HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 22 March 2000
(*Morning*)

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CONTENTS

Wednesday 22 March 2000

HEALTH AND COMMUNITY CARE COMMITTEE
7th 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

Joe Campbell (Scottish Care)
Noni Cobban (Scottish Care)
Colin Cowie (Scottish Care)
Annie Gunner (Community Care Providers Scotland)
Nigel Henderson (Community Care Providers Scotland)
Jim Jackson (Community Care Providers Scotland)
Peter Laing (Scottish Care)
Stephen Maxwell (Scottish Council for Voluntary Organisations)

CLERK TEAM LEADER

Jennifer Smart

ASSISTANT CLERK

Irene Fleming

LOCATION

The Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 22 March 2000

(*Morning*)

[THE CONVENER *opened the meeting at 10:05*]

Community Care Inquiry

The Convener (Mrs Margaret Smith): Good morning everybody and welcome to the Health and Community Care Committee.

We intend to ask each group of witnesses a series of questions. The witnesses are stacked up in rows, but if they have something useful to add to what another group is talking about or is being asked about, they can catch my eye and speak. I hope that everybody will have the chance to present evidence and answer questions, but they should not feel that they can participate only while we are directing our questions to them.

The first witnesses from whom we will hear are Annie Gunner, Nigel Henderson and Jim Jackson, of Community Care Providers Scotland. They may open with a statement or, if they prefer, we can move directly to questions.

Annie Gunner (Community Care Providers Scotland): We will make an opening statement. First, I will introduce myself and my colleagues. I am the development co-ordinator of Community Care Providers Scotland. Nigel Henderson is a member of the management committee of the association and is the chief executive of Penumbra, which is a mental health service provider. Jim Jackson is a member of the management committee of the association and is the chief executive of Alzheimer Scotland—Action on Dementia. We thank the committee for its invitation. I want to talk briefly about CCPS and why it exists, and about the voluntary sector in relation to community care.

CCPS is an independent association of voluntary organisations that provide community care services to adults in Scotland. All our members are recognised as Scottish charities by the Inland Revenue. Our 33 members manage a total annual income of about £150 million, a substantial proportion of which comes from contracts or other formal service agreements with local authority social work departments. Those organisations deliver a substantial amount of services on behalf of local authorities.

Our members provide services to the two key groups that are of interest to this committee: people with mental health problems and elderly people. However, many of our comments will also apply to providers of services to the whole range of community care client groups, such as people with learning disabilities, people with physical disabilities, people with sensory impairments and people with drug and alcohol problems. CCPS is a collective association that addresses community care issues that affect providers of services to all those groups, but we will focus our remarks on the committee's areas of concern.

It is important to say that CCPS members support absolutely the philosophy behind community care policy in Scotland—the provision of community-based alternatives to caring for people in larger institutions. The National Health Service and Community Care Act 1990 opened up significant opportunities for the voluntary sector to give expression to the kinds of services for which they had campaigned—it enabled the voluntary sector to run services. The voluntary sector has moved from being small-scale partners in pilot projects and plugging gaps in services to providing about a third of all community-based residential care for adults in Scotland. The proportion of community-based residential care that is provided by the voluntary sector is high for some client groups, including people with learning disabilities, people with physical disabilities and people with mental health problems. The voluntary sector provides between 60 and more than 90 per cent of the community-based alternatives to hospital care for those groups.

We contend that, as well as providing core services, voluntary organisations bring added value to community care. Very few CCPS members do not carry out a range of other activities, which include: policy development; the provision of research expertise and legal and public information services; advocacy projects; and the mobilisation of voluntary efforts. Because of their charitable status, many voluntary organisations are able to lever in funding that does not come from statutory sources for those services.

Kay Ullrich (West of Scotland) (SNP): I have a general question. What is the most significant difficulty currently facing your organisation in relation to the delivery of community care?

Annie Gunner: CCPS was set up to be many things—a good practice exchange, a guardian of standards, a conduit for consultation—but since day 1 our efforts have concentrated on the funding constraints that are experienced by our members; funding constraints have been the key driver of the association's activities. More specifically, we have put much of our effort into examining contracting

difficulties within the context of general funding constraints. We have published some material, including a document on contracting problems, which I will leave with the committee. We are happy to say that a joint working party of CCPS and the Association of Directors of Social Work is trying to sort that matter out.

Kay Ullrich: I am particularly concerned by what your submission says about resource transfer, which, I assume, mainly relates to people with mental health problems and to the closure of long-stay psychiatric hospitals. You point out that since 1995 the amount of money that the voluntary sector receives has not increased with inflation. Will you expand on that and tell us about the problems that it causes?

I am also concerned by what your submission says about Department of Social Security money. The submission says that

"some local authorities deduct an equivalent amount from their own contribution to the cost of care".

That concerns me because a person's DSS entitlement is simply that—their entitlement.

Nigel Henderson (Community Care Providers Scotland): The lack of inflation proofing does not just affect resource transfer contracts. It is a general concern in the voluntary sector that in our work with local authorities we have had level funding for a number of years and therefore have to meet any increase in service cost through efficiency savings—making staff redundant—or through cutting the quality of the service. As far as possible, most voluntary organisations have resisted cutting the quality of the direct service to the service user. However, we have had to make other adjustments such as implementing pay freezes for staff, as a result of which the pay and conditions of our staff are drifting further away from those of their local authority colleagues. As an end recipient of resource transfer, we do not know whether that money is inflation proofed; we have not been able to find that out. If it is inflation proofed, why is it not coming through to us as a service provider? That is a concern.

Kay Ullrich: There is certainly a lack of transparency in that whole deal.

Nigel Henderson: Absolutely, yes.

Kay Ullrich: We will have to look into that.

10:15

Nigel Henderson: The issue has been highlighted by the Accounts Commission and in the Scottish Affairs Select Committee inquiry into community care. At the moment, £166 million is being spent on resource transfer, yet it is not clear how or where that money is being spent. There is a lack of transparency and perhaps of accountability.

The DSS issue is slightly more complicated to explain. A service might cost £275 a week for a user who is on preserved rights—that means that they came to the service before 1993, when the National Health Service and Community Care Act 1990 was implemented, and therefore receive the preserved residential care allowance. That allowance in respect of mental health is currently £230 a week. Although the cost of that service has been pegged at £275 for the past five years, the DSS element of it has risen from £207 to £230. The net difference between the £230 and the £275 is paid by local authorities, which have been able to save by allowing the increases that are given to service users to be absorbed; in that way, they have been able to retain some of their funding.

Kay Ullrich: Is that widespread throughout local authorities?

Nigel Henderson: That is our understanding.

Dr Richard Simpson (Ochil) (Lab): If there was one recommendation that you wanted to come out of the report that we intend to produce, what would that be? What would be the most important one for your organisation?

Jim Jackson (Community Care Providers Scotland): The most important recommendation, from our perspective, would be to have a proper assessment of the full funding needs of community care in Scotland, so that we know how much is being spent on community care. That is an issue of transparency. If that recommendation were followed, it would be possible to judge whether providers were providing—in the jargon—best value. As voluntary sector service providers, we often feel that our contracts are given on a "take it or leave it" basis. We sometimes feel that we may not be receiving fair contracts in comparison with other service providers in the statutory or private sectors. Until there is transparency, we will not be able to know that. Our top priorities are sufficient funding for the community care sector and transparency in the way in which money is allocated and spent.

Hugh Henry (Paisley South) (Lab): Can you give us some examples of the unfairness that you have described?

Jim Jackson: At the moment, it is difficult to provide examples because of the lack of transparency. If my own organisation—Alzheimer Scotland—bids for a contract and is successful, that is fine. However, if we do not get it, we do not know the terms on which other providers have been given the contract. The problem is that we all operate in a vacuum. Although the ethos of best value argues for transparency, at the moment we cannot see it. I am sorry to be unhelpful, but I cannot be more specific than that.

Dr Simpson: What length are the contracts that your member organisations tend to get? We have heard from others that there are problems with the short-term nature of the contracts, which makes for considerable difficulties. Is that a problem?

Nigel Henderson: We have been living with that problem for more years than we would care to remember. Traditionally, we have argued for three-year contracts, but in an ideal world we would like three-year rolling contracts so that, if a funder had reservations about our service or had come to the conclusion that it was time for an alternative service to be provided, there could be an orderly and logical rundown of that service over three years. Certainly, we would prefer contracts that gave us future security, although in practice we have been living with annual contracts.

Dr Simpson: Is there a problem with the annual contracts in that often they are not renewed until the last minute? The annual contract round seems to be inefficient—every year, organisations appear to have to spend a lot of time on the contracts.

Jim Jackson: I agree. On Friday, my organisation has to set its budget for 2000-01. That budget must be based on assumptions about local authority funding, which has not yet been confirmed.

