HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 8 March 2000
(*Morning*)

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CONTENTS

Wednesday 8 March 2000

HEALTH AND COMMUNITY CARE COMMITTEE
6th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Irene Oldfather (Cunninghame South) (Lab)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
Kay Ullrich (West of Scotland) (SNP)
*Ben Wallace (North-East Scotland) (Con)

*attended

WITNESSES

Richard Norris (Scottish Association for Mental Health)
Karen Prentice (Scottish Association for Mental Health)

CLERK TEAM LEADER

Jennifer Smart

ASSISTANT CLERK

Irene Fleming

LOCATION

Committee Room 3

Scottish Parliament

Health and Community Care Committee

Wednesday 8 March 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:30*]

The Convener (Mrs Margaret Smith): Good morning, everybody, and welcome to the Health and Community Care Committee. We have apologies from Hugh Henry and Kay Ullrich.

Community Care Inquiry

The Convener: This is our first evidence-taking session in this inquiry. I welcome Richard Norris and Karen Prentice from the Scottish Association for Mental Health. We have a series of questions for you; but first I would like you to take a few minutes to add anything you would like to the information in the written submission we received from you some time ago.

Richard Norris (Scottish Association for Mental Health): First of all, I would like to thank the Health and Community Care Committee for giving us the opportunity to give evidence. SAMH welcomes the fact that the committee has decided to hold this inquiry into community care, with particular reference to mental health and services for the elderly. In the past, there has not been enough political scrutiny of community care in Scotland, and we are encouraged that the Scottish Parliament has decided to look at it closely.

I hope that committee members have had the chance to look through our submission, although I am aware that you have a received a large number of submissions—72, I believe. We have focused on four of the five issues that were mentioned in the inquiry remit: resource transfer; the co-ordination of services between health boards and local authorities; particular examples of best practice; the best means of delivering the most appropriate care to patients.

What we have put under the heading "Resource Transfer Issues" is based on a thorough examination of figures that are in the public domain. Our calculations were checked by an actuary and by an official from the Accounts Commission. The figures show that, despite mental health being a declared Government priority, spending in real terms fell by 9 per cent between 1995-96 and 1998-99. The committee should note, however, that because figures for resource transfer are not in the public domain, nobody has a precise idea of the real level of spending. In its inquiry in 1996-97, the Scottish Affairs Committee exercised caution in accepting the resource transfer figures that it was given. We have included its comments in our submission.

In a report produced last October, the Accounts Commission considered a shorter period—from 1996-97 to 1998-99—and found that, although total spending on health had increased by 10 per cent, spending on mental health, including resource transfer, had increased by only 7 per cent. That figure does not take into account inflation during those years.

It is beyond dispute that mental health spending is not keeping up with general health service spending, despite the fact that mental health has been declared a priority.

Two recent Scottish Health Advisory Service reports into mental health services in Renfrewshire and Fife have identified a lack of investment as causing problems—affecting staff levels, the planning of new services and morale. Both reports praised the voluntary sector organisations, including local associations for mental health, but the committee should know that those organisations are now under severe financial pressure.

In the voluntary sector, level funding has been a reality for a number of years. For example, mental illness specific grants have been frozen since 1995-96. That has had several results: no inflation-matching increases in salaries for staff in some cases; local associations using up their reserves to keep services going; increasing compromises in delivering quality services; decisions having to be made about which services to close.

Mental illness specific grant, or MISG, was intended to set up new services that could then be mainstreamed. That has not happened. Continued level funding has meant that staff and volunteers have become increasingly demoralised. Not knowing what the yearly funding will be from one year to the next has added to the general uncertainty.

I would like to pass on to the committee some of the views that have been expressed to us by local associations in the past few weeks. They are just a small selection, and they are typical of the problems that are being encountered.

"We have now exhausted our reserves trying to keep services going."

"Total funding for mental health associations three years ago was £40,000—now it is £10,000."

"The council include 5% for inflation in their own budgetary calculations but do not allow voluntary organisations to put in a percentage for inflation in their

own budgets."

"We have three weeks to go until the end of the financial year—but do not know yet what we will be given for next year."

"The Local Authority has set unreasonable bed occupancy targets, which means that we are effectively subsidising a £10,000 deficit. The Local Authority maintains that we should meet this out of our reserves. We may have to close the project, which would mean redundancy for nine staff and 12 service users losing their homes."

"We will be closing counselling, befriending and day care services in the next few weeks as a result of continued level funding."

"Lack of resources is creating extra strain. People are on the verge of burnout. Our management committee will have to consider what services to cut in the coming year. We are in March but we still don't know what our funding will be from April."

That final quotation comes from an association in the Highlands. Highland Council has just announced that its voluntary sector budget will be cut by £220,000, although I understand that that will be discussed again tomorrow.

One example that I would like to give the committee is of the Skye and Lochalsh Mental Health Association, which provides a drop-in centre and training facility known as the Cabin to 197 members in Portree. The service is vital, given that the nearest alternative services are 150 miles away in Inverness, which would entail three hours of travelling. Seventy per cent of the funding for the service comes from MISG.

The Cabin is extremely cost efficient—the cost of providing the service to each member works out at between £1 and £24 per person per day. However, inflation pressures mean that the Cabin now needs £12,500 more annually than it did when it started. Last year, Craig Dunain hospital helped it out at the last minute by providing that money. This year, it is not sure whether it will be so fortunate. The association must find £12,500 by the end of this month if the service is to survive.

If no money is found, the Cabin will close. Community psychiatric nurses and doctors in Inverness wholeheartedly support the Cabin and fear that they will be swamped if the service closes. It is unlikely that users will feel able to cope with the long journey to Inverness, not to mention the cost of travel. Staff at the Cabin are permanently fearful for their jobs. The manager spends half of her week begging for more money.

SAMH is also a service provider. It provides services through its projects across Scotland. We have problems too. In our experience, some health boards include inflationary increases—for example in resource transfer moneys—but local authorities do not pass them on to voluntary organisations. Because of purchasers' reluctance to pay for the full cost, we recently had to close a supported accommodation unit that provided 10 people in the north-east with somewhere to live. We could not afford to fund that shortfall out of our reserves.

We are not saying that there is a problem only in health and social work. A significant amount of community care activity is delivered through the training for work programme and the European Social Fund. Our experience of training for work and other such programmes is that there always seems to be a financial incentive to work with people who are the most able and who will progress most quickly through the system, but there is a financial disincentive to work with people who require greater levels of support and who will take longer to achieve their goals. We are in the process of closing three training for work projects in the west of Scotland that are funded by local enterprise agencies. In one, the amount of funding has fallen from £56 per trainee per week in 1992, to £30 per trainee per week at present. It is not economically viable for any organisation to provide services under that pressure.

There is no broad strategy for special needs training in Scotland, yet research shows that relapse rates reduce by more than 50 per cent if someone is given a structured work or training environment.

We also use ESF moneys to provide training. Our current funding ends in June. There are changes in the programme this year, and there have been delays in making those changes. Our latest information is that applications will be accepted in July and August of this year and that we will be told about funding in September or October. We cannot afford to run projects during that period of uncertainty if we do not know whether we will be funded for them. For SAMH, the consequences of that are that eight projects are facing closure—projects that deliver services to 500 trainees. At the end of this month, 55 SAMH staff will receive redundancy notices. Since October, we have been asking what contingency funding may be available to fill the gap until we know what the new funding will be. We are still waiting for that information.

This is often seen as a European issue, but it is a cross-cutting one. There will be a huge knock-on effect on community care services if the ESF funded projects close. For us alone, that will mean 500 people seeking support from already overstretched community care services. Even in my department at SAMH we have a funding crisis. A few years ago, we were able to cross-subsidise our policy and information activities from our other activities, but that is no longer possible. We had a national lottery grant—which will run out this summer—that supported four posts. We provide the only nationwide mental health information

service in Scotland, which provides specialist legal and benefits advice. We face having to close that service soon unless we find alternative funding. Fundraising for mental health is difficult.

The framework for mental health services is now two and a half years old and there is no evidence of new services appearing. For example, there are still no community-based crisis services in Scotland. Many people feel that user and carer involvement in consultations on new services has been tokenistic. There seems to be a planning blight created by long meetings between health, social work and other organisations and lots of long strategy documents with nothing much appearing in terms of front-line services. We worry that the framework will slowly drift into the sand, similar to the all-Wales strategy of the early 1990s.

There is not enough prescription in the framework document—there is a need for more carrots and sticks. Institutional care in Scotland still accounts for 78 per cent of expenditure on secondary mental health services for adults, according to the recent Accounts Commission report. Concrete targets should be set for the transfer of resources, or new money should be ring-fenced for community projects.

