence of our concern.

Added to that is the increasing deliberate blurring of the boundary between health and social work. Although we welcome that, it will be difficult to separate a social work complaint from a health complaint, so allowing investigation of the substance of one and just the process of another does not make a lot of sense. We understand the difficulties—local authority functions are carried out with the authority of elected representatives, so it is difficult for an appointed official to investigate those functions. However, that leads to a serious anomaly, which the public will find hard to understand.

Mary Scanlon: We will continue to focus on the patient's journey, which is our main concern.

In paragraph 9 of your submission, you mention the problems that you feel will arise as a result of clinical judgments—but not professional judgments—being open to scrutiny. Will you clarify what you mean by that?

Dr Dyer: We are thinking about somebody who lives in the community and receives mental health care from a community mental health team, which might have a manager who is appointed jointly by health and social work. In the future, the team might be funded jointly via health and social work. The care plan will be multidisciplinary and agreed by social workers and health people. If the person who receives the care complains about an aspect of their treatment, is not satisfied with the local resolution and goes to the public sector ombudsman, who is to say whether their complaint is a health complaint or a local authority complaint? The service is deliberately blurred—it is provided jointly by health and social work.

As a result, the public sector ombudsman will have difficulty. They will be able to look at clinical judgment, because that is a health service thing, but not social work judgment. Teasing those apart will prove difficult, given the structure that is built into the bill. That structure is simply a bringing together of the existing arrangements for the health service ombudsman and the local government ombudsman.

Mary Scanlon: So you are saying that not only will local authority input be excluded, but—taking the patient's journey as a whole—complaints into NHS decisions could be undermined.

Professor Cheetham: Precisely. In our experience, the most passionate complaints of most people concern the action that was taken or the service that was given or the decision that was made. People complain about delays and the fact that they were not properly consulted and other matters that are properly investigated as maladministration. However, the issues that they really mind about are, for example: "I don't think that you should have told me to go to that day centre"; "It wasn't right for you to take my mother into care"; and "It wasn't right that you refused me that domiciliary service."

In the social work examples that I used, it would not be possible to investigate those matters of professional judgment in their entirety. It would be possible to examine whether the social worker had gone through the agreed protocols for assessment, but not why a decision was made and whether it was the right decision. Such areas are difficult—professionals like to talk about their clinical judgment and their professional discretion. As we were coming here, we talked about how interesting it was that the medical profession—as far as we could remember—went along reasonably easily with the decision that the health service ombudsman should investigate clinical judgment. Although we would have expected a lot of opposition, that state of affairs is just accepted

in the health service.

We think that the fact that other matters will be excluded is an anomaly. I used the example of social work because I know about that field, but the policy memorandum also states specifically that

"matters directly relating to education"

will be excluded. You can imagine that there would be a huge hoo-hah about some aspects of education, such as teachers' discretionary decisions and the curriculum, which are difficult. Why should one be able to examine doctors' and nurses' judgments but not anyone else's judgment?

Mary Scanlon: I want to draw your attention to a further anomaly that is raised in your submission. Paragraph 8, which concerns voluntary and independent providers, states:

"It is not clear why the Ombudsman can conduct such investigations while he or she is precluded from investigating the actions of independent providers who are commissioned by local authorities which at present commission by far the majority of independent services."

The voluntary, independent and private sector provides an enormous proportion of care in the community. Is it too far removed from the kind of scrutiny that we want along the patient journey?

11:30

Professor Cheetham: Yes. It is far removed in two ways. I am baffled by the part of the bill that will mean that the ombudsman can investigate only independent providers that are commissioned by the health service and not those in other circumstances. I think that complaints about voluntary and independent providers will go to the Scottish commission for the regulation of care. However, it is not yet clear what form the last stage—the independent investigation—will take under the commission. Proposals are out for consultation. We do not know whether the ombudsman will be able to investigate voluntary and independent providers, but he probably will not be able to, because he can investigate only listed authorities. Even if he could investigate those providers, he would be able to investigate bodies that are commissioned by a local authority only on charges of maladministration and not for the substance of what they do. That is peculiar. Some thinking must be behind it, but I cannot elucidate it.

