THE SCOTTISH OFFICE

NHS MEL(1995)16

National Health Service in Scotland
Management Executive

St. Andrew's House
Edinburgh EH1 3DG

COMMON SERVICES AGENCY
RECEIVED:
3 APR 1995
FILE No.
REFERRED TO | ACTION

8724

31 March 1995

Dear Colleague

SCOTTISH HOSPITAL ADVISORY SERVICE

Summary

1. This letter advises you of changes to the role and title of the Scottish Hospital Advisory Service (SHAS), revised arrangements for visits by SHAS and for the handling of SHAS reports. These changes will take effect from 1 April 1995.

Action

2. Purchasers and providers should:

2.1 grant SHAS unrestricted access to any establishment providing services for NHS patients in the client groups within its remit;

2.2 co-operate fully with SHAS and with each other in addressing issues raised in a SHAS report; and

2.3 bring the terms of this MEL to the attention of all appropriate staff.

2.4 Further information is contained in the attached Annex.

2.5 Any enquiries about this MEL should be directed to: Mr Trevor Lodge, Room 265, St Andrew's House.

Yours sincerely

GEOFF SCAIFE
Chief Executive
NHS Management Executive

Addressees

For action:
Chief Executives, NHS Trusts

Unit General Managers, DMUs

General Manager, State Hospital

General Manager, Common Services Agency

General Managers, Health Boards

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Enquiries to:

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Background

1. SHAS was established in 1970 to give information and advice to the Secretary of State and Health Boards on the management of hospitals and units for the people with a mental illness, people with a learning disability, elderly people and younger physically disabled adults and to promote high standards of patient care.

2. SHAS carries out a programme of visits to hospitals and units covered by its remit. The objectives of these visits are: to examine and assess the accommodation and health care services for the client group concerned; to provide advice designed to maintain and improve the management arrangements and organisation of patient care, inter-disciplinary collaboration, education and training of staff; and to produce following each visit a report containing information, comments and recommendations which is sent to the Secretary of State and the appropriate Health Board.

3. The conclusions of a 1990 review of SHAS were conveyed to General Managers in the Chief Executive's letter of 3 May 1990. That letter set out details of the content and format of SHAS reports, recorded arrangements for the dissemination and publication of its reports, and for their follow-up. It identified a need to update SHAS's remit in the light of developments affecting the NHS and, subsequently, MEL(1992)13 advised General Managers that, to reflect community care developments, SHAS's remit had been extended to cover Health Board services provided under contract in independent sector facilities.

The Need for Change

4. The current arrangements were devised at a time when the units inspected by SHAS were directly managed by a Health Board. Following the introduction of the internal market, Boards have assumed a purchasing role and, with a few exceptions, have no direct responsibility for the day-to-day management of the services they purchase. For SHAS to remain effective its inspection arrangements must be set firmly within the context of this market environment and the contracts agreed between purchasers and providers. Following discussion with Health Board General Managers and Trust Chief Executives, it has been agreed that the arrangements set out in the Chief Executive's letter of 3 May 1990 should be adjusted to reflect this.

The New Role

5. SHAS's primary role will now be to:

5.1 assess a Boards' specification of the services purchased for its client groups;

5.2 assess the Board's arrangements for monitoring providers' performance against that specification; and

5.3 inspect the service delivered by providers.

6. To allow SHAS to carry out this role, it should have right of access to any establishment providing care for NHS patients in any of the client groups within its remit. Purchasers will wish to ensure that this is

reflected in their contracts with non-NHS providers. Purchasers and providers should make available to SHAS on request contract documentation or other supporting papers on the service being visited. They should also co-operate fully with SHAS and each other in addressing the issues raised in SHAS reports. SHAS normally gives notice of a visit, but retains the right to make an unannounced visit. Any problems with access or co-operation, which cannot be resolved locally, should be referred to the Purchasing Directorate of the Management Executive.

7. A multi-professional panel is being established, with a view to increasing SHAS's annual programme of visits. Health Board General Managers and Trust Chief Executives have agreed to release staff to serve on the panel. Teams of 4 NHS staff will be selected from the panel for their expertise in the service needs of one of SHAS's client groups. Panel members will be expected to devote no more than 14 days per year to SHAS work. They will be trained and supported by SHAS full-time staff. There will be no requirement for SHAS to reimburse salary costs of NHS secondees but travel and subsistence and support costs will be met by SHAS.

8. To promote the development of community care, Health Boards are transferring resources to social work authorities. Health Boards remain accountable to the NHS Management Executive for these funds and for ensuring that they are used efficiently and cost-effectively for the purpose for which they were transferred. Where social care services are being provided, responsibility for inspecting these services lies with local authority inspection units (for residential and day services) and with the Social Work Services Inspectorate (SWSI) in respect of the overall evaluation of services. Agreement on resource transfer should include agreements that Health Boards will receive copies of relevant local inspection reports so long as they remain financially accountable for the services being provided. In respect of other services, and the evaluation of services provided through resource transfer overall, SWSI will continue to have responsibility and co-ordinate its inspection programme with the SHAS programme. SHAS will share with SWSI responsibility for assessing specifications of services and arrangements for monitoring performance against specification.