In its report, the Accounts Commission also referred to the continuing conflicts over resource transfer, the true number of bed closures since 1990, the calculation of cash savings, and the amount retained by health boards. It noted that there is a considerable variation across Scotland in resource transfer amounts, from under £8,000 to just more than £25,000 per bed closed. Its report also noted the difficulties caused for local authorities and the voluntary sector by the freezing of mental illness specific grant for the past four years. The Scottish Affairs Select Committee recommended in its report in 1997 that MISG should be increased in line with inflation.

I make no apologies for having concentrated on funding issues in this overview. No amount of strategies, joint working initiatives or good intentions can compensate for badly funded services.

The Convener: I was going to ask what you regard as the top priority for the development of mental health provision over the next five years, especially as it relates to community care services, but I think that you have answered my question before I asked it. I assume that you would respond that it is funding, so I will add to that question—what are the greatest barriers in the way of mental health services being provided as you want them? I expect that you will respond that funding is one of them, but can you give me some other ideas as to what barriers there are to your priorities being met?

Richard Norris: A number of reports have identified the fact that provision of mental health services is still based on historic provision rather than on current need. The pattern of provision of mental health services means that money is still going into the old services—resources are not being redirected. Funding is important in relation to that as well, because if there is not funding for new services people will, naturally, be protective about their budgets.

The framework document, which came out two and a half years ago, was an attempt to find a way forward on that. It has a six-year implementation plan. I mentioned in my overview that many people's experience of user and carer involvement in that planning seems to have been tokenistic. I talked to someone in the north-east recently who said that one of the problems is often that user and carer involvement involves a token user or carer on a planning committee. The one successful example in the north-east that she could cite was an education group that had been set up where 50 per cent of that group were users and carers. Critical mass is an issue, as one carer on a committee feels isolated. There have been examples of good practice to try to overcome that.

In our submission we mention a project in Glasgow that is examining user evaluation of services. There is also the allies in change programme, which is examining how to ensure users and carers feel more empowered and able to deal with committees. That is a recognition that there is a real problem. The problem has also been identified by Scottish health advisory service reports and by the Accounts Commission.

Dr Richard Simpson (Ochil) (Lab): You have painted a stark picture of the fact that we have a good framework but we are not moving forward on it. I asked an oral question on whether targets were being set in relation to the implementation of the mental health framework. The response was that a working party is arising out of the summit that took place in January. What are your views on that mechanism for taking this matter forward?

Richard Norris: I agree that there should be targets. I did not attend the mental health meeting in January, but setting up a working group to consider targets sounds like a positive development. A problem with the framework is that there has not been enough prescription. Ambitious mental health strategies are produced, but they tend to be long lists that lack hard commitments in terms of time scale and resources. A typical mental health strategy would have a list of good community services and would give no undertaking as to how money would be found to fund them or when they would come on stream. I would welcome any development that introduces more prescription into the implementation of the

framework.

09:45

Dr Simpson: Are the various special funds that are associated with the mental health framework effective, or are they too short-term? One of my concerns in relation to three-year funding is that when you get your funding it takes at least three or four months to get the project working, so you might be six months into the project before it functions. You then have a maximum of two years to run the project and prove that it is worthwhile. There is then six months of planning blight at the end, during which the best staff are looking for new berths.

I am concerned about your point about the pick-up of continuing funding. Can you see a way out of that problem? Is there any indication that health boards are involved, with you, in the joint planning of those resources? Are the boards saying, "Yes, we want this services and for a period at the end of the funding we will assist to avoid this situation"? I have had this problem in my constituency—not only in health but in relation to young offender projects and family mediation: staff have been given redundancy notices and must wait for three weeks to find out whether they have a job. That is totally unacceptable. Can you suggest any ways out of that problem?

Richard Norris: Three-year funding would be a luxury for many organisations—often, they have yearly funding. One local association told me that they all get a form from their local health board in April to fill in, send back and be told what their funding is from the beginning of that month. Many local associations and many services that we provide do not know what funding they will get from next month. There needs to be more prescription in relation to the length of time of funding. Various documents have said that three-year funding would be a good thing and that the voluntary sector needs more stable funding, but that is not happening. Perhaps the Government needs to be more prescriptive about the contracts that are awarded, through either health boards or social work departments.

As we provide services throughout Scotland, we have a nightmare in relation to contracts, because every purchaser has a different contract and procedure—the approach is not unified. Every local authority or health board has a different set of contracts and we—as a national organisation—provide services throughout Scotland. That ties up an enormous amount of time on administration, which is wasted time that could be spent on developing new services.

Dr Simpson: You will also have tendering problems because the tenders are all different. Is there any evidence that the Scottish Executive is trying to co-ordinate this in any meaningful way?

Richard Norris: Not that we are aware of. The Scottish Executive is sometimes reluctant to appear to interfere in local government affairs. We are often caught in the political problem of the Executive being unwilling to be too prescriptive towards local government as it is conscious of the boundaries between their powers. I think that there have been recommendations in the past.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): You have highlighted the fact that there has been a fall in national health service expenditure on mental health. Do you believe that expenditure should be targeted on social care provided by voluntary organisations or local authorities, or should we be considering some other mechanism?

Richard Norris: This is a difficult and complex area. The framework document, which mentions the need for joint commissioning and pooling of budgets, is almost half way through its implementation plan. We supported the framework and would still like it to be implemented. There is no stomach for reorganisation, either in local government or in the health service. Local government reorganisation a few years ago caused immense problems for voluntary sector bodies, which had to re-establish relationships. The recent reconfiguration of health trusts is also causing delays in implementing the framework.

Our view is that now is not the time to consider more radical restructuring of how moneys are spent rather than putting carrots and sticks in the framework. However, if we are still in the same position in two or three years' time, we would reluctantly suggest that we should consider once again whether it is a structural problem that must be addressed.

Margaret Jamieson: You said that there is no stomach for further reorganisation, but since the previous reorganisation little use has been made of the joint investment fund, which was supposed to bridge the gap between primary care and acute services and to include voluntary organisations. Should we pursue that mechanism to ensure that a joined-up and well-thought-out service can be provided?

Richard Norris: Can you elaborate on the joint investment fund? I am not familiar with it.

Margaret Jamieson: I think that you are not alone. It is something that has not been exploited. It is supposed to be the structural mechanism for individuals who are coming out of institutional care, either from the acute sector or from various types of mental health care. All members find that that mechanism is not being used to best advantage in their constituencies. An organisation

such as yours may not have been involved in it, but it is something that we should pick up on.

You said that there is no stomach for reorganisation because it affects the delivery of care by trusts or local authorities, but the strategic planning of services allegedly remains with health boards. Is there stomach for investigating that?

Richard Norris: The framework document made it clear that social work departments are expected to play a strategic part in the planning of services. The evidence shows that working relationships between health boards and social work departments differ throughout Scotland; some are good and some are not so good.

As I said in my overview, community care is a cross-cutting issue. Even a radical solution of combining health and social work might not solve the problem, because other community services such as training, enterprise and development agencies, the criminal justice service and housing are all important to community care. I would therefore be reluctant to go for a solution that attempts to create a new combined organisation, because something will always be left out.

Mr Duncan Hamilton (Highlands and Islands) (SNP): The committee is considering a thematic approach to community care as part of a continuing wider inquiry. We can develop some of your points about a unified approach and the failure of long-term planning. There are two other areas that will crop up again and again in this inquiry. One is the attitude to resource transfer, which is crucial.

There is a debate about the level of compulsion or discretion within budgets. You have said that you are in favour of ring-fencing, so you are strongly in favour of compulsion. Would you like to expand on that, as there are many people who would oppose compulsion?

Your other point was about transparency, but it could be argued that the more transparent the system, the less the need for ring-fencing. Do you believe that if we move towards the level of transparency that you were talking about, the requirement for ring-fencing would be reduced or removed? Why do you think that ring-fencing is the way forward?

Richard Norris: In our submission we give the example of money from the sale of psychiatric hospitals going into other services. We think that there is a good case for saying that that money should be earmarked for the development of mental health services. One health board responded that if it did not spend the money, it would lose it, so it had to spend the money quickly on something else. Ring-fencing would help health boards to protect that money for mental health. If the rules on capital receipts being returned to the Executive were relaxed, boards would be able to spend the money better and more strategically on mental health.

I take the point about transparency. If we had more transparency about levels of resource transfer, it could be policed more easily. The problem at the moment is that we do not have a clear picture of what is happening with resource transfer and the figures are not in the public domain.

Mr Hamilton: Can you outline exactly what you are looking for, so that we can be absolutely clear about what transparency means in this context?