Nigel Henderson: The other issue about contracts relates to the amount of spot purchasing. There may be a headline agreement that allows the local authority to call off a service, and all the risk of under-occupancy lies with the service provider. That produces considerable tension. There might be a perfectly reasonable agreement, but unless the local authority follows through and makes spot purchases, the agreement is worth nothing.

Dr Simpson: Do you not have occupancy rate agreements?

Nigel Henderson: We do. Most service providers have to meet a target of 95 per cent occupancy. I do not know how that compares with that of our colleagues in the private sector—perhaps they will tell us.

Dr Simpson: It is 87 per cent in the local authority.

Nigel Henderson: We find that it is often difficult to meet the target. Sometimes, that is not because the people are not there, but because, particularly at this time of year, community care budgets are rationed and there is insufficient funding to purchase places. There was an example of that in the Borders the other day, where people remained in hospital rather than re-entering the community.

Dr Simpson: You have said that the funds are frozen and you have outlined your problems with contracts, but is there also a problem in the fact that local authorities require an increase in standards without providing additional funds?

Nigel Henderson: Basically, that is correct, but the pressure comes from the registration inspection part of the local authority, which has a duty to enhance and to drive up standards. However, if we do not have the money, that is difficult to implement. There is a tension because one part of the local authority tells us to implement certain things and we have to go to the purchasing part of the authority and say that we have a problem. We are caught in the middle. As the registered providers, we have a duty to meet the requirements and recommendations of registration inspection; if we do not, we are in danger of losing our registration.

Dr Simpson: Are you saying that the present arrangements are wholly unsatisfactory?

Nigel Henderson *indicated agreement.*

The Convener: We will take that as a yes.

Nigel Henderson: The arrangements are good in parts, but there are some significant tensions.

The Convener: You could be a politician with answers like that.

Dorothy-Grace Elder (Glasgow) (SNP): We are trying to build up a picture of the multiple pressures that you are under. I notice that the Scottish Council for Voluntary Organisations report says that, in past five years or so, the voluntary sector has lost around £50 million in local authority contributions. There is another side to that, which is the chasing of money from various bodies, including the lottery. How much of your time is taken up with the endless chase for money—dealing with application forms and the rest of the convoluted process?

Jim Jackson: That is difficult to say in precise terms. Alzheimer Scotland has six regional managers and a small fundraising team. We devote a significant proportion of our time to that process. I could analyse my budgets to produce a figure on the cost of that. Our biggest difficulty is that if we get lottery funding—which has brought a lot of money into the voluntary sector—we face the question of what will happen three years later when the funding runs out.

My organisation has a project in the Highlands and another in Glasgow that are unlikely to be continued in the next financial year, as the local authorities have indicated that funding is not available for new services because those services become growth items. A much valued carer resource project for rural communities in the Highlands of Scotland is now at risk and an innovative project for people in the early stages of dementia in Glasgow is vulnerable. We have submitted applications, but I cannot tell you when,

or if, they will be refunded.

Dorothy-Grace Elder: Many applications are totally unsuccessful, although submitting them consumes a considerable proportion of a project's time. You say that you have six regional managers and a small fundraising team, some of whom may be voluntary. Are you saying that the six regional managers do work other than fundraising, or are their tasks now largely consumed by fundraising?

Jim Jackson: The six regional managers are jointly responsible for managing our services and for ensuring that funding is in place to keep those services going. I estimate that at least 25 per cent of their time is taken up with negotiating contracts and providing information to funders to meet accountability requirements.

Dorothy-Grace Elder: On that point—

The Convener: Before we move on, I want to pick up on a point that Annie Gunner made. I understand that you have a document on contracts and so on that you can give us. We would like to get further information on that, so it would be useful if you could leave us a copy.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Given that you represent a large number of organisations, how do you define certain aspects of the care process, in order to identify difficulties that arise in the sharing of understanding and in the different reference points of each organisation?

Annie Gunner: Do you mean what are the differences among voluntary organisations on aspects of the care process?

Margaret Jamieson: Yes.

Annie Gunner: I am not quite sure what you mean by that.

Margaret Jamieson: You are a large umbrella organisation. Each organisation deals with specific client groups and, obviously, the organisations' methods will be different. How do you marry those methods together when defining a care process or a care package?

Jim Jackson: I do not think that we do that, for the reason that you outline—we all deal with different client groups.

We have examined common issues, such as contracting and best value, because those are generic and cross all the boundaries. It would be fair to say that, individually, we are all concerned about care processes. The current jargon is "care pathways"—how people receive services that are additional to those that we provide and how people are referred to our services.

Nigel Henderson referred to the fact that sometimes we may have places available but, for funding reasons or because of delays in assessment, people are not referred to our services. The concept of the care pathway, of having a clear understanding of who is responsible for which services, is important. It is also crucial that we have more multidisciplinary ways of working.

I give as an example the multidisciplinary dementia care teams in Aberdeenshire. The teams include the local authority, the local health trust and the voluntary sector. People with dementia get the comprehensive services that they need because, although an individual agency—statutory, voluntary or private—does not provide the whole picture, collectively we work to achieve that.

The Convener: Hugh, do you have a supplementary question?

Hugh Henry: Well, my question is not supplementary to that point. I want to examine the shift from institutional—

The Convener: Duncan, did you have a supplementary question?

Mr Duncan Hamilton (Highlands and Islands) (SNP): This is a good point at which to introduce this issue. I quote two sentences from the first paragraph on page 4 of the submission:

"The Committee will be aware that differences of opinion can arise as to whether the funding of a particular service, or the needs of a particular service user, should be the responsibility of a local authority or of a health board. Voluntary sector providers have in some instances been caught in the middle of such disputes, and can attest to the fact that service users find them virtually impossible to comprehend."

That is a fairly damning statement on the inability of people to work together in the sense that you have described. Could you expand on that, giving a few concrete examples? Can you speculate on why the confusion exists in the first place? What is the driving reason for the inability of the agencies to work together in the way that you would like? What would you like to see done to remove that confusion?

Annie Gunner: I think that we understood the first question to refer to the view of the different voluntary organisations.

The Convener: I think that we could take the original question on the different aspects in relation to the various care providers across the range, including health boards, private care facilities and the voluntary sector, which see the community care sector in different ways from their respective points of reference. It is perfectly reasonable to extend the question that Margaret Jamieson asked.

Annie Gunner: Jim Jackson was going to make

some comments on that kind of co-ordination, so I will leave him to answer that point.

10:30

Jim Jackson: Co-ordination is needed at all levels; I have distinguished three. The first is strategic planning and change management. We do not give enough attention to the fact that we are trying to change the pattern of services. It is easy enough to plan for new, add-on services; what is difficult is the change when facilities are closed down in order to offer new services and choices. The second level relates to the need for joint work on commissioning and purchasing. The third level relates to the need for joint work to provide services.

On services, we might look for a single assessment of someone instead of multiple assessments by the health providers and social work providers. Multidisciplinary teams exist, but there are not as many of them as we would like. We also want a creative, flexible use of staff, which would enable us to avoid the hoary old chestnuts "Is this a social bath or a medical bath?" and "Are home visitors able to change light bulbs?" Such questions may sound petty, but we are looking for people who can work across boundaries, which would minimise the need for lots of different people coming into people's homes.

Those three levels of joint work are essential and need to involve all key parties. We want to emphasise the importance of the involvement of providers, users, potential users of services and carers.

The issue goes beyond health and social work, however, and we must recognise the crucial contribution of housing, training, educational services, transport and the interaction with the benefit system. If we do not get that interaction right, people who plan for services would have no viable model of funding them.

Mr Hamilton: I appreciate what you are saying about the various areas that need to be knitted together, but would it be unfair to suggest that the idea of people coming together in such an equal partnership is not wholly realistic, and that, ultimately, one side will be driving things more than the other? One of the themes of all today's submissions is the division between local authorities and health boards. Given that, where should the primary responsibility for providing the momentum lie?

Jim Jackson: CCPS does not have a position on that. We believe that the specific mechanisms are less important in the short term than other matters. The first of those is pooled budgets. Do all the partners put all the money on the table? Secondly, does the joint co-operative exercise have delegated powers, or does it constantly have to refer back to health or to social work? Thirdly, is there a willingness within the alternative structure to lead, so that change can be effected? We believe that pooled budgets, delegated powers and a willingness to lead in whatever structure is set up will result in improved joint working. I have the impression that there has been some improvement in the past two or three years, but there is still an awful long way to go.

Hugh Henry: You say that you do not have a view on who should take the lead as long as matters such as pooled budgets are addressed, but if organisations pool budgets there will inevitably be tensions, differences of opinion and disputes. How can those be resolved without someone somewhere taking responsibility or taking the lead? Is it not naive to expect large organisations to pool budgets and allow someone else to make decisions on how the money is spent when, ultimately, they will be held responsible for their budget?