The Content and Format of SHAS Reports

9. SHAS will continue to report on circumstances as it finds them and offer proposals for improvement, where appropriate, particularly where service specification or delivery appears to be out of line with national policy. Where policy has not been settled nationally, or where there are clear resource implications, the report will highlight the problem and recommend to the Health Board or the Department, as appropriate, the action that is required.

10. The format of the recommendations section of the report will also be revised so that it more clearly differentiates between service specification or contractual matters and service delivery issues. Health Boards as purchasers of health care are accountable for the quality of all services purchased for their residents and it is their responsibility to ensure, through the contracting process, that any problems identified by SHAS are put right by the provider.

Dissemination and Publication of SHAS Reports

11. Following the visit and local discussion of SHAS's draft recommendations, the draft report will be sent to the Chief Executive of the Trust, or other service visited, and to the General Manager of the appropriate purchaser Board(s) for comment within 4 weeks on matters of factual accuracy. The absence of a response by the end of that period will be taken as signifying assent. SHAS will continue to have the final say on expressions of opinion in the report.

12. The final report will issue within 8 weeks of the completion of the visit. The report will issue jointly to the Chairman of the provider unit, for action on operational recommendations, to the Health Board Chairman for action on purchaser issues, and to the Chairman of the Local Health Council. It will be the responsibility of the recipients to ensure that all employees with a direct interest in the report receive a copy. A copy of the report will also be sent to the Chief Executive of the NHS Management Executive.

13. Where contracts exist between the provider and a GP fundholder(s) SHAS will send a copy of its report to each of the fundholders concerned. In any event a copy of the report will be sent to all GP fundholders in the Health Board area in which the provider is located. In commenting on the report the General Manager of the purchaser Board should ensure that the Board's response takes account of the views of GP fundholders.

Follow-up to SHAS Visits

14. SHAS will seek a response from the Chairmen on the recommendations affecting their respective responsibilities within 3 months of the report's publication. Provider units will be expected to respond directly to SHAS on service delivery matters identified for their attention. Their response should be copied to the purchaser Board(s) who would only intervene if SHAS requested them to do so because it appeared that the provider was, for no good reason, ignoring a recommendation. Similarly, the Management Executive would only intervene if invited to do so by SHAS, the purchaser, or the provider as appropriate. Comments on the extent to which the purchaser's contract specification is being delivered in practice will be for the purchaser to follow up directly with the provider. SHAS will also have reported on other purchaser matters, for example the adequacy of the service specification, and the Board's response on these points should be copied to the Management Executive.

15. Where SHAS reports specifically on a purchaser's monitoring of the services it receives from its providers, both NHS and independent sector, they will once again seek a response from the Board within 3 months of the report's publication. The Board should respond directly to SHAS on these matters and copy its response to the Management Executive.

16. SHAS will, additionally, monitor the implementation of the agreed recommendations, normally through the issue of a questionnaire or, where it considers it more appropriate, by a follow-up visit within 12 months.

The Role of SOHHD

17. As noted above, the Management Executive should continue to receive copies of all SHAS reports and of Board responses. However, as Boards should now respond direct to SHAS, the Management Executive

would only intervene if SHAS requested them to do so. The Management Executive will, however, continue to monitor a Board's record in implementing SHAS's recommendations.

18. Each year SHAS will submit to the Chief Executive of the NHS and the Secretary of The Scottish Office Home and Health Department a report on major issues and action which may be required by the NHS Management Executive and offer a forward action plan for the next financial year. Following discussion of that report, the Chief Executive of the NHS, in consultation with the Secretary, will agree with the Director the visits or subjects to be reported on in the coming year. A report of SHAS's activities will be published each year.

Change of Name

19. As SHAS's remit now extends to cover health services provided for its client group in the community, and is not confined to hospitals, from 1 April 1995 the Service will be known as the Scottish Health Advisory Service.

Extension of SHAS's Remit and the Relationship between SHAS and Other Advisory Bodies

20. It has been agreed that SHAS's remit will be extended to include the inspection of the delivery of a service for specific client groups, for example services purchased for younger physically disabled adults across Scotland, and secondly allowing purchasers to contract with SHAS to undertake particular inspections in addition to its normal programme.

21. A further possible extension of SHAS's remit is under consideration. With developments in community care, members of SHAS's client groups are increasingly being cared for in the community and MEL(1992)13 indicated that SHAS's remit now extends to cover Health Board services provided under contract in private sector facilities. As the Mental Welfare Commission for Scotland and the Social Work Services Inspectorate have separate, but complementary roles to play in these developments, these agencies and SHAS have begun to pool information from their inspection activities and are considering whether they should carry out co-ordinated inspections of services in a particular area. Arrangements for any such inspection will be intimated to purchasers and providers if and when they are arranged.

Effective Date

22. The changes outlined above will take effect from 1 April 1995.