Karen Prentice (Scottish Association for Mental Health): It is very difficult to ascertain the level of spending on NHS mental health services because the resource transfer levels are not contained in Scottish health service costs. Whereas we can work out how much money has been spent on hospital beds or community mental health teams, we do not know how much money from resource transfer is going into the community. We have to rely on the Accounts Commission producing a report, which states the resource transfer levels as a fait accompli, as we cannot go back to check them. We need more transparency so that we can keep an eye on individual health boards and ascertain whether the money is being invested in mental health services and not leaking out somewhere. That would enable us to check whether the money that is being freed up from hospital services is being used for community mental health services.

Mr Hamilton: Because the case for transparency is so obvious, presumably you have been pushing it for some time. How do you explain the resistance to that?

Richard Norris: It is difficult to give you an explanation. We are not the only ones calling for more transparency. In its report in 1997, the Scottish Affairs Select Committee once again called for more transparency in resource transfer. I do not know why there is a problem achieving that.

Mr Hamilton: I am a bit confused about your approach to pooled budgets, which you were talking about a minute ago, and how it fits with your support for ring-fencing. What is your position on that?

Richard Norris: When we talk about pooling budgets we are talking principally about health and social work departments, as well as budgets that are available from other organisations. In the framework document and other papers that they have issued, both the previous Government and this Government have said that organisations need to be transparent about pooling their resources—in other words, to be honest about what budget they have for mental health. There is

a continuing problem in this area, because the evidence indicates that people try to hold on to their budgets. In one sense that is perfectly understandable—it is very human, particularly at a time of severe financial stringency. If a provider thinks that it can hold back some of its budget to spend on something else and get someone else to pick up the tab, it will do that. Unfortunately, the framework document did not offer people incentives to invest in new services. It required a level of honesty and openness that it was unreasonable to expect from people who want to protect their budgets.

Dr Simpson: In your submission, you mention Forth Valley Health Board, which covers my area. I do not go to the barricades lightly, but I can assure you that, if the £20 million from the retraction of Bellsdyke is used in the acute sector, I will be standing on a barricade somewhere. The primary care trust has said that that will not happen. As it is the trust's land and resources, I have great confidence in the chair and chief executive, who have just been appointed.

Ian Mullen's announcement was a reflection of the situation in the health service as a whole. The acute sector expects to pick up a lot of the resources that are sitting unused in mental health services. I want to have on record the fact that the rather weak reply from Forth Valley Health Board does not reflect its true position. It will be much stronger in its view of the transfer of that money.

10:00

The Accounts Commission report says that the tracking of transferred resources by the health service—the NHS is responsible for accounting for all the money that is transferred to local authorities—is often extremely difficult. Given that, do you support my view that all funds available on retraction should be the subject of a joint agreement between the health board, the local authority and the voluntary sector? In other words, do you agree, not that there should be an agreement on a proportional transfer of a range of money—from £8,000 to £25,000 per bed—but that all moneys released should go into a joint investment fund, as Margaret Jamieson said? Do you also agree that the parties should then ask how best to spend the money? If the money has come from the primary care trust due to the release of land, as we have been discussing, do you agree that there should be discussion about how to apply it to the new mental health services within the mental health framework?

Richard Norris: I strongly agree. In a sense, this is about information. I refer again to the SHAS report, which comments not only on underfunding, but on the fact that there is poor communication between the health boards, local authorities and the voluntary sector. A local association in the Highlands recently told me that there had been a £3 million resource transfer fee, but that no one knew where it had gone.

Margaret Jamieson: I want to pick up on that. Resource transfer varies depending on the health board area. However, we are moving towards planning the delivery of services and putting a lot of emphasis on ensuring that community planning takes place in each locality, particularly in local authority areas. Do those factors allow you to have more strategic involvement both in indicating the level of provision that is required and in consultation with the public? I am aware of the general public's attitude to moving mental health services from the old institutions into the community. Can the community plan be used to break down the barriers that are perceived to exist, and that do exist in some areas? Is the community plan a way forward in terms of funding and saying what services should be provided?

Richard Norris: Yes. You identify the fact that there is sometimes opposition to mental health projects in the community. We have encountered opposition when we have tried to set up supported accommodation projects, for example. However, we usually find that opposition evaporates once the project is set up. In one case, people commented that their new neighbours were much better than the old ones. Nevertheless, opposition is a continuing problem.

Mary Scanlon (Highlands and Islands) (Con): We are skirting around the relationship between local authorities and the NHS. What do you mean by

"Cultural incompatibilities between health and social work"?

Is it possible to establish a relationship in future? We have tried for seven years, but it is not working. If that is what is wrong, there is little hope for partnership in future.

Richard Norris: The comment was about the professional boundaries that can exist between the two organisations. For example, I heard of a group in the central belt that was trying to set up a self-help project for women suffering from post-natal depression. That got a lot of encouragement from the social work department, because the project fitted in with its agenda, but it did not get any support from the health board. On the other hand, we tend to find that, in terms of contracting, it is easier to deal with health boards and health trusts than with social work departments.

There are myriad issues. Sometimes, there are professional jealousies between groups and different ways of approaching issues such as contracting and the services that are required. There is probably a role for joint training in future. It may be that someone training in social work

should be seconded for a short while to a health organisation, and vice versa. That might help to break down the barriers.

The barriers have been acknowledged. I have attended meetings and conferences at which professionals from both sides of the boundary have recognised the barriers and expressed a wish to overcome them. In practice, the difficulty comes down to personalities in different areas. Where there is the will to cross that boundary, it happens.

Mary Scanlon: Mentally ill patients—who are not at the heart of the service, as you pointed out in the bleak picture that you painted at the beginning of the meeting—are being failed on account of the personalities of people in health boards and in social work departments. If there are serious issues, I wonder why we are bothering talking about pooled budgets and so on. If health boards and social work departments cannot work together—if their heads cannot be knocked together—we have to look at the issue much more radically. What is your answer, given the personalities, divisions and so on?

Richard Norris: I do not want to reiterate the point that I made earlier. There is an experiment in Perth to try to ensure that the social work and health organisations work together more closely. My view is that we should stick with the framework but add more carrots and sticks. If, in two or three years' time, we are still not seeing progress on the ground, we may ask whether a deeper, structural problem needs to be addressed. It may simply be that this is like trying to change the direction of an oil tanker—it takes a long time to do it. However, there is considerable frustration on the ground that services are not appearing.

Mary Scanlon: Last night, I read that, sadly, the National Schizophrenia Fellowship, the Institute of Psychiatry and other mental health bodies with an input into care in the community are all saying what you are saying. We have spent seven years on this. You have painted a bleak picture and I wonder how much more time we have to waste.

The Convener: Can I stop you there, Mary? I take it that you were going to ask about beds. Ben has a point arising from Richard's comments.

Ben Wallace (North-East Scotland) (Con): I wanted to expand on the relationship between health boards or hospital trusts and local authorities. Resentment seems to be building among the health boards about where their transferred resources are going. If they cannot see any tangible benefit, they are questioning the amount of money that they are transferring. A number of health boards have told me, "We are under massive pressure because of bedblocking, and we are not getting anything out of the relationship, so what are we doing? We could use the money elsewhere." Have you picked up on that? Do you have any comments?

Richard Norris: My comment is a general one. One could speculate that the reason why the funding has not delivered locally, despite mental health being a priority, is that funding decisions are made by health boards and health trusts, which are more interested in what are seen as the politically high-profile areas of waiting lists and acute services. You could ask, "What has been happening for the past seven years?" Care in the community has been a declared objective of different Governments for many years. We may have to recognise that mental health is not a politically attractive issue. Although there has been a clear political will and a recognition that community-based care is more suited to the needs of people with mental health problems, we cannot underestimate the huge amount of political will that might be needed to move things on.

Mary Scanlon: In your submission, you say that

"people experiencing serious mental distress have been turned away from hospital because of a lack of beds".

The converse is that, while that is happening, people might be inappropriately taking up a bed in hospital. As has been suggested, people are almost becoming prisoners in our hospitals because of the lack of social work support and because we are not understanding exactly when they want to come back into the community. The whole picture is tragic. How many beds are being blocked by mentally ill patients who cannot get the appropriate care that they need in the community?

Karen Prentice: We do not have any figures for that, although both SHAS reports drew attention to the problem. The requirement for beds is running at more than 100 per cent capacity because, at the weekend, people in acute states are taking over the beds of people with weekend passes.

We heard about a woman who was taken to a hospital in serious mental distress. When the doctor asked the woman's daughter whether he should section her, she said that she would prefer her mother to be admitted as a voluntary patient. She was then told that the hospital could admit only sectioned patients. As no alternative was available, the mother and daughter were sent home to fend for themselves.

No other crisis services are open outwith office hours or at weekends, which is when most crises happen. We have to consider other kinds of crisis services; if beds are not available, something must take their place. If that does not happen, people in serious mental distress will continue to be turned away from hospital or will be admitted inappropriately. People might not need hospital care but, once they are in such care, it might be

difficult for them to leave because appropriate community services are not available.