Mary Scanlon: You made a point about local authorities that commission care. Is the situation different for someone who is self-financing?

Professor Cheetham: Yes. My point was about local authorities that ask voluntary or independent providers to provide individual care for a person or, as often happens, that buy a number of beds or places in a service and refer people to it. In such cases, the local authority pays and the voluntary or independent body provides the service.

Mary Scanlon: What about someone who is self-financing?

Professor Cheetham: As I understand the system, people who are self-financing will have to complain to the Scottish commission for the regulation of care as part of the primary stage of a complaint. However, it is not clear from the proposals for the commission whether the ombudsman will have a function in relation to the commission's investigations. The commission is a listed body and the ombudsman can investigate its actions, but we do not know whether he can investigate a complaint that the commission is investigating. That has not been worked out yet.

Mary Scanlon: Although the problems that you raised about local authorities will not be dealt with by the public sector ombudsman, will there be recourse through the Scottish social services council and the Scottish commission for the regulation of care?

Professor Cheetham: It depends on the type of complaint. A complaint about the provisions in a care home will go to the commission and should do so as part of the primary stage. A complaint about a social worker who is alleged to have made a wrong decision about removing a child from home, or not placing a child in a care home, will not go to the commission, because it will regulate care services.

Mary Scanlon: That is confusing.

Mr McAllion: I want to return briefly to the question whether the ombudsman should be able to investigate the professional judgments of social workers. In the real world, the professional judgments of social workers are often constrained by budgetary disciplines. They cannot give the package of care to the patient because they cannot afford it. Are you suggesting that the ombudsman should be able to investigate such a complaint, overturn the social work committee's decision that the budget does not meet the needs and force it to reprioritise its budget? Should it be the ombudsman or the elected social work committee that decides how to allocate the resources?

Professor Cheetham: The ombudsman could not overturn a decision. We talked earlier about whether he would have a right to remedy something.

Mr McAllion: But the ombudsman could uphold the complaint, which would put the social work department in a serious position.

Professor Cheetham: He might investigate a complaint and find that a decision was reasonable within the constraints of the available resources. He might then have to criticise the distribution of resources. One sees that happening with complaints that are investigated in the health service. There are strong criticisms of the available resources.

One of the marvels of an ombudsman is that he or she has the independence to make such criticisms. We do not argue that an ombudsman should somehow magic up resources to change everything. However, an ombudsman provides an independent shaft of light into what goes on. It would be unfair for an individual professional to be criticised for making a decision, or for failing to provide a service that was not available but which everyone thought should be. An ombudsman's report could make that situation plain.

Mr McAllion: So the ombudsman's report would highlight the system's deficiencies rather than a social worker's decision.

Professor Cheetham: Indeed. That is what the health service ombudsman does.

The Deputy Convener: You talked about the blurring of the edges between the health service and social work and about the complaint processes in the health service and local government. However, we are developing joined-up delivery that involves more than one employer. Surely it is anomalous that complaints procedures will be different, depending on whether an individual is employed by the health service or by the local authority. That situation is difficult to understand; it could exacerbate the conditions that a complainant with a mental health problem was trying to complain about.

Dr Dyer: That is the point that we tried to make in our submission. Services on the ground are being encouraged—rightly—to blur boundaries to offer seamless care to individuals, so that it does not matter whether the service comes from the health service or social work, or a combination of both, but that individuals get the service that they need.

Higher-level bodies such as the public sector ombudsman and those that are involved in the complaints system do not yet reflect the coming together of the on-the-ground services. That means that the ombudsman could fully investigate a health service complaint, but could consider only the administrative issues of a local authority complaint. That situation must be sorted out.

The Deputy Convener: I hope that the Local Government Committee will take those points on board and that the civil servants who are present will also consider the matter.

Janis Hughes: The Adults with Incapacity (Scotland) Act 2000 gave the Mental Welfare Commission for Scotland the duty of investigating complaints that are made about welfare attorneys, guardians or other authorised persons when the commission is not satisfied with a local authority's investigation. Given the proposed new arrangements, do you believe that the commission should retain that power or should it be passed to the new ombudsman?