Jim Jackson: Those are the traditional arguments for saying that someone should be given lead responsibility. When they prepared their mental health framework, the health board and the three local authorities in Ayrshire identified specific needs of older people and their mental health problems, instead of concentrating simply on dementia. They produced a joint report and are now jointly inviting tenders for particular pieces of work. As part of that joint work, they are involving local carers in assessing who should get the services. That shows that joint working is possible.

I would be surprised if, in the next few years, local authorities and health boards do not get their act together, you or your successors do not begin to make decisions on who should take the lead. An increasing number of people are putting aside their differences, as is happening with the invest to save exercise in Perth and Kinross. CCPS has an open mind on whether that will succeed. We want it to succeed, but if it does not we would like there to be changes.

The Convener: We seem to have reached a very rich seam; several members want to ask questions on this issue.

Margaret Jamieson: I want to pick up on the point about Perth. Although the invest to save exercise is an innovative way of examining the services, it should not be compared with the situation in Ayrshire. The scheme there looks good on paper, but we have yet to see the funding behind it. The mental health strategy for Ayrshire is to be commended, but it cannot be delivered without the financial support of all the partners. I understand that support is present in Perth and Kinross and I would like to examine what is

happening there, so that I can indicate to Ayrshire and Arran Health Board that this is a good news story and that we should be investing in a similar scheme. Ayrshire and Perth and Kinross are poles apart—in the first we are dealing with a scheme that exists only on paper, whereas in the second we are dealing with one that exists in practice.

Jim Jackson: One of the new services in Ayrshire is the wisdom project to provide support from the point of diagnosis to the point of needing long-term care. The first contract for that has been let. That indicates that some funding is already on the table. I am trying to offer the committee examples that show that local authorities and health boards are making an effort to work together. However, unless the criteria that I outlined earlier—pooled budgets and delegated authority—are being met, we are unlikely to see the full benefits of the scheme. I agree with Margaret Jamieson on that.

Irene Oldfather (Cunninghame South) (Lab): I notice that your membership consists of fairly large voluntary sector organisations. Do you feel that small organisations have a role to play and that you are able to represent them? Do they face any particular problems, over and above those that you have mentioned in relation to pooled budgets and so on?

Jim Jackson: We are a self-financing organisation, so there is an inevitable bias towards larger organisations that can afford to pay for our staff and structure. We believe that the voluntary sector needs to be rich and varied. We are not the only people in the sector, but we believe that we have a particular contribution to make. We also believe that smaller voluntary organisations have a particular contribution to make. The fact that the Pilton health project, for example, is based in the locality has been essential to its success. It has not needed the benefits or expertise that a national organisation offering standardised high-quality services could provide. There is a place for both types of organisation in the wonderful world of community care. It is important for local organisations to identify their areas of particular expertise, which I know they have.

The Convener: I am interested in the fact that the example that Jim has just given us is in the deputy convener's constituency.

Jim Jackson: That was pure coincidence.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): The example is quite relevant, as yesterday I wrote to City of Edinburgh Council on this subject. Here we have a model community health project whose funding the local authority is cutting by 10 per cent this year. I cannot understand why health bodies and local authorities do not support innovative mental health projects better. I will ask Stephen Maxwell about that later.

Nigel Henderson: In some ways, local voluntary organisations feel the funding freeze or the funding cuts much more acutely than larger voluntary organisations, which are able to some extent to absorb them as part of the economy of scale. Malcolm Chisholm has just given us an example of that. Smaller organisations have only one purchaser for their services—they have nowhere else to go.

Mary Scanlon (Highlands and Islands) (Con): In your submission, you talk about mistrust and tension between health boards and local authorities. Last week, we heard the Scottish Association for Mental Health talk about cultural incompatibilities. Other problems are to the fore, rather than the interests of the patient. Have you been involved in any of the strategic planning, change management and multidisciplinary work? Do you simply sit on the sidelines and wait for decisions to be made that will impact on you, or are you able to have an input?

Nigel Henderson: Member organisations have a variety of inputs. They differ in different circumstances. I am aware that we are able to contribute in a number of forums, which in turn are represented in the joint planning process. We also receive consultation documents, so we are able to comment at that stage. Our ability to do that at the same time as providing services, when the funding for those services is being squeezed, is limited—my organisation works in 12 local authority areas. It is difficult for us to free up the staff to participate in the work to which you have referred.

Mary Scanlon: However, if you are looking for openness and transparency, you ought to be willing to take part in efforts to co-ordinate joint working and ensure transparency.

Nigel Henderson: Absolutely. We and a number of other mental health organisations are part of the Edinburgh mental health partnership, which links the health service, the local authority and the voluntary sector. It is resettling 92 people from the Royal Edinburgh hospital. There is a great deal of partnership working at all levels, from a very senior level down to people on the ground. We have established a creative and innovative multi-agency assessment team, which comprises people from the local authority, the health service and the voluntary sector, who carry out assessments jointly.

Mary Scanlon: What would be the ideal way of overcoming all the problems that you have outlined? In your submission you refer to a briefing paper that you issued in response to the white paper "Aiming for Excellence: Modernising Social Work Services in Scotland". What can we get out of that for good working relationships in future?

What issues outlined in the paper would you like to bring to the committee's attention? What is your wish list?

The Convener: You have two minutes.

Jim Jackson: As is standard in the voluntary sector, we wish that we had more time for consultation. Consultation periods are often rather short. In terms of the modernising community care agenda, our position is that we support the Scottish commission on the regulation of care and the Scottish social services council in principle, but the devil will be in detail. We are particularly concerned about the funding of those bodies, if they are meant to be self-funding, either from registration fees, in the case of the commission, or from individual registrations, in the case of the Scottish social services council. We have put in a submission. We will continue to respond to the consultative opportunities, but we recognise that we are being asked to approve what will be a piece of enabling legislation. Our real concerns will be about the detail.

10:45

Hugh Henry: I want to ask about some of the problems that have been identified—the tensions and the difficulties. I am not quite clear why those have arisen. Is it because of problems with the management in local authorities and in health boards, or is it a structural problem—the legacy of things that have happened over a longer period of time?

Nigel Henderson: Joint working between health and social work suffered a setback with the reorganisation of local government. Lack of coterminous boundaries in some parts of Scotland is a distinct complication and continuous reorganisation of local authority social work or social work and housing departments is not helping matters. If the situation stabilises and the local authorities set up a joint mechanism with health, that will be a start.

The other issue is whether we are invited to comment at an early enough stage. Voluntary sector providers would not argue that they should be in the lead, but they do want to be partners who are consulted. We also want to ensure that users of services and carers are consulted.

The Convener: Duncan Hamilton wants to pick up on that point and then I have one further question.

Mr Hamilton: There is a risk of going over old ground, but I am still not entirely clear what your view is. You outline a position on joint working and what the end result should be with which I think we can all agree. You say that there are some examples of good practice, but you say that that is almost in spite of the system, rather than because of it. You also say that someone will eventually have to take the lead, but you do not have a view on who that should be. Why not? It strikes me that it is not particularly useful to know where we want to get to without really knowing how to get there. The committee is determined to find a way to achieve what, as you have outlined, we all want to achieve.

Jim Jackson: The lead varies, depending on the client group. In the mental health framework, for example, health has been given the clear lead. However, for the care of older people, social work may be given the lead. In not having a view, we recognise that the lead could be different for different client groups.

Nigel Henderson: You are right to point out the inconsistency. One of the reasons for it is that the organisation has not taken a poll of its members, so it is difficult to form a view. From my point of view and from the point of view of my organisation, there are structural difficulties that get in the way.

My wish list would include ensuring that money follows people. At the moment, we have man-made—or people-made—constructions that get in the way of the money following the people. If people are in an NHS bed, resource transfer is possible and the money can follow the person out into the community, but we do not know how much is following the person out into the community. That is a lack of transparency.

Residential care is paid for out of the local authority residential care budget but if, as often happens in mental health, people move to a more domiciliary-type setting, they stop getting money from that budget and must wait in the queue for money from the domiciliary care budget. That seems inconsistent with having person-centred services that meet people's needs when they need them to be met. There must be a system that allows money to follow the person and ensures that his or her needs are met—and replaces the artificial constructs that we have at the moment.

The other structural problem, which I know is being considered by a Scottish Executive group, is charging and non-charging. The NHS is free at the point of delivery, yet local authority services are means tested and charges are often imposed. That can be another structural barrier to true joint working and to the ability of the money to follow the person.

The Convener: What do your providers consider to be the main barriers to a shift in the balance from institutional to domiciliary care? Is it the amount of funding or the means of funding? You talked about a parcel of money that follows the person, which is an idea that we have heard from other people and that we will probably want

to consider further.