Mary Scanlon: So some people in the community are desperate for hospital care and others in hospital are desperate to be in the community. The whole situation is a real mess.

Karen Prentice: Our submission also draws attention to the fact that people are sometimes blocked in because no one is willing to earmark funds for a bed in SAMH-supported accommodation. As a result, we have to pick up the cost until that money can be found.

Mary Scanlon: I think that I am right in saying that weekly care costs SAMH £268 and the NHS £700 to £800.

Your submission ends with the question:

"Why is it that markets are seen as bureaucratic and wasteful in health care, but actively promoted in social care?"

Richard Norris: That was partly a rhetorical question. The internal market was abolished because it was seen as bureaucratic and wasteful; however, we still have a market in social care. We must carefully think through a market for social care; it is not a perfect market situation, as the consumers are not the purchasers. One way around that problem is to examine regulating contracts on a more unified basis, so that we are all on a level playing field, and to involve users and carers in evaluating services. Without those factors, the market is a sham.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I am interested in the crisis services to which you have referred. I have worked with users of mental health services in Edinburgh; one of their top priorities is to have at least one crisis centre in place. I understand that users groups elsewhere in Scotland have similar concerns.

Who do you think the crisis service should be for? One of the tensions in discussions about mental health seems to be whether we should concentrate on those people who have the most serious mental health difficulties or on mental health problems in general.

What would a crisis service be like? Where would it be located and—more controversial—how would it be staffed? Staffing contributed to the breakdown in Lothian, where the health board has a narrow, medical model of a crisis centre. Although the users of such a service include medical personnel, a much broader range of people would also be included.

10:15

Richard Norris: You are right—we tend to end up discussing those who have the most severe mental health problems. One in four people in Scotland will experience some form of mental health problem at some point in their life, although the vast majority of them will never go anywhere near a psychiatric hospital. General practitioners are the health service contact for most people when they have a mental health problem. Research indicates that about a third of GP consultations involve mental health problems.

Our view is that a crisis service should be open to people who are experiencing a crisis and that they should not have to have been a psychiatric patient in the past. We would go for an accessible model. We know of a weekend crisis service established elsewhere in the United Kingdom at which people who wished to use the service had to book themselves in during the week—that is not much use for a weekend crisis service.

The Convener: I often feel a crisis coming on in this place.

Richard Norris: We should consider non-crisis needs. There is no reason why one has to be facing a crisis in order to use a 24-hour counselling service.

We run services that are similar to drop-in and day-care centres, such as the clubhouse model that we run in Fife. Service users are members of the club, take part in club activities and pretty much run the club. A wide range of community-based services is available and we do not want to give the impression that we are concerned only about those people in crisis. That is also why we think it important to consider how to give people structured days, through training, work and supported employment.

Karen Prentice: If people receive appropriate community care, crises are far less likely to occur. In our submission, we cite an example of one of our service users, a woman who was a "revolving-door patient" when she was living on her own in the community but who, since she entered SAMH's supported accommodation, has not been in hospital.

The debate should be about early intervention. We should move away from the position where people have to reach a crisis before they can get help. A lot of service users say that they want time-out centres or 24-hour drop-in centres. A time-out centre that opened in Clackmannanshire was the focus of a lot of cultural resentment from NHS staff, who tend to work towards medical models. We must establish innovative projects to help people before they reach a crisis.

Malcolm Chisholm: I strongly support that kind of project. I was using the phrase "crisis centre" in a more narrow sense, but I happened to have a meeting on Friday with Lothian Health and Lothian Primary Care NHS Trust about an excellent

community mental health project in Pilton in my constituency. The funding of that project is being halved because its urban aid funding is coming to an end. Everyone says that the project provides a wonderful service and that more people will end up in hospital if that service contracts.

My understanding is that a crisis centre provides a service all the time. I take it that the emergency team in Birmingham, which is mentioned in your submission, goes out to people, but users groups in Edinburgh have suggested to me the model of a building in the community that is open all the time. Are there any such centres in Scotland or the United Kingdom? Is that a viable model?

Karen Prentice: We are not aware of any in Scotland. Our service users also cite that model as a service that they would like to have.

Dr Simpson: We have an anti-virus service that is run by general practitioners and nurses, an accident and emergency system that operates 24 hours a day, a social work emergency team that is operating 24 hours a day, housing work that goes on 24 hours a day, some voluntary sector stuff and NHS Direct on the horizon. All those teams offer different types of service, but my worry is that for people with mental illness—as you have described—all the components may be required together. To expect a person out there to ask, "Wait a minute; do I have a social crisis, a housing crisis or an accident and emergency crisis?" is totally ridiculous.

We need far better co-ordination of those services, so that the user can access them all at a single point before being directed to the appropriate service or having that service directed to them. The crisis intervention teams come in as an additional measure for the seriously mentally ill, rather than for those mentally ill people who are just beginning to have significant problems that require attention.

Sorry, I have gone on a bit. Do you think that there should be better co-ordination of services?

Karen Prentice: Another problem is that service users often do not know where to go in a crisis. In England, a survey was conducted of service users who were in receipt of help from two or three professionals. They did not have a clue where to go in a crisis. According to the survey, 39 per cent said that they had been turned away when they had gone somewhere in a crisis, or had turned up at their former hospital ward only to be told that they could not just walk in. There should certainly be better co-ordination.

Ben Wallace: I have an appointment with the doctor at 10.30 am. May I ask a question now?

The Convener: I will be kind to you, Ben.

Ben Wallace: My question concerns the waste of resources and the breakdown in co-ordination. I have a constituent whose clinicians—his psychiatrist and his GP—have said that there is no need for him to be sectioned. Nevertheless, the social work department of the local authority has persisted—through meetings and with the police—in trying to get him sectioned. The money that has been spent, through ignoring the advice of the clinicians, shows that a bad procedure has been followed and that resources have been wasted. Do you have a view on that? The clinicians say that it is a reflection of the way in which some mental health officers work, and the social workers persist in the opinion that they are right in overruling what the clinicians have said. Do you think that that is one reason for the waste of resources throughout Scotland?

Richard Norris: That sounds like a particular problem rather than a general one, in which the mental health officer is insisting on having someone sectioned against medical opinion. That is not a common scenario.

Irene Oldfather (Cunninghame South) (Lab): I have a supplementary question to what Richard Simpson said about crisis centres. We have not mentioned people with mental illness who are placed inappropriately in police care because of the lack of crisis centres—I have two friends who are police surgeons, so I know that that seems to be a problem. If nobody knows how to deal with such people, they are taken to the police cells. The police surgeon is then called in, although the problem is clearly one of mental health, and the person is inappropriately put through the criminal justice system. Do you have any experience of that? It is important to put that point about crisis centres on record.

Richard Norris: Our information service, which also provides legal advice, comes across such cases. Ben Wallace's constituent might find it worth while to contact our legal service to find out whether it has any advice on the situation. We sometimes hear of people being inappropriately referred to the criminal justice system. In a case that made the headlines a year ago, a woman was sent to Cornton Vale after attempting to commit suicide.

There is a problem. A new strategy for mentally disordered offenders is being put together. Better mental health training for police officers would be helpful. Karen Prentice made a point about information. We publish a range of information booklets on legal rights, including "You, the police and the courts".

Irene Oldfather: Some sort of crisis-intervention centre would probably prevent such incidents, as the centre would have professional staff who were well trained in the range of mental illnesses and there would be no need to involve the penal

system, which is totally inappropriate.

Mr Hamilton: I wanted to follow up on Richard Simpson's point. He is absolutely right about the need to pull together the disparate groups that are involved. We all agree that we need one point of entry and a much greater focus on the individual. I would like to hear a clear statement from you on what you think that point of entry should be. You talked about the enormous work load of GPs. Do you think that GPs are the best starting point, and if not, who is?

Richard Norris: At the moment, GPs are still the gatekeepers to secondary mental health services. I can understand the reasons for wanting to maintain that position. However, we would like to see walk-in facilities—on the lines of those that are being established in other sectors—at which people could refer themselves directly to specialist mental health services. That would be our preference.

Dorothy-Grace Elder (Glasgow) (SNP): You make it clear in your report that there is no middle ground. You say that in many cases

"individuals must reach a state of absolute crisis before help can be obtained."

I do not know what your experience is in Scotland as a whole, but in Glasgow it is not just crisis centres that have ceased to exist—even day psychiatric hospitals are closing. Four have closed recently or are closing, including Auchinlee in Easterhouse, which is relatively modern. In your experience, is that happening beyond Glasgow?

Richard Norris: In our experience, the hospital closure programme has been proceeding slowly. The Government made available a large amount of bridging money to Glasgow so that it could close psychiatric hospitals and move people into more appropriate community facilities, but in Scotland as a whole the pace of closing down long-stay psychiatric hospitals to provide more appropriate care in the community has been slow.