Dr Dyer: That is a good question; I am glad that it has been raised. It is an anomaly that a complaints function that derives from the Mental Health (Scotland) Act 1984 is to be removed from the Mental Welfare Commission for Scotland and given to the proposed public sector ombudsman, yet the Adults with Incapacity (Scotland) Act 2000 gave us a new specific function, as you said, to investigate complaints against welfare attorneys and guardians, and people with welfare powers who had made intervention orders. We exercise that function only as a back-up if the local authority has not investigated or if we are not satisfied with the local authority's investigation.

The simple solution to the anomaly might be for such matters to be the local government ombudsman's responsibility. However, difficulties might arise in that some functions would be carried out by private individuals and I do not think that the ombudsman would be able to investigate private individuals. Even if some functions were performed by local authority officers—a social worker, for example, could be a welfare guardian—there is the difficulty, which we discussed, that we could investigate the whole substance of the complaint, but the public sector ombudsman could not. We do not know the solution, but there is an anomaly—we still carry a complaints function under that act.

Janis Hughes: Would a possible solution be that you retain that function?

Dr Dyer: In the immediate future, it is difficult to see how things could be different, but I would be interested in what Juliet Cheetham thinks. Given that some functions would be performed by private individuals, an alternative solution is difficult to see.

Professor Cheetham: If the one-stop shop were truly a one-stop shop and excluded us completely, the new ombudsman would be able to investigate how the local authority had conducted its investigation of a private individual, which is how the commissioner for local administration operates. However, as we said, they would not be able to investigate the substance of a local authority person's decision and would probably be excluded from considering the actions that had been taken by a private individual because of the prescription about investigating public authorities.

Something is hanging in the air that we do not know how to resolve neatly.

Janis Hughes: Would there be any downside to your retaining that function?

Professor Cheetham: The downside would be that things would be a bit confusing. The one-stop shop is nearly a one-stop shop, but it has a little alleyway up the side. We have no experience of investigating such complaints or of considering the local authority investigation of complaints, so we cannot speak from experience, which I like to do when I am talking to groups such as the committee.

Janis Hughes: The Executive, in its summary of response to the second consultation paper, states that the proposals on staffing were unanimously agreed to, but in written evidence to the committee, the health commissioner expressed concern about the transfer of staff. Concerns have also been expressed this morning. Notwithstanding the comments that were made about the possible benefit of having a deputy commissioner who would be responsible for health in particular, is there a danger that the specialism that has been developed by staff working in the various departments could be diluted?

Dr Dyer: We understood that the proposal was that existing staff would be able to transfer if they chose to do so, so that expertise would be retained.

Janis Hughes: If no specialist areas were designated to deputies, for example, perhaps staff from one area would work in another area. Is that a potential problem? Should areas be defined so that staff specialism is maintained?

Dr Dyer: That would be desirable. Some skills in investigation would be transferable across different subject areas, but there would be a need to build up knowledge and experience of particular specialisms such as health and to understand the structures and different bodies that are involved. Sub-divisions that would allow a build-up of particular experience would be desirable.

Janis Hughes: Are there any additional proposals that you have not mentioned that should be included in the bill?

Dr Dyer: We would like to ask a question. We talked about the Adults with Incapacity (Scotland) Act 2000, under which important public functions are carried by the public guardian and other authorities. The public guardian does not appear to be a listed authority in the Scottish Public Sector Ombudsman Bill. Is it intended that the public guardian's functions will be open to scrutiny by the public sector ombudsman? Court administration will come under the public sector ombudsman—we welcome that—but we do not know whether the public guardian is broadly included in court administration or whether there should be a specific reference to the public guardian in that role as one of the listed bodies.

Professor Cheetham: Members know that the public guardian has extensive investigatory functions, which he carries out energetically. We share information and are aware of investigations in which people may have welfare issues. Some people will not be happy with what the public guardian does and I am not sure what they should do about that.

Janis Hughes: I defer to the convener for further information. I am afraid that I do not know the answer to the question.

The Deputy Convener: We will seek information from the Executive on the points that have been raised.

As there are no further questions, I thank the witnesses for giving evidence. The committee will now move into private session.

11:45

Meeting continued in private until 12:01.

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