Nigel Henderson: There are a range of issues, from the initial assessment of the person and their needs to whether services that can meet those needs are available. With spot purchasing, the range of services may not always be available in a particular area because it is not viable for providers to provide them. I also mentioned the barriers between local authority residential and domiciliary budgets, which are a huge impediment to meeting people's needs when they need them to be met.

It is easy to say that the problem is a lack of money. Obviously, there is a lack of money, but there is also a lack of proper targeting of the money. We do not know that we are always making best use of the money that is available. That goes back to the fact that we do not know how much money is spent on community care in Scotland.

The Convener: Which goes back to your initial point about transparency.

Nigel Henderson: Some of our projects have six or seven sources of funding, not all of them the local authority. Mapping out what comes into community care is a huge exercise.

The Convener: I am aware that we have gone way over time for this section. I ask members to hold on to their questions. Once we have gone through the three sets of witnesses, we will see whether we still need the answers and can tie them all up in the general discussion. That way we can ensure that we give everybody a reasonable amount of time.

Hugh Henry: I am sorry, convener, but I want to ask something that is specific to this group of witnesses, about their motivation for the delivery of care.

The Convener: Hugh, perhaps you can direct that question to the Scottish Council for Voluntary Organisations, which is also here to represent voluntary organisations. We can pick up on the answer from the first group then. I am trying to move things on, so that people will not feel that we have spent all our time talking to one group.

We move now to Stephen Maxwell from the Scottish Council for Voluntary Organisations. Good morning. Do you want to make a short presentation or do you want to kick off straight away with questions?

Stephen Maxwell (Scottish Council for Voluntary Organisations): I am happy to kick off with questions.

Kay Ullrich: I always seem to get the first question to start the ball rolling. What is the most significant difficulty for your organisations, particularly the smaller ones, in the delivery of community care?

Stephen Maxwell: Without any doubt, the most significant difficulty is the stability of funding. Levels of funding—the absolute quantity of funding—are important, but the particular problem faced by smaller voluntary organisations is the uncertainty that accompanies much of the funding that they get from local authorities. That was illustrated recently in a number of public rows between voluntary organisations and councils.

Kay Ullrich: I am very concerned about the statement in your submission—the point has already been made—that smaller organisations are even more dependent on local authority funding. We know about the cuts in local authority funding. Do you have any evidence of projects or services that have been lost specifically through local authority funding cuts? Can you give us a picture of where services are being lost, or are not being taken forward?

Stephen Maxwell: Yes. One example of services being cut is in Pilton, which was mentioned by Mr Chisholm. In Renfrewshire, there is a public row between voluntary organisations and the council. A number of the voluntary organisations that are refusing to sign the conditions of grant that are being offered by councils provide community care services.

There are almost too many examples to mention of organisations operating at a local level that have budgets way below those of members of CCPS—perhaps one tenth of those £25,000 or £50,000 budgets. They are facing uncertainties about whether they will get funding in the next financial year; or they are facing offers of grant from councils that do not include an inflation element; or they are in dispute with councils about whether the council should take modest reserves into account when determining the level of grant. As they dispute or negotiate those issues, their attention is being diverted from the delivery of services, which is their main purpose.

Hugh Henry: What you have just said, particularly about Renfrewshire, is inaccurate. The dispute in Renfrewshire is not about cuts in funding; it is about whether voluntary organisations are prepared to sign a contract, which they feel is inappropriate. The council is attempting to recover money that is spent fraudulently, and it has asked voluntary organisations to sign a contract. The legal dispute is over whether that is appropriate; it is not about the level of funding. It is unfortunate if we mix up the two, because voluntary sector contracts is an important issue that should be resolved.

Stephen Maxwell: I agree that it is an important issue, but I said that the issue is either the level of

funding or the stability of funding and the conditions under which it becomes available. The issues that are being pursued between voluntary organisations and a number of councils at the moment are not just about the level of funding. They concern whether councils are following best practice, as recommended by the Convention of Scottish Local Authorities and promoted by the Scottish Executive, in meeting their funding commitments to voluntary organisations. There is a lot of strong feeling about that in the voluntary sector at the moment.

Hugh Henry: I do not want to get into the issue of contracts, but service delivery is an issue for the voluntary sector. Some of the points that were made earlier about secure funding over a longer period are important but, equally, just as we expect councils to spend money appropriately to meet levels of service and to ensure best value for money, is there not also a responsibility on those who provide funds to local organisations to ask that they meet service level agreements? If they do not meet those targets, is not it right that money should be withdrawn? We hear a lot of complaints about money being withdrawn, but we do not often hear politicians and organisations admitting that money has not been spent effectively. We have to have an open and honest discussion about that, but so far that has not happened.

Stephen Maxwell: The voluntary sector is willing to have an entirely open discussion about the conditions under which public funds, particularly local authority funds, for community care or other topics can be spent effectively. That is not the issue in Renfrewshire.

Hugh Henry: Renfrewshire is a separate issue altogether.

The Convener: Can we move on from Renfrewshire, wonderful as it is.

Hugh Henry: I am talking about a general issue, not that specific example.

Stephen Maxwell: The voluntary sector has fully accepted its obligations to ensure that public funds are spent effectively. It has various lines of accountability for funding, which it has to acknowledge in the internal management of its organisations and in its obligations to external funders. The disputes concern the exact terms of how that accountability is secured.

Kay Ullrich: I have one final point. Do you share your colleagues' concern at the lack of transparency?

Stephen Maxwell: The smaller organisations, which I am talking about this morning, do not have the same concern about transparency at the planning level as many of the larger organisations. They think of themselves as funding clients of, in most cases, local authorities. Their concern is to have transparency in that relationship. They are less concerned about transparency in multi-agency funding negotiations because most small organisations are not able to operate effectively at that level. That is why the local authority relationship is so crucial to the capacity of smaller organisations to contribute to community care.

11:00

Dr Simpson: Before I ask my question, I offer my apologies to the committee because I should have made some declarations of interest this morning—again.

The Convener: We have only an hour and a half left, Richard. I do not know whether that is enough time.

Dr Simpson: I am a member of the Scottish Association for Mental Health, which I think is a CCPS organisation. I am a member of the British Agencies for Adoption and Fostering, although I am not sure anyone is representing it. I also have some funding from Alzheimers (UK) for research, and I hold a directorship in Nursing Home Management Ltd, a nursing home company in England. I am not involved in situ, but I should put that on record so that it is clear and so that nobody can come back at me.

Would you like to see firm recommendations on contracting and funding, or is there another area that you regard as the most important and on which this committee could make recommendations?

Stephen Maxwell: For the bulk of the smaller organisations, those are the two most important areas, particularly the stability of funding over a three-year period—preferably longer—so that they can concentrate on the quality of the service they provide and build on the stability that they would enjoy over a three or four-year period.

Dr Simpson: We are hearing firm comments about three-year contracts. One matter that I am hoping to move a motion on in the Parliament in the next couple of days is the suggestion that with time-limited funding the clock should stop three months before the end of the funding. By that I mean that the decision whether to continue funding often seems to be taken when only a few weeks of the current funding is left. Redundancy notices had to be issued recently in one organisation that I am involved with because it was still waiting for funding when it had only three weeks' funding left. If the organisation is large, that can be tolerated to some extent, although in terms of human resources and management it is indefensible, but for small organisations it must be very difficult. The suggestion is that you should

always have three months' further funding until a decision is made. Do you feel that that would be of some help, along with three-year rolling contracts?

Stephen Maxwell: Yes, I am sure that it would be. It is all too common, particularly with smaller voluntary organisations, to have to issue precautionary redundancy notices because of the uncertainties and delays in funding decisions.

One other matter that would help to stabilise voluntary organisations, and smaller ones in particular, would be clear agreement from councils on how organisations' reserves should be treated in applications for funding. Some councils have a habit of looking at the reserve as possible cover against any cuts or failures to meet inflationary costs. Voluntary organisations often find themselves in dispute on that issue, in spite of good-practice guidance from COSLA and the Scottish Executive.

Dr Simpson: Is that good-practice guidance something that you would concur with in terms of the treatment of reserves?

Stephen Maxwell: Yes.

Malcolm Chisholm: I want to ask you about the last section of your submission, on health relationships, but I will start with a general question, which is relevant to all the other questions. In relation to community care, what can the voluntary sector can do more effectively than other sectors?

Stephen Maxwell: The voluntary sector can add value to the public pound in terms of mobilising volunteer input, which is not easily mobilised from a public or private-sector base. Many voluntary organisations are started by people with a clear focus on a specific need. Many of them are relatives of people who have a particular need, so that gives a clarity of focus to the service that they wish to provide.