Dorothy-Grace Elder: The hospitals that I am talking about tend to be very small and based in the community; in Glasgow at least, they are still being closed.

I want to ask about your plea for ring-fencing. What you have been telling us matches my experience over the past few years. In a financial sense, the problem boils down to lack of security, rather than simply to the amount of money that services receive. As Richard Simpson pointed out, funds for three-year projects are often available only on a year-by-year basis. Do you have any research, or do you think that it would be useful to have us or some other body conduct research, on the amount of time that you lose from your hands-on duties with the public because you are involved in a constant search for cash? You referred to your manager having to spend about half her week begging for money, as you put it. I have come across many cases of managers who spend almost their whole week on that, when they should be assigned to other duties. How much time and effort do you waste looking for money, and what are the long-term effects of the insecurity that you face?

Richard Norris: It is very difficult to produce exact figures for that, because in the voluntary sector managers are spending their time sourcing funding so that they can continue projects when they would be better off spending that time developing new models and setting up new projects. The emphasis of the framework is on setting up new services and it is increasingly difficult to get money for existing worthwhile services. I am talking not only about statutory funding but about other sources of funding. People tend to be keener to fund new services than worthwhile services that are already up and running. Even though it might be cheaper to refer people to an existing service, people are referred to the more expensive services that are funded through transferred resources, because that costs the social work department nothing.

10:30

Margaret Jamieson: You talk about new models and services but the difficulty is that there is no service that fits all. Each area has particular needs. In some areas, there has been a move towards linking accident and emergency. For example, in Crosshouse hospital in my constituency, a consultant psychiatrist will soon be based in the accident and emergency department. That is a welcome development and might assist Irene Oldfather's police surgeon friends.

However, how do we know that that is best practice? Is there a sharing of ideas and knowledge? Is the person with a mental health problem asked whether the treatment suits them? In the past, we have only asked whether we are getting value for money. My question is this: is what we are doing now and what we plan to do in the future what the service users need or want?

Richard Norris: There is sometimes a tension between what is seen as an effective medical intervention and what users of services want. We are entering into an area of evidence-based medicine and we need to be aware of issues relating to that. The Scottish Executive's health research bulletin talked about the mushrooming of counselling services that are provided by general practitioners. That was seen as a response to a demand for such services. However, the bulletin cast doubt on whether those services were medically effective.

In terms of evidence-based medicine, effective treatment must be balanced against the views of the patients. Recently, a three-year audit of electroconvulsive therapy in Scotland was completed. It examined issues of consent and how effective the treatment had been. However, as not a single patient was asked for their opinion on ECT, the end result was a good clinical study that did not take patients' views into account. I am not saying that medical evidence should be ignored, but patients' views should be taken into account as well.

Margaret Jamieson: Both things should have equal weight in any audit trail.

Karen Prentice: Margaret Jamieson mentioned that Crosshouse hospital will have a psychiatrist in the accident and emergency department. That is a good idea and might prevent people ending up in police custody. However, unless there is somewhere that the psychiatrist is able to refer people to, the policy will not be effective.

There are excellent examples of best practice in other countries. In Finland, there is a mobile counselling service that people can phone up. It can assess whether people need further help or simply someone to talk to. In fact, most service users only need to talk to someone and the service therefore diverts them from a crisis.

Mary Scanlon: I want to talk about budgets. On Lennox Castle hospital patients, is there any evidence that taking a mentally ill patient home to their family, where they will face their own daily challenges, is the most appropriate level of care for the long-term mentally ill? Is that best for their care or best for the budget? It would have no impact on national health or social work budgets because the bill for that care would be picked up by the Westminster social security budget. Is that option merely a way of overcoming the difficulties that you have mentioned today? Is the buck being passed not to the NHS, but elsewhere?

Richard Norris: Lennox Castle is a facility for people with learning difficulties, not mental health problems. We have not been directly involved in discussions about Lennox Castle. Carers believe that care in the community too often means care by the family. They feel that they are not offered proper support. I am not sure what your point is about social security.

Mary Scanlon: I was referring to attendance allowance, disability living allowance and so on.

Richard Norris: In that sense there is a resource transfer away from a health or social work budget to a central Government budget. One could also examine what is happening about housing benefit in that regard. In the past, a person going into a supported accommodation project would have a care component included in their housing benefit. That is ending and housing benefit is being examined with a view to redesigning the care component so that it can be distributed by local authorities from their limited budgets. That will impact on many supported accommodation projects in Scotland.

In our view, not nearly enough information is given about benefits to people with mental health problems. If somebody with a mental health problem is being discharged from hospital into the community, it is vital not only that they are given information, but that they are given advice and help on claiming the benefits to which they are entitled. There are cases of people being discharged into the community with no advice or information on benefits being offered to them and subsequently—but not surprisingly—being readmitted to hospital. That can happen only weeks after their discharge, because they have no money.

Mary Scanlon: Many such patients have been in hospital for 20 or 30 years. I want to know whether what is being offered to them is most appropriate in terms of care levels or in terms of budget.

Richard Norris: Individual cases must be examined. It is not possible to make the generalisation that somebody should not be discharged because they have been in an institution for more than 20 years.

Mary Scanlon: Is that evidence-based care? It has been tried in Liverpool and it was not a success.

Richard Norris: The general principle behind discharging somebody from a long-stay bed into the community is that discharge will result in more appropriate and more therapeutic care. There might be cases in which discharge is not appropriate. SAMH is, in principle, in favour of offering as much independence and community care as possible. We accept that that does not mean that it is appropriate that everybody in a long-stay bed should be cared for in the community.

SAMH provides services and we have experienced difficulties when people have moved into one of our supported accommodation projects. Such people are given support from specialist support workers to help build their independence. At one project, in order to save money the local authority decided to replace our support workers with a home help who went in to make breakfast for the service users. The initial reaction of the service users was that that was great—they were having things done for them. That, however, is not therapeutic. The purpose of discharging someone from a long-stay bed into the community is normalisation—helping people to

build the skills to live independently in the community. Bringing in a home help was done to save money. It is cheaper to send a home help to make breakfast for somebody than it is to provide a support worker who can help them build the skills required for daily living.

The Convener: Absolutely.

Irene Oldfather: A crucial element of any strategy to integrate people with mental health difficulties back into communities is providing them with employment and training opportunities. Your submission says that a national or local strategy for that is lacking. I am aware of groups in my area that do work along these lines, but I take your point about the lack of an overall strategy. However, there are barriers to that because of the breadth of mental illness that you are trying to encompass. What is your view of the components of a national or local strategy? How would they fit together?

Richard Norris: We have talked about the need for a number of agencies to work together. Enterprise agencies and employment programmes must be included and must not be regarded as add-ons. Too often it has been thought okay to discharge patients into the community without thinking about the structure that they will have. We have drawn the committee's attention to the problems facing our training programmes, but our programmes are not the only ones that are under threat because of, for example, the uncertainty with the European social fund.

The framework talked about the need for training and employment, but we do not think that that need has been taken on board properly. We would welcome an examination of the reasons for that by the committee. We have been asking since last October what is happening with the ESF, but we still do not know.

I agree that structured daytime activities are extremely therapeutic. They reduce relapse rates by more than 50 per cent and have to be part of any strategy. It is not enough to have a mental health strategy only for such things as a drop-in centre or a crisis line; any strategy must also address the provision of life opportunities.

Irene Oldfather: Is the core problem the fact that there is no strategy, or does it lie with funding? I am aware of the problems with the European social fund. That may be a transient factor as the fund and the agencies that support it can change from year to year. The ESF is not core, mainstream funding.

Richard Norris: The problem relates to both funding and strategy. It is important to co-ordinate the work of different agencies. That is done better in some parts of the country than in others. Our projects are partly funded by ESF and, in the west of Scotland, by Greater Glasgow Health Board, as well as by the social work department.

A national strategy would help us to focus on those areas in which we need to go further or to secure what we have. However, the uncertainty of funding also causes difficulties. It is bad enough for anyone to have to cope with the uncertainty of not knowing whether a project is going to run from one year to the next, but one can imagine the effect on a client group with mental health problems that depends on that project for its daytime activity.

Dr Simpson: You have raised the question of ESF funding. If the Executive does not sort out ESF funding—presumably it is the Executive's responsibility to do that—should there be a period of time for which programmes are automatically extended? For example, there could be an arrangement whereby the clock stops when there are six months to closure and funding has to continue until a decision is made. We have to find some new mechanism to end that uncertainty. In my area of family mediation, which is also supported by European funding, redundancy notices have been issued, because there are three weeks to go and the voluntary organisation cannot afford to issue them after the work has finished.