More voluntary organisations now involve users in the management of their organisations. That should help to focus the service on the specific needs of users. A fourth area where they can add value, as has already been mentioned by CCPS, is their ability to lever in dedicated charitable funds that might not be available to providers from other sectors.

Malcolm Chisholm: Most people would agree about the effectiveness of the voluntary sector. In view of that, why is health board funding pegged at about £8 million? What is the problem?

Stephen Maxwell: I do not want to suggest that it is pegged by a collective decision by the health boards—it is stuck, and has been for several years.

The Convener: Is stuck a technical term?

Stephen Maxwell: Not at all.

The health sector had no tradition of working with the voluntary sector. Despite all the problems and tensions in the relationship between voluntary organisations and local authorities, over the years the two sides have had a working relationship, which is developing and improving through all the difficulties. The health sector still reflects an institutional bias. The low-intensity, community-based services that the voluntary organisations provide have not been given the prominence in health provision that they should, perhaps, have been given. Parts of Scottish Executive policy encourage that prominence be given to them. The situation is improving as the Scottish Executive switches its emphasis to health inequalities and the social dimensions of health. It is partly to meet that opportunity that investment is being made in the development of the relationship between the voluntary and health sectors.

Malcolm Chisholm: Will you tell us about the Scottish voluntary sector health network? Has it been launched? What will its role be?

Stephen Maxwell: It is being launched now, but it will be officially launched in May. Its purpose is to pull together many of the smaller national voluntary health organisations. Those organisations do not have the capacity—within their own resources—to contribute to the policy debate or to make representations to the statutory sector and have a relationship with it. The network gives them the collective capacity to project their needs and interests to Government and to the public and private sectors. It will play part of the role—in relation to smaller national health organisations—that CCPS plays in relation to larger community care providers.

Some of those organisations do not distinguish clearly between their health role and their community care role; the distinction is becoming increasingly difficult to sustain. The health network will undertake functions such as that.

Dorothy-Grace Elder: It has seemed to me for some years that bureaucracy is increasing considerably in the voluntary sector and that it impinges much more on its time. As Dr Simpson openly declared his interests, I will declare that I am not speaking on behalf of the following organisations, with which I am involved. I am honorary president of the Glasgow north-east multiple sclerosis society and I am a trustee of and do fund raising for the Royal Hospital for Sick Children, Glasgow. I am on the committee of ACHE—Action on Child Exploitation—and I am a patron of No Panic, an English charity. I receive no emolument for any of those.

Do you agree that in the voluntary sector there are constant and increasing complaints about the

amount of bureaucracy? Is there a new Circumlocution Office operating with all those great demands on the voluntary sector? There seems to be an endless cycle of bureaucracy and red tape.

Stephen Maxwell: Voluntary organisations sense that they might face increased procedural complications, but some of those might be inevitable. For example, the more that voluntary organisations are funded through service contracts rather than through grant in aid, the more they are drawn into discussions about how highly specified the services that they provide should be in return for that money. That process might have other advantages for the definition and clarity of the services that they provide.

We have heard about the problems that multi-funded voluntary organisations face in keeping track of all the bids that they put in. They will also face separate accounting and reporting responsibilities for each separate funding source. If an organisation is funded from seven or eight different sources, its financial reporting and accounting obligations are pretty onerous. The voluntary sector feels that it faces more and more procedural obstacles. Many people in the voluntary sector would say that some of those are necessary and do not damage service provision, but some obstacles are resented more actively.

Dorothy-Grace Elder: Simultaneously, voluntary organisations have lost money. Among the more significant figures that the SCVO presented to us in its submission is one that I quoted earlier to CCPS. There has been an estimated loss of £50 million annually since 1995 and a loss of £15 million from urban programme funding, which tends to end after a short time.

It is incumbent on members of Parliament—especially as we are always praising the voluntary sector—to examine what we are doing for it. Will you say more about that loss of income?

Stephen Maxwell: It is difficult to get hold of reliable figures even on local authority funding of the voluntary sector, quite apart from figures on other sources of funding. Those that we have been able to get hold of show clearly that there has been a steady loss of funding from local authorities. The figures do not relate only to community care organisations—they relate to all voluntary organisations. The bulk of local authority funding of voluntary organisations will be directed at social welfare organisations, which might be thought of as community care in its broadest sense.

Local authorities have been responding to the pressure on their own mainstream funding throughout those years. We are not suggesting that local authorities have targeted the voluntary sector—local government has responded to its overall funding cuts. We argue that the loss of a public pound to the voluntary sector might have a knock-on effect. The service, which that £1 helped to support, might be cut not only by the £1 less from the local authority, but by £2, £3 or £4. That is because the other added-value element that the voluntary sector can contribute is lost along with the public pound. There is a multiplier effect on the volume and quality of services from the loss of a public pound to the voluntary sector.

Irene Oldfather: I will pick up on a point that Stephen Maxwell made in relation to moving towards service contracts. I am concerned that, in the move towards contract delivery, we might lose some of the broader community care projects. In my constituency one such project provides daily social activities, including a lunch club, to old people. The problem is that the health board does not think that it is a health project, so it is difficult for the board to fund the project. The local authority does not see it as a local authority project, although it provides some services in kind. That project is crucial to keeping about 30 old people in its community independent in their own homes, rather than in residential care. I worry that, in concentrating on service contracts, we might lose broader community care projects. Is that your experience?

Stephen Maxwell: Yes. I suggested that there were some advantages for the quality of services in moving to service contracts. The SCVO has always been clear that however far service contracts might be extended, it is important that councils retain grants in aid, which can be given to the less formalised, community-based, low-intensity services that you have described. We believe that they have an important contribution to make to the overall provision of community care.

11:15

We would argue strongly to councils—as the main funders of the smaller voluntary organisations—that they should retain a balance between grant in aid and service contracting. Many councils have not moved to contract funding as quickly as was expected when the NHS and Community Care Act 1990 was introduced. There is a lot of grant-in-aid funding that ought to be made available to organisations of the sort that you mention.

Mr Hamilton: I have a fairly simple question. I take your point about the potential savings that preventive low-intensity services can make by avoiding the need for intensive services. Why is it that that obvious and straightforward point has been ignored? What can the committee do to toughen up any recommendation that the point be taken more seriously? Action can, perhaps, be

taken in concert with the Executive's efforts. The committee might be able to add muscle to a recommendation.

Stephen Maxwell: Part of the explanation is that bodies that have to meet statutory responsibilities must meet those responsibilities first. Statutory responsibilities tend to focus on people who have the most intensive needs, so there is a in-built tendency to direct resources to those needs before meeting the wider range of low-intensity needs.

There are probably still institutional forces in councils and health boards that cause money to be directed toward particular forms of provision and that make it more difficult for councils and health boards to justify using resources on lower-intensity services. It is less easy to demonstrate a direct bang for one's buck in preventive work than in work for people whose extreme or urgent need has been identified.

There are a number of reasons why it is difficult to push resources away from obvious targets and statutory responsibilities toward the wider range of preventive need in the community. I do not know whether I can suggest any single measure to encourage that shift of resources. It has been said that the care in the community needs assessment system should, in principle, help to identify needs. If more emphasis were put on the initial community-based assessment of need, there would be a better framework in which the planning of particular services could be pursued.

Kay Ullrich: You mentioned that local authorities have statutory responsibilities, particularly in social work. The committee is concerned that local authorities are not using the full indicative amount that is given to them in grants for community care funding. Do you have any evidence of that? Would you favour the ring-fencing of money for community care?

Stephen Maxwell: The voluntary sector has benefited from ring-fenced funding, such as specific grants for mental illness. There is a conflict between the voluntary sector's sectoral interest in increasing its funding, and its wider interest in ensuring that democratically elected and responsible authorities have adequate discretion for the allocation of resources according to their assessments of need. Although voluntary organisations have benefited often from tied funding, the voluntary sector would be cautious about generalising ring-fenced funding and would prefer that there was a wider system of community care need assessment, with a stronger community dimension, as a framework in which local authorities can allocate their community care resources. I know that that answer is slightly evasive.

Kay Ullrich: I asked that question because a representative of the Association of Directors of Social Work told us that local authorities tend to put money into statutory services—services for children and families and so on—and that that is to the detriment of community-care services.

Stephen Maxwell: Many voluntary organisations will recognise that dilemma, although they might not be sure what the solution is.

Margaret Jamieson: Can you clarify what you understand to be the boundaries between community care and social welfare clients?

Stephen Maxwell: The voluntary sector would resist making too rigid a distinction between community care and social welfare clients. Of course, we recognise that in discharging their statutory duties under community care legislation, local authorities and health boards must identify certain groups as being in special need of community care. Many of the activities and services that voluntary organisations provide as social welfare organisations, however, contribute to the total community care package. For example, family support services and informal services such as lunch clubs have a part to play in maintaining people in the community who have various levels of dependency and special need.