Secondly, have you been involved in the rough sleepers initiative? A lot of mental health problems are associated with rough sleeping. The RSI is be part of the community care package that is being developed. Have any of the local groups been consulted on that?

10:45

Richard Norris: First, on the issue of the uncertainty of funding, it would certainly help if a contingency plan could be made in advance. For example, we know that we are funded until June, but we will not find out until October whether the project funding will continue. It would be enormously helpful to hear that six months of contingency funding has been made available, not in June or May but in January or February. That would mean that we would not need to issue redundancy notices and would not have to tell staff and project users that the project might end in June.

A few years ago, we found out on 20 December that contingency funding was going to be available from 1 January. By that time, we had already issued redundancy notices and trainees had already been told that the project might close. Contingency funding solves a problem, but we should not be told about it at the last minute.

Dr Simpson: What does it do to the clients, knowing that the workers might be about to be made redundant? If a person has a mental health

problem and does not know whether their support worker will be there on 1 January, they will be distressed. It is bad enough for the staff, but it is even more important for the clients.

Richard Norris: We have not had a great deal of involvement in the rough sleepers initiative. I can only speak for my own department, which has not been asked to do any work on that. However, that does not mean that other parts of SAMH have not been involved at a local level. There are 70 different projects.

Dorothy-Grace Elder: It seems to me that, overall, the state has made vast savings in the last 20 years or so by closing psychiatric units. Roughly 8,000 beds have been lost. However, your big concern is that that money has not been redirected into care in the community.

I do not remember when the desperate scramble for funding began, but I have seen the effect on the clients. I am often contacted by voluntary organisations when they are on the brink of closure. I have seen young people with disabilities standing in tears at the gates of a project. I have gone in and found the care workers in tears. The effects on those people are indescribable. I agree with what you have said.

Would you say that security of funding is the key issue?

Richard Norris: I would probably have to say yes. If we knew what our income stream was going to be for the next three years, it would make an enormous improvement.

Dorothy-Grace Elder: Are you saying that the key is not even an increase in funding, but simply security of funding?

Richard Norris: Yes. At least then we would be able to plan.

The Convener: Thank you for coming to the meeting. Your contribution has been extremely useful.

10:48

Meeting adjourned.

11:02

On resuming—

Subordinate Legislation

The Convener: Item 2 concerns subordinate legislation. The National Health Service (Vocational Training for General Medical Practice) (Scotland) Amendment Regulations 2000 (SSI 2000/23) is a negative instrument. No motion has been lodged recommending that nothing further be done under the instrument. After consideration of the instrument, the Subordinate Legislation Committee determined that the attention of the Parliament need not be drawn to the instrument. I suggest to the committee that we do not wish to make any recommendation in relation to this instrument. Are we agreed?

Members *indicated agreement.*

The Convener: The National Health Service (General Medical Services) (Scotland) Amendment Regulations 2000 (SSI 2000/28) is also a negative instrument. No motion has been lodged recommending that nothing further be done under the instrument. Again, after consideration of the instrument, the Subordinate Legislation Committee determined that the attention of the Parliament need not be drawn to it. I suggest to the committee that we do not wish to make any recommendation in relation to this instrument. Are we agreed?

Members *indicated agreement.*

Petitions

The Convener: We will now consider petition PE77, from Age Concern Scotland, which calls for the Parliament to implement all the recommendations contained in the report of the Royal Commission on Long Term Care for the Elderly, otherwise known as the Sutherland report.

I will invite comments from members, but I feel that, as we have decided to spend considerable time in the coming year on examining community care and focusing on mental health, as well as long-term care of the elderly, we have demonstrated graphically that we share Age Concern Scotland's concerns.

Through our inquiry, we are trying to improve community care. That will involve talking again to Sir Stewart Sutherland—we have already had an informal briefing from him. He was unable to join us this morning, but will be one of the first people from whom we hear during our inquiry. The royal commission report will form the focus of much of the inquiry.

We should say that we plan to examine the matter as part of our community care inquiry and that we will take oral evidence from Age Concern Scotland as part of that inquiry.

Mary Scanlon: That makes sense, convener. There is no point in jumping the gun; a full, in-depth inquiry is planned.

The Convener: Does everyone agree?

Members *indicated agreement.*

The Convener: Agenda item 4 concerns a pair of petitions, PE51 from Friends of the Earth and PE60 from the Scottish Green party; the Transport and the Environment Committee is the lead committee on both petitions. The petitions concern the release of genetically modified crops into the environment. There have been calls for a debate on the matter.

Members may wish to note that the commercial release of genetically modified food is covered by European directives. However, the matter is largely devolved, and the Scottish Executive is the competent authority.

I would be happy to encourage the calls for a debate on the matter, and the committee may want to recommend to the Transport and the Environment Committee that the matter be debated in Parliament. Does any member want the committee to do any more than that at this stage?

Mary Scanlon: Robin Harper has lodged a motion calling for a debate on organic and GM foods. I am supporting his motion, and I hope that we have a debate on it, as it is important. We should be aware, however, that the Westminster Government has instigated an inquiry into the matter. It would seem sensible to wait for the full outcome of the research, which is being carried out over a period of three years, rather than jumping the gun and going one way or the other.

The Convener: Is it the committee's general view that we reply to the Transport and the Environment Committee, recommending that time be found for a debate on the issue in the chamber?

Members *indicated agreement.*

Mary Scanlon: We would welcome such a debate.

The Convener: Can I just check: does everyone agree?

Members: Yes.

Arbuthnott Report

The Convener: Item 5 is our old friend, the Arbuthnott report. It has been some time since we made our submission in the course of the Executive's consultation exercise.

For the sake of people who may have forgotten what the report is all about, it concerns the funding allocation for the national health service in Scotland. It was an attempt by the Executive to move forward from the old SHARE—Scottish health authorities revenue equalisation—system that had operated for the past 20 years.

We made a submission to the Executive, and we have received an interim response. I have discussed that response with John Forbes, who was our expert adviser on the Arbuthnott report inquiry, and I have had a chance to discuss it with representatives of the various parties.

I am generally pleased with the Executive's response, which is a move in the right direction. It is a positive response to the conclusions and recommendations that were outlined in our report. It accepts many of the major concerns that we raised, and they are now being addressed. The Executive's response mentions that our comments have been echoed by others during the consultation exercise, so we were obviously on the right track on several points. Sir John Arbuthnott has been asked to reconvene the steering group to examine the responses that have been received.

I welcome the positive interim response to our conclusions and recommendations. In view of the fact that the steering group is to be reconvened to address the issues that were raised during the consultation process, we should ask the Executive to tell us its intended implementation date for the Arbuthnott report's recommendations. John Forbes suggested that we do that.

The committee paper on the Executive's interim response suggests that we

"note that the Steering Group aims to provide the Minister for Health and Community Care with revised recommendations by 31 March 2000."

It suggests that we ask the minister whether the Executive intends to consult the committee again on the conclusions of that further work. It also suggests that we note the fact that further work is being done on inequalities, which was the subject matter of chapter 15 and one of the innovative parts of the Arbuthnott report. As further work is being carried out, we would appreciate it if the minister could indicate the time scale for publication of the consultation document outlining possible methods for addressing those issues. It is clear that the Executive and Sir John Arbuthnott are finding that that work on inequalities is taking longer than they had predicted initially.

John Forbes has suggested that the committee should be furnished with a membership list for the working group that is reviewing the general medical services model and the community data aspects of the report. Again, the committee highlighted those matters as being worryingly lacking in data.

Having gone through the Executive's interim response to the committee, I think that it is positive, and I welcome it.

Margaret Jamieson: I agree, but if further consultation takes account of inequalities and re-examines the GMS model, that will significantly alter the original report. Rather than ask whether the minister intends to consult us, we should say that we expect to be consulted. Taking those points on board will alter significantly the whole thrust of the document.

We should go through a further round of consultation. Our comments were based on evidence that we heard from organisations that will be affected by the report, directly and indirectly. Although I am not in the game of throwing it out again, we must reconsider the whole report. If we are to do as our adviser suggests, we should ensure that that is the best possible route to take. I understand that the further work on the GMS model will not be available at 31 March, but will involve longer-term investigation. I would like to know exactly what the Executive plans to introduce as a short-term measure.

Mr Hamilton: I agree 100 per cent with what Margaret Jamieson just said. We must toughen up point 7 of our suggested response. If the committee is to play a serious role, we expect to be consulted again.

Point 6 states that

"the Committee would be obliged if the Executive could give an indication as to the intended implementation date".

It might be worth restating our resolution that implementation should be delayed until the changes had been analysed. That was the central contention of our report.

I have a number of comments on the Executive's response. First, on the stability of the formula, the Executive said

"Some Health Boards expressed concern that the proposed resource allocation formula might be unstable from year to year . . ."—

those boards included Shetland and others—

"The stability of the formula will be assessed by looking at how allocations would vary over a period of years."