Margaret Jamieson: Is it, therefore, true that your definition of community care is within the terms of the NHS and Community Care Act 1990, and that other services support individuals in the community, even though they have not received an assessment under the terms of that act?

Stephen Maxwell: Yes. Some of the wider welfare services about which I am talking will support people who have had a formal assessment and who might be the subject of a community care package. People who might become subject to community care assessment might benefit from those services, which might prolong the period for which they can do without formal assessment. It is a grey area. I do not think that the voluntary sector would want to make distinctions that do not reflect the reality of people's lives.

Margaret Jamieson: I think that that point complicates matters for the inquiry. Our remit is to consider community care within the parameters of the NHS and Community Care Act 1990.

Mary Scanlon: I have two questions to ask Stephen Maxwell. First, on value for money, when you say that the public pound has a multiplier effect of four or five, are you saying that councils should give you more funding because you can ensure greater value and can meet health needs better than a council can? Are you saying that you can provide more care per pound?

Stephen Maxwell: In many cases the voluntary sector can add value through mobilising a volunteer contribution either at management committee or volunteer worker level. The sector taps into sources of funding that would not otherwise be available. Perhaps—this is the boldest claim—because of the structure of voluntary groups as independent organisations with a clear needs focus, the sector can produce a more efficient focus on particular need. That will not operate to the same extent across the whole range of services, but we think that we can make that claim across services as a whole.

Mary Scanlon: Highland Council is considering cutting £200,000 from the sum that it gives to the voluntary sector. Would your advice be that the council should give more money to the voluntary sector because it can meet the need better than the council?

Stephen Maxwell: We have said to Highland Council that, before the decision is taken to cut that money out of the voluntary sector budget, the added-value elements of the voluntary sector should be taken into account. When the best-value guidance was being promoted in the then Scottish Office, we argued that the guidance should draw the attention of local authorities and other public bodies to that added-value element.

Mary Scanlon: Are you saying that the added-value element does not exist within direct council spending?

Stephen Maxwell: We would not say that, but we believe that the voluntary sector can provide distinct services that should be taken into account when best-value and added-value estimates are made.

Mary Scanlon: The new system for performance evidence will increase bureaucracy, yet, as we have heard from Dorothy-Grace Elder, there is a criticism that the voluntary sector is becoming more bureaucratic. How can the ability of your member organisations to operate the new management systems be increased to ensure the delivery of openness and accountability without too much bureaucracy? We would hope that most of your funding would go towards front-line services.

Dorothy-Grace Elder: I was not implying that the voluntary sector was becoming more bureaucratic, but that bureaucracy was being forced upon it.

Stephen Maxwell: The organisations must, of course, meet whatever criteria of good value are imposed by the public funders. Voluntary organisations acknowledge that they must create systems for assessing the effectiveness of the work that they do. We argue that the demands made by public funders should be proportionate to the moneys that are being made available to the voluntary sector. That will ensure that reporting and accounting do not take up too large a proportion of what are often rather modest grants. There must be an element of trust, especially at the lower level of funding. That can consist of first-hand assessment by council officials, for instance. It need not develop into an elaborately bureaucratic system.

Mary Scanlon: I would like Nigel Henderson to reply as well.

The Convener: We are running late and we have not yet brought in the final group of witnesses. I thank Stephen Maxwell for his contribution.

I thank the representatives of Scottish Care for being so patient. I hope that they have found this morning interesting.

Colin Cowie (Scottish Care): I would like to make a short introduction. Our submission was made under the aegis of the Scottish Association of Care Home Owners, of which I was the chair for a short time. The independent sector associations in Scotland—of which there are many—entered discussions last year with a view to coming together as one organisation that could speak with one voice. That organisation is Scottish Care, which was launched on 11 January in Glasgow. Our membership includes groups from the whole spectrum of care services, both private and non-profit making.

I am the chair of the organisation. My colleagues are Joe Campbell, the chief executive, Peter Laing, the secretary and treasurer and Noni Cobban, our home care representative and the chair in Scotland of the United Kingdom Homecare Association.

The private sector, to which most of our members belong, represents some 28,000 places in the nursing home sector and employs more than 35,000 people. Including carers, relatives, residents and staff, a community of more than 100,000 people is involved in the sector in Scotland. It represents a substantial part of the provider sector.

I would liken our sector to a flotilla of ships, with the captain of each managing their vessel in the choppy sea of community care. We are attempting to work together to develop a unified approach to general strategic issues, such as those on which the committee is working. We applaud the fact that the committee has chosen to address community care and wish it luck in its attempts to reach an equitable conclusion.

The Convener: I think that we will need it.

11:30

Kay Ullrich: Can you outline the most significant difficulties that your organisation faces in the delivery of community care?

Colin Cowie: Our key concerns are the funding and purchasing of our services by the local authorities and the split in the local authorities between purchaser and provider.

Kay Ullrich: In your submission, you say that the cost of a local authority care home place is higher than a similar place in the independent sector. Why is that, and what effect does it have on your organisation?

Colin Cowie: The Accounts Commission's February 1999 report shows that, in general, a local authority care home place is more expensive than a comparable place in a private sector care home. The reasons are varied. Money is, obviously, spent on administration and staffing in public and private care homes, but a larger chunk of community care money is used up by local authority places.

Local authorities pay for the care that they provide at the beginning of the budget year. The beds are all paid for and it is a benefit if they fill them, rather than leave them empty. The local authorities then spot purchase places from the independent sector when they feel that they have the funds to do so. They do not do that if they run out of money, which has an effect on us.

Kay Ullrich: Your submission seems to suggest that the tendency is for local authorities to fill their homes first. Local authority homes tend to be residential—I assume that most of your homes are nursing homes. There used to be a clear distinction between people who were assessed for residential care and people who were assessed for nursing care, but we appear to be moving away from that position.

The submission states:

"It is unacceptable that the body responsible for assessment, placement and funding of care is also a major provider".

Do you believe that the local authority, which acts as a provider, should not be responsible for the placement?

Colin Cowie: I am saying that there is a dichotomy for the local authorities, which they recognise. I am trying to paraphrase what you said, but I am not quite sure about what I wanted to say. I apologise.

The Convener: If only members could do that every time we forgot something. We shall ignore that point.

Colin Cowie: The local authorities face a dichotomy. They have a legal obligation to assess and care-manage clients in the community and to refer and place them in appropriate care environments. They are also a provider in that area, having their own residential-based provision. I have not said in my submission that local authorities are filling their own homes first, but there is evidence that that is the case now, and local authorities have even admitted openly that they are doing it. That is the first time that that has happened.

My submission alludes to the fact that local authorities cannot hold their hands up and say that they can never be accused of filling their own homes first. They must be seen to be completely impartial but, with the myriad roles that they are asked to perform, they certainly cannot claim that they are. The risk arises from the fact that they can fill their own homes first, and that is what we are concerned about.

Kay Ullrich: Do you have evidence that local authorities are mis-placing people who should perhaps not be in a local authority home? Do you have evidence that people are being put in such homes for reasons of resources rather than of needs?

Colin Cowie: No, we have only supposition; we cannot prove it at all. An assessment would need to be done on the individuals in any home, with some tracking of what process they went through to get there. I do not think that local authorities would deny that a large number of the residents in their homes would perhaps be better suited to nursing homes than to residential homes. There may be many reasons why that is the case, but not all of them relate to admission.

Kay Ullrich: Residential homes do not have nursing care. I am concerned that people who should have nursing care may be inappropriately placed.

Colin Cowie: The logical conclusion of the renewed thrust on keeping people at home and providing services at home would be that there was less demand for residential care places than for nursing places. There is evidence that that is the case. The next question is why the residential homes in the local authority sector are so full. Local authority homes, in the main, are full, whereas independent residential homes are not.

Kay Ullrich: What is the difference in cost per person per week between those types of care?

Colin Cowie: I can cite an example from Aberdeenshire. The cost varies greatly from local authority to local authority. The difference in cost could range from £100 for a residential place in the private sector or in a local authority home to £200 or more.

Margaret Jamieson: You make assumptions

about those who are in residential care. I understood that, for residential care, the assessment is undertaken by social workers, who are part of the local government arm of the service. However, anyone who is assessed as requiring nursing care has that assessment done by a separate organisation for the health service, perhaps with support from colleagues in mental health. Are you saying that something different is happening?

Colin Cowie: The National Health Service and Community Care Act 1990 gives local authorities, not the health service, the responsibility and legal obligation to assess people's care needs. In every case, the local authority care management team assesses individuals in the community who have a right under that act to an assessment. The team will assess whether that person needs home care services, residential place services, nursing home services or any services at all. Such is the authority of the care management function that the team can even override a geriatric consultant's decision about where an individual goes for care; those teams have that power and have used it.

Margaret Jamieson: Do you have evidence of a geriatrician's advice being overruled by a local authority?

Colin Cowie: Yes, but not recently.

Margaret Jamieson: I would be interested in that. To me, that is unacceptable. Obviously, the interests of the individual should be central, rather than the interests of the local authority or any other organisation.

Colin Cowie: I understand your point of view, but it may surprise you to hear me say that I am not shocked. At a conference that we held, Mary Hartnell, the former director of Strathclyde region social work department, was asked to justify a case that she had had. She said that, in her opinion, it was correct for her care manager to override the geriatric consultant and that she would support a similar decision if it happened again. I do not question that. It does not happen often and I know of no recent cases. If you ask for evidence, I would cite the Strathclyde case. The responsibilities of the care managers are firm and clear in law. Social work departments are the lead authority and have that power and responsibility. They assess people for all care services.

Mr Hamilton: Kay Ullrich referred to the part of your submission that states:

"It is unacceptable that the body responsible for assessment, placement and funding of care is also a major provider".

I do not know what point you wanted to make about that—it was the one that you could not remember. However, it strikes me that your submission takes a fairly hefty swipe at the role of local authorities and casts fairly serious aspersions on their motivation. That is a difficult position to defend. If you are asked whether you have any evidence of cases in which inappropriate care has been proposed, you cannot provide it.

Colin Cowie: I have never accused local authorities of that, in my submission or anywhere else.

Mr Hamilton: If I heard you correctly, when we asked for some evidence of how your assertion could be supported, you could not give us any. Can you comment on that?

My second question concerns the role of local authorities. Perhaps one of the points that is being missed is that they are publicly accountable bodies that are spending public money—all that spending is out in the open. Why is there a suggestion that there is some kind of closed conspiracy behind all this? I do not see where that is coming from.

Colin Cowie: That is your word, not mine, and it is not mentioned in the submission either.

Mr Hamilton: I know that, but I am summarising what you are saying.

Colin Cowie: What I said in the submission, which I stand by, is that it is unacceptable that the same body has those disparate responsibilities and that it is difficult to see how fairness and equity can be maintained in all cases.

Mr Hamilton: I am asking you how you can say that without any evidence that you can give to the committee.

Ben Wallace (North-East Scotland) (Con): My interpretation is that the position in the submission is similar to ours as MSPs—when we declare our interests, that does not mean that we are guilty of any wrongdoing. Local authorities have to assess their competition as well as their own homes. To me, that is wholly inappropriate, but it does not mean to say that there is necessarily wrongdoing.

The Convener: Let us move on from that point; we have a lot of things to cover.

Dr Simpson: I wanted to amplify the point slightly. Local authorities are currently responsible for registration. As I understand it, that function will be transferred to a national commission, so that point is already answered. Local authorities are legally responsible, however, for the assessment, but we are trying to move to joint assessment, of which I assume you would approve. If someone is in hospital, a joint assessment is undertaken and the work is not duplicated.

Local authorities purchase and provide. I want to be quite clear about your position—you are concerned about the fact that they assess, purchase and provide.

Colin Cowie: Precisely.

Dr Simpson: I wanted to be quite clear about that. What one recommendation would your organisation like this inquiry to make?

Colin Cowie: We would like to help local authorities to resolve the dilemma by giving funding to a central integrated budget holder such as a national care commission.

11:45

Hugh Henry: Three strands flow from your opening statement. You have put a lot of effort into compiling statistics—you have mentioned the 28,000 places that are available in nursing home care, the 35,000 jobs in the sector and so on. Do you know the turnover of the sector in Scotland and its profits?

Colin Cowie: No.

Hugh Henry: You mentioned differences in costs in the private sector and local authorities. Can you give the committee figures on differences in wage levels, in per capita spending on training and in the amount spent on health and safety?

Colin Cowie: I cannot, because—to use my earlier analogy—I would have to jump in and out of every ship to find those figures out. Local authorities pay, on average, more than the private sector. Training budgets are a difficult issue—many of our members are involved with local authorities and other partners in co-operative arrangements for joint training initiatives. We are committed to training and to quality in care. We recommend that our members have a formal training plan and budget.

Hugh Henry: The voluntary sector has indicated its belief in the need for transparency and for justification of the expenditure of public funds. Do you share that view? If so, would you be prepared to publish your accounts and be accountable for your use of public sector money?

Colin Cowie: Limited companies—of which there are quite a few in the sector—publish their accounts through Companies House. I am not sure that it would add any value for other operators to publish their accounts. It is clear that if an independent or private sector operator can run a good-quality care service that charges significantly lower fees than the equivalent local authority service, there must be some acceptance that they are doing a good job and that they are spending the money wisely and efficiently.

Dorothy-Grace Elder: Are all your members making a profit?

Colin Cowie: That is difficult to answer. The owner of a home who was in difficulty would not be very keen to publicise the fact—

Dorothy-Grace Elder: There must be annual reports. Do you accept that care homes are reasonably big businesses these days? Some chains in the British isles are registered as having turnover of more than £45 million a year.

Colin Cowie: I do not know. I assume that that is entirely possible.

Dorothy-Grace Elder: Such chains are sometimes registered in tax havens outside Britain.

Colin Cowie: I do not know—I have no knowledge of that. I can assure the committee that none of Scottish Care's members are in that category.

Dorothy-Grace Elder: Are some of your members offshoots of the English companies?

Colin Cowie: No—not so far.

Dorothy-Grace Elder: You referred to the 35,000 jobs that staffing of homes provides. How many of those jobs are part time.

Colin Cowie: I am not sure. Do you know, Joe?

Joe Campbell (Scottish Care): I would imagine that very few of the jobs are part time. Most of the jobs in Scottish nursing and residential homes are full time.

Dorothy-Grace Elder: Approximately how many of those jobs will be occupied by qualified nurses?

Joe Campbell: Not a large proportion. There will, however, be a significant proportion because there is a statutory requirement to have nurses in nursing homes—but not residential homes—at all times.

Malcolm Chisholm: I am interested in two aspects. The first is the argument about being both a purchaser and a provider. There is nothing unusual about that in local authorities. In seeking best value, local authorities must compare their own provision of a range of services with external provision. Why do you regard your situation as different? Are you suggesting that local authorities should not commission services?

Colin Cowie: The dichotomy lies in the way that they pay for their own services. At the beginning of a budget year they fund their services entirely. Services in the independent sector are spot purchased throughout the year. Most, if not all, authorities have restrictions on placing people in care in the independent sector—some place none in that sector. In the Borders there has not been a placement or referral to a private home since September 1999.

Malcolm Chisholm: People would be concerned if there were inherent inefficiencies in the council sector. The major issue for you is

staffing costs. How much of the difference in the cost of care is to do with staffing costs? Is most of it to do with staffing costs?

Colin Cowie: I cannot say—I have no access to homes' accounts or their financial information. The Accounts Commission report indicates that staffing costs are significant in local authority operations. They do not, however, account for all the difference.

Malcolm Chisholm: Is not it legitimate that local authorities should be concerned about the wages and conditions of their workers?

Colin Cowie: That is entirely up to them.

Malcolm Chisholm: You propose to transfer the purchase of care to a national agency. Do you assume that a national agency would not be so interested in those matters?

Colin Cowie: No. A national agency would be interested in best value for the money that it spent on services. I would be surprised if such an agency would purchase the more expensive local authority services if there was a level playing field and best value was the criterion.

Malcolm Chisholm: Do not you think it reasonable that best value should include a level playing field for wages and conditions?

Colin Cowie: We offer our staff rates of pay and terms and conditions of employment that are comparable with others in the community within which we operate. That is perfectly correct and equitable.

Malcolm Chisholm: Are there differences in skill levels?

Colin Cowie: No.

Malcolm Chisholm: So the problem is mainly wages and conditions.

Irene Oldfather: You mentioned the difficulties of spot purchasing. You also mention in your submission the financial difficulties of the independent sector and the fact that the sector is at risk of collapse in some areas. To what degree is that the result of the massive expansion of the private sector?

Colin Cowie: That is a fair question. The charge can be made that expansion caused over-provision in some areas. There are significant issues related to the fact that local authorities have stopped or have restricted purchasing, which is a problem throughout Scotland. The number of bed vacancies is growing in homes that would otherwise be full. There are 2,900 people in hospitals in Scotland who have been assessed as requiring that sort of care. The only reason they are in hospital is that local authorities have restricted referring people to them in order to limit spending. The demand exists and the beds that are vacant could be filled.

Mary Scanlon: I seem to be having difficulty getting questions in today, so I will ask my three questions together in case I am not allowed supplementaries.