I would like a more substantial response. We would have worked out that the assessment would be done over a period of years, so we do not learn

a great deal from that response. We should ask the Executive whether it is taking the issue seriously, and what it is considering putting in place, rather than just letting it say that it will look at the matter.

11:15

The Convener: We will ask for that.

Mr Hamilton: Secondly, on the plausibility of the results:

"We are aware of a few areas where it is felt that there were some anomalies in the results for different Health Boards, and these are being examined."

Which health boards? Let us push the Executive to explain the basis on which results are being re-examined.

The Convener: We highlighted Borders Health Board and Dumfries and Galloway Health Board.

Mr Hamilton: Exactly, but the Executive should tell us when the re-examination will happen, to which health boards, and under which criteria.

A working group has been set up on general medical services, and a reference group has been set up on methodological issues. Would it be part of our role to ask those groups to liaise with us while we can still influence their thinking—before their findings go to the Executive—so that we are keying in to the process at a more useful stage?

Finally, the Executive made a point about remoteness adjustment and Argyll and Clyde Health Board, with which I am closely involved.

"Officials who have been closely involved in the Arbuthnott Review have discussed this issue with Argyll and Clyde Health Board and are considering how best to take into account the particular circumstances of Argyll and Clyde in an adjustment for remoteness."

Could we ask the Executive to keep us fully up to date with those discussions, and with the representations that are received from Argyll and Clyde Health Board?

Mary Scanlon: I welcome the Executive's response; it addresses many of the major issues that we raised. Margaret Jamieson mentioned "throwing it out again", but I do not think that we threw out the Arbuthnott report last time. We recognised it as a work in progress. We have moved on, and the issues are being addressed.

On Margaret Jamieson and Duncan Hamilton's points, I am slightly worried by the language that is used in our suggested response to the Executive's response. For example, point 7 says

"The Committee would be obliged if the Minister would indicate whether or not it is intended".

That sounds as though we are begging. We will be consulted, and that is the end of the matter. The minister will get our opinion whether she likes it or not. Such woolly language—begging whether she will, perhaps, grace us with her presence—is nonsense. This is a partnership; we are not begging anyone.

The Convener: Okay. Point 7 will be a clear statement that the committee will be involved in the consultation on the further work.

Mr Hamilton: Or the minister will have to answer to Mary.

Mary Scanlon: Once a teacher, always a teacher.

The Convener: We will be consulted, and it will be up to us to decide whether we take further evidence. That picks up Margaret Jamieson's point that events have moved on considerably since the original report. If members cast their minds back, they will remember that one of the constraints under which were working when we considered the Arbuthnott report was that work was already going on in the background; we knew that we were on shifting sand. During the consultation stage, it would be right for us to consider whether we want to take further evidence, possibly from the Executive and the minister, and certainly from other people who were involved, such as Sir John Arbuthnott. That will be for us to decide.

Dr Simpson: I have a number of suggestions, which are not dissimilar to those that have been made by my colleagues. First, on point 6 of the paper on the Executive's interim response, after it says

"during the consultation process the Committee"

we should add that there is a need for further consultation after completion of that process. That would reinforce what we say in point 7.

I suggest that the last words of point 7 be changed to, "the committee wishes the minister to consult the committee on the conclusion of this further work before implementation." In addition, point 6 should come after point 8; the request to be consulted on the outcomes should come before the request for the Executive to state the implementation date of any recommendations.

The Convener: Is the committee happy that we ask for the Executive's intended implementation date, and that, as Duncan Hamilton suggested, we restate the position on implementation that formed part of our initial report?

Members *indicated agreement.*

Dr Simpson: Last, we should add a clause to say that, in view of the delay, we would like a statement from the Executive on the interim measures to deal with inequalities that it may propose over the summer. We need some clarity

on that, because our report called on the Executive to begin the process of tackling inequalities now and not to wait for Arbuthnott.

Dorothy-Grace Elder: I too am bit concerned about the time factor. The three-month schedule that the Executive has set itself could be viewed as quite tight, but we do not know how much more time will drag on before anything is implemented.

I am also concerned about the paragraph on data quality on page 2 of Susan Deacon's letter, in which she largely defends the quality of the data used. It reads:

"The basic problem in both of these areas is the restricted range of data available, and the scope for including a wider range of data is being explored."

We should ask the Executive to reveal the range of data that is being considered or that has been pinpointed. I welcome the fact that the Executive will run data for two years after the one-year test, but may we ask that question?

The Convener: That is perfectly acceptable.

Irene Oldfather: I want to follow up on Dorothy-Grace's point. Point 9 of our response is a bit weak and shallow—all that we are asking for is the membership of the working group.

Mr Hamilton: That might be the point at which we could add the need for consultation with the committee on both of the working groups that are being set up.

The Convener: Yes. We can add that to point 9. We will also take on board Dorothy-Grace's point and ask for further information about the community data situation in general medical services.

Irene Oldfather: We highlighted that point from the evidence that we gathered for our initial report. I am pleased to note that Professor Graham Watt appears to have been included in the working group. We should take some of the credit for that. However, we need to tighten up on that issue.

The Convener: The committee can take quite a lot of credit for quite a lot of things.

Mr Hamilton: I have a suggestion on what Richard Simpson said regarding point 7. Rather than saying that the committee wants to be consulted before implementation, would not it be better to say that we expect to be consulted before a decision is made on the time scale for implementation? Those are two very different things. That would make it a bit tighter.

Mary Scanlon: That would be not a request, but a positive statement.

Mr Hamilton: I think that that is clear.

The Convener: We had worked that one out. I will have some of whatever Mary put on her cornflakes this morning.

Are there any further comments? No.

I thank colleagues, not only for their comments this morning, but for the incredible amount of work that they have put in on this issue in the past. I take on board the fact that the Executive's interim response to what I—and all members—consider to be a good committee report is generally positive.

Petition

The Convener: The next agenda item is the Executive's response to the petition that we passed to it in December from Mr Ooms about the NHS complaints procedures. Mr Ooms wanted to bring a particular set of circumstances to Parliament's attention, but his petition opened up a debate on some of the wider issues. That is the way in which we deal with petitions—we try to consider the wider issues.

It is clear from the Executive's response that the NHS complaints procedure is undergoing a UK-wide evaluation, and that a Scottish group is taking part in that evaluation. The minister expects to receive an interim report in March this year and a final report in January next year. The evaluation is being led by the Department of Health in England; it is being assisted by a Scottish advisory group of complaints personnel and patients' representatives, which was set up to oversee the Scottish evaluation. That is the current situation. Are there any comments?

Mr Hamilton: Health is a fully devolved matter, so would not it be entirely competent for the Executive to make its own statement? The Executive's response says that there is Scottish representation on the on-going project, but I am not entirely clear on why we have to wait for the results of a United Kingdom initiative. I am not being stupidly nationalistic about this.

The Convener: I confess that I am not aware of the background to this, but Margaret Jamieson is.

Margaret Jamieson: The main reason for the evaluation being UK-wide is that people can obtain health care south of the border. On occasion, individuals are transferred from a Scottish hospital to one in London because they require specialist services. The aim is to create a seamless system, so that if someone who has moved around the country has a complaint, the process will be the same, although different individuals will deal with it. That is for the convenience of patients and also assists those against whom a complaint is made.

We may be able to put a different slant on things, but the procedure will remain basically the same. The only difficulty that I have with that is that I am unaware whether it extends to co-operatives of general practitioners providing out-of-hours services, who seem to think that the NHS complaints procedure does not apply to them. Richard Simpson may be able to assist us on that.

Dr Simpson: There is a primary care NHS procedure. The problem is that such co-operatives are not part of the primary care trusts, the acute trusts or the individual primary care units—the partnerships. They are a new entity, which was created after the current complaints procedure was introduced. Most of them have a complaints procedure, but nothing is defined for them.

The Convener: We can respond to the Executive with that point.

In its letter, the Executive says

"When letters are received in this department from patients or their representatives who have grievances in relation to the NHS complaints procedure their names (with their permission) are passed to the evaluators, who may contact them in the course of their research."

We can seek clarification on whether Mr Ooms's case has been passed to the evaluators. We will also bring to the attention of the evaluators the situation regarding co-ops and their English equivalent, whose name I cannot remember. I try to forget the name of the English equivalent, so that I do not get too confused.

Margaret Jamieson: We are talking not about the local health care co-operatives, but about GP out-of-hours co-operatives.

The Convener: We will bring that to the Executive's attention.

Malcolm Chisholm: I do not know the status of the interim report, but can we ask to see it? I imagine that that will be possible and that we will be able to comment on it. Our work load is becoming rather unmanageable, but we should be able to submit our comments on the evaluation. I accept what Margaret Jamieson said, but the Scotland Act 1998 gives us the option of having our own system if we find what is proposed unacceptable.

Mr Hamilton: That is absolutely right, and I support that fully. Would it be worth finding out what the Executive's approach is to that process, and what representation it is making in the UK process? I would like to know its current attitude, and the representations that are being made on our behalf. Can we write to the minister?

The Convener: We can ask for further information on the Executive's input so far.

Mary Scanlon: On the second page of her letter, the minister says that this

"is not intended to be an academic project, but a practical and realistic analysis based as far as possible on . . . actual experiences".

I have received various complaints from people, some of them going back a few years. Should I say to them that they can submit their complaints as part of this process? Is this an continuing process to which we can refer people who have been through the complaints procedure?

The Convener: Yes. We could ask for some guidance for elected representatives on whether, when we pass things on, this is what will happen to them. What is the time frame for this? When did

these letters start being passed on? If you passed something on to the Executive six months ago about a constituent, has that gone in, or is this something that has just happened in the past month, the past six weeks or whatever? We need some guidance, for us and for our colleagues, on what may be happening to letters that we pass on to the Executive about complaints against the NHS.

11:30

Mary Scanlon: If we have received letters that we feel epitomise the problems that underlie the complaints procedures within the NHS—problems similar to those that have been experienced by Mr Ooms—is it in order for us to pass them on as part of this process? I have three such letters on my desk.

The Convener: We can get some guidance on that matter. If the NHS has been dealing with such complaints regularly only for the past two months as part of this evaluation process, it might be that if you had anything prior to that date which you considered to be a classic example of where the complaints procedure is falling apart, then you could proactively pass that on. I think that guidance would be useful not only to members of this committee, but to all our colleagues who are having to deal with this as well.

Mary Scanlon: Can I just finish—

Margaret Jamieson: Mary needs to understand that there are local complaints procedures as well as the Scottish complaints procedures.

Mary Scanlon: These are people who have been through all that.

Margaret Jamieson: On occasion, individuals continue to complain because they do not receive the answer that they are looking for.

Mary Scanlon: I appreciate that.

Margaret Jamieson: I am well aware that, in my local area, the acute trust is evaluating its complaints procedure. That evaluation is being conducted by the local health council, and the trust has put me forward as somebody who should be interviewed by the health council because of the system that we operate.

Mary Scanlon: At the same time, if someone has a specific experience, for example, if they have lost a child, and if they feel that we can learn from that experience, we should not exclude them.

My desk is a bit of a mess with all the complaints just now. I do not mean to muddy the waters, but there seems to be a problem with the grievance and disciplinary procedure for NHS staff. They are disciplined and off work sometimes for three, four or five years. We are talking about the patients complaints procedure. Could we not consider the staffing procedure as well? A lot of them are nurses or doctors. There is a crying need for this to be carried out fairly and efficiently within the NHS, which does not seem to be happening just now.

Margaret Jamieson: That is a specific contract of employment issue. I do not think that we have the right, under any devolved settlement, to interfere with individuals' employment.

Mary Scanlon: It costs the NHS hundreds of thousands of pounds and—

The Convener : Right.

Margaret Jamieson: It is totally separate from the complaints procedure.

Mary Scanlon: Well, I think we should—

The Convener: Dorothy-Grace is next.

Dorothy-Grace Elder: There has been a fair amount of work done on workplace bullying, of which there is a great deal in the NHS, as there is in any large organisation.

Dr Simpson: We are straying from the agenda.

Dorothy-Grace Elder: Staff are our best possible sources of—

Dr Simpson: I am sorry, Dorothy. We should move on from this subject.

The Convener: I shall bring that item to a conclusion. As members know, it is my style to allow people to have their say as far as possible, but I agree with Richard Simpson that we have strayed from the agenda. I suggest that we send the minutes and the *Official Report* of this discussion to the Executive, along with our response, so that ministers can see what we have touched on. Complaints by patients will always have implications for the staff who are complained about. Thank you for your contributions to that subject.

Convener's Report

The Convener: The heading "Convener's Report" is something of a catchall, but the main piece of business that it covers concerns our recent report on Stobhill hospital. It was generally well received and was a good piece of work by all committee members and particularly by Richard Simpson.

Members may recall that all conveners were asked to suggest business that could be debated in the chamber. Before we had finalised the Stobhill petition report, I had suggested that the Stracathro and Stobhill petitions would highlight issues of public consultation and accountability.

Unfortunately, I was not at last week's meeting of the conveners liaison group, at which my recommendation was accepted for the first subject committee debate. I do not use the word "unfortunately" because I do not want to be the first convener to lead off a subject committee debate; it is a good topic and reflects the good work done by all of you. I say "unfortunately" because a key component is missing from the motion that we have had to lodge, the Stobhill report, as the Executive has had no time to comment on the report or make a full response to it.

Instead, the Stracathro report, which highlighted some of the same issues, although not so starkly, will be mentioned. That may not lend the debate the same validity as it would have if both reports were to be debated. A motion has nevertheless been lodged for next week, and I shall attempt to strengthen it a little. It notes our recent and continuing work, which highlights the need for full public consultation and accountability of health boards and trusts. It also mentions principles of openness, accessibility and participation. The Stracathro petition is cited as an example of committee work. I shall attempt to amend the motion to note the concerns of the committee on those matters and I shall use the Stracathro petition as an illustration.

I believe that we will have a two-hour debate. I hope that during that time all members of the committee will have a chance to contribute to the debate. In my opening remarks, I shall concentrate on the wider issues that our two reports have highlighted. All of you will have the opportunity to refer to other current work and to anecdotal constituency issues that illustrate the principles of the reports.

Although the Stracathro petition was important to the committee and is obviously an important local issue, I do not want the debate on the future work of the Parliament, the committees and the Executive on wider issues to be dominated by one local issue. I hope that the debate will provide an opportunity for all members to talk about what we consider to be the major issues. I am sure that the debate will be valuable.

Dorothy-Grace Elder: Can I suggest that the committee gets together to discuss the speaking list before next week's debate?

The Convener: The debate is on 16 March.

Dorothy-Grace Elder: That is the day of the by-election. Is the debate in the morning?

The Convener: It is the first committee day and we are the only committee that has published reports that we can discuss. We are the lucky people.

Mr Hamilton: Do we take it that the Liberals are not expecting a victory in Ayr?

The Convener: If they are relying on me being there to tip the scales, they might have a problem.

Some people might find it more difficult to attend the debate than others. Unfortunately, the number of committee days is limited and at least we have been lucky enough to get one of them.

Members visit many health organisations as part of their work, but I want to mention that last Friday, I visited Rachel House, the children's hospice in Kinross. It was an incredible experience and a great privilege. I want to put on record the wonderful welcome that I was given by the children and staff. The hospice has a continuing need for assistance from the Executive and others and I have made representations on that already. If committee members want to visit Rachel House at any time, they will be made very welcome.

Dr Simpson: Rachel House is in my constituency and I welcome your comments, convener. It is important that we discuss the funding of hospices in general. I am very pleased to say that the public response to appeals by Rachel House has been such that the hospice has a reserve fund of about £18 million. It is extraordinarily well supported by the public and I hope that that will continue. There are other hospices that may require further support, and there are plans to develop another child hospice in the west of Scotland.

The Convener: I want to flag up the fact that Rachel House plans to open another hospice in the west of Scotland. It is thought that Scotland needs three children's hospices—one in the north of the country, too. Rachel House was opened with a large amount of public support, much of which was encouraged by the *Daily Record*.

Mr Hamilton: Finally, a use for the *Daily Record*.

Dorothy-Grace Elder: I want to put on record

that I first suggested it to the paper. The editor was Endell Laird and the paper did a magnificent job. *Daily Record* readers built that hospice.

The Convener: Those readers are helping again. When the first hospice was built, there was great public support and an input from the Scottish Office. If we believe that those services should be nationally provided, we should ensure that the Executive is aware of the situation and that Rachel House is on track to raise the funds for a second hospice.

Susan Deacon visited Rachel House fairly recently, as did Jackie Baillie. There is a lot of interest and the hospice is doing great work.

Mr Hamilton: I have two procedural points. What is the procedure for opening, closing and speaking in the committee debate next week?

The Convener: At the moment, I am opening the debate, but I am not sure who is closing it. I will take advice on that. Details will be circulated to committee members.

Mr Hamilton: It is the first time that it has been done and we need to know the position under standing orders.

The Convener: Exactly.

Mr Hamilton: The second point is on agenda item 5. There were many good suggestions about amending the response to the Executive. Will the amended response be circulated to members?

The Convener: Yes. That is normal practice. If we make substantive changes, we always circulate those to committee members.

Meeting closed at 11:45.

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