First, how many homes have gone bankrupt in the past few years and how many have left the sector? Secondly, what would be the implications for your sector if the Sutherland recommendation that nursing care be delivered free of cost to the individual were to be implemented? Thirdly, could you provide some examples of the way in which disputes at the boundary between health and social work affect residents in care homes? Does the imbalance lead to a two-tier system of care, distinguishing between people who can fund themselves and people who are dependent on local authority funding?

Colin Cowie: I do not have a figure for bankruptcies.

Mary Scanlon: Have there been any, to your knowledge?

Colin Cowie: We estimate that around 10 per cent of homes have gone out of business. It is difficult to find out how many of those simply gave up and closed the doors and how many were forced into bankruptcy. We do not have those figures.

Mary Scanlon: Are you saying that they closed the doors because they did not have enough referrals, and that their overheads were the same as other homes but their bed usage was much lower?

Colin Cowie: Yes.

Mary Scanlon: What about the Sutherland recommendation?

Colin Cowie: That would have the effect of reducing the overall cost of care to the purchasing agency. If the agency did not have to find that element of funding, it could purchase more care.

Mary Scanlon: Would patients receive a more appropriate level of care?

Colin Cowie: I assert that they already receive an appropriate level of care if they are placed in a home, because the whole reason for the home is to give that level of care. We have to meet standards and criteria that are set down by the regulator and by our contracts with the local authority. There would be no diminution of service, but there would be more funding in the pot, with which whoever the paymaster is could buy more care.

Mary Scanlon: Would that allow access to more people?

Colin Cowie: Yes, it would.

Hugh Henry: Is there an inconsistency between the notion of providing service free to all those who need it—as Mary suggests that Sutherland recommends—and the exhortation of some national politicians that people should take out private health insurance to cover their health care?

Colin Cowie: No. My belief is that we should all attempt to provide for our health care to supplement what will be provided by the state. The state clearly cannot afford to give free service at all care levels to everybody for ever. There has to be some way of supplementing the provision, as we mention in our submission.

Mary Scanlon: My third question entails consideration of the 2,400 blocked beds in Scotland. Can you give us examples of the way in which disputes between health and social work departments may affect residents in care homes? Do those who are unable to pay for themselves receive a lower level of care?

Joe Campbell: I have seen no examples of there being two types of care in a home. I have never seen that, and we would abhor it if we did.

Mary Scanlon: I am asking about access to care. Are those who are able to fund themselves placed much more quickly than those who have to wait for social work funding?

Joe Campbell: Yes—those who can pay for care get it right away, because they have no problems with the assessment process. However, in any home that I have ever seen, they do not get any better care than the poor soul who has been kept for weeks and months in a hospital.

Mary Scanlon: Can we assume that the people who are in blocked beds do not have the funding to pay for their care, and that that is why they are blocking beds?

Joe Campbell: Correct.

Colin Cowie: Absolutely.

Mary Scanlon: But those who can pay for their own care now are receiving it now; does that not mean that we have a two-tier system, in which the tier depends on the person's wealth?

Colin Cowie: Yes, certainly.

Joe Campbell: Yes. All over Scotland, if you cannot fund your own care, it is a lottery whether you get care.

Ben Wallace: At the top of page 4 of your submission, you say:

"Social Work and Health Boards differ in their interpretation of residents' of nursing homes entitlement to some Health Board services. This often leaves the resident caught in the middle".

How can that problem be solved and what kind of organisation would be able to solve it?

Colin Cowie: What has happened in many cases is that community general practices are disputing whether some items of care are appropriate for the prescription to be paid through their budgets. Homes have to provide those items and then go into dispute with the practice. Usually, the piggy in the middle is the client. Although she has all the legal rights of community support that she had before going into the home, there is a difficult problem.

Ben Wallace: Who could solve that problem?

12:00

Colin Cowie: That is difficult to answer: the problem varies from circumstance to circumstance. In one case that I am looking at, an individual in a nursing home requires a new form of treatment from a unit in a hospital. The medicines and the means of delivering them should be supplied through the practice, but the practice, although it will supply the medicine, refuses to supply the means to deliver the medicine. The home is having to buy—at some considerable cost—the means to deliver the medicine. We are trying to resolve that situation by finding out the exact legal position of the practice in its role in the community.

Ben Wallace: Do you think that the Executive, or a national body, could solve the problem?

Colin Cowie: We have approached the Executive. We think that it is its responsibility to give us guidelines.

Ben Wallace: With clearer standards?

Colin Cowie: Yes.

Dr Simpson: I am interested in two aspects of the concept that one size fits all. First, there is a standardised reimbursement by the purchaser for care in the nursing homes, in the public sector at least. Secondly, and related to that, the very large nursing homes that are being developed in Scotland by large private sector companies do not seem to be appropriate for groups such as those with learning disabilities and mental health problems, with whom our investigation is concerned. Can you give us any evidence of local authorities that are purchasing, in a more flexible and imaginative way, smaller units with a domestic style that is more appropriate for people with mental disorders, people with more severe Alzheimer's who cannot be supported at home, and people with mental illness?

Colin Cowie: I cannot give you examples of where that is happening. I can, however, give examples of providers who have tried and failed to

negotiate with local authorities an appropriate fee that would fund that kind of undertaking.

Dr Simpson: From direct experience with the authorities in Manchester, I am aware that a combination of health authorities and local authorities—working jointly and recognising the additional care requirements and costs in small homes—has supplemented the basic fee. Could such a system be appropriate?

Colin Cowie: We would welcome that. I know that many providers are keen to provide what is necessary and what is most appropriate. Some providers have approached their local authorities and Scottish Homes to put together packages that would provide a more appropriate environment and more appropriate care services to meet the needs of individuals and to meet their quality of life requirements. However, we found that they failed to attract the interest of the local authorities.

Dr Simpson: Convener, I know that time is running on, but may I ask whether either of the other two organisations would like to comment on this point about individual care?

The Convener: I have allowed the community care part of our agenda to run over time. I did that deliberately having looked at the rest of the agenda, which I hoped that we could get through quickly. We are within half an hour of the end of the committee meeting. Although I am happy to let members ask any urgent final questions that cannot be dealt with in written form, we can take only five minutes to do so.

Dorothy-Grace Elder: Bearing in mind the fact that we are dealing with very vulnerable people, what do you think of the regularity, value and thoroughness of home inspections?

Colin Cowie: In the main, inspections are frequent and thorough. The health board in my area has a target of six inspections a year, including a formal inspection of all general areas of organisation within the home and another based on quality-of-life issues. The other inspections are unannounced; at least one happens out of hours.

Dorothy-Grace Elder: Does the health board meet its target of six inspections a year?

Colin Cowie: The health board would probably agree that it does not meet the target in every case. There is probably more of a focus on homes where there are issues to resolve; if the health board tried to meet its target, it might be robbed of the capacity to make more visits to homes that were undergoing more detailed investigation and to assist with improvements.

Dorothy-Grace Elder: What do you mean by unannounced inspections? Is there a discernible pattern to inspections that might allow people to work out when the next one was going to be?

Colin Cowie: In my experience, inspections have been completely unannounced.

Joe Campbell: We had a visit at five past midnight on new year's day, and we welcomed it. Our federation, the Ayrshire Care Home Federation, which is now called Scottish Care—Ayrshire Branch, was one of the very first to say that such visits should be unannounced.

Annie Gunner: I want to come back to a few points that have been raised. Colin Cowie mentioned the division between purchasing and providing of care by local authorities. I am interested that Scottish Care advocates the establishment of a national body to perform that role instead of local authorities. Although we have concerns about that, we think that the problem is better solved by direct payments to service users, to empower them to purchase services and manage their own packages of care.

On a point that Malcolm Chisholm raised, I hope that members have received copies of our latest publication on staff pay and conditions. When the community care market came into being, the SCVO published a code of practice that said:

"Voluntary sector employers should seek to offer their employees similar conditions of service to those provided by local authorities and health boards and pay them at rates that are negotiated for comparable statutory services' employees."

The gist of our report on staff pay and conditions is that that stipulation is becoming almost impossible to maintain. Organisations now have to dip into reserves to pay such salaries. I agree with Malcolm Chisholm that this is a best value issue.

Finally, we were concerned at Duncan Hamilton's frustration about our inability to provide solutions to joint working.

The Convener: Mr Hamilton is always frustrated about something. [*Laughter.*]

Annie Gunner: Although voluntary organisations are regularly consulted about planning exercises, they are not part of the statutory services loop, which makes it difficult to come up with solutions. For example, although the Scottish Executive has recently established a joint futures group to examine how health and social work can work together, the voluntary sector has not been included. We do not know how the group's deliberations will impact on the voluntary sector. We are as frustrated as Mr Hamilton by our inability to suggest concrete solutions because we are not part of that organisational arrangement.

The Convener: I have to bring the session to a close. I thank the witnesses for coming along and giving us the benefit of their expertise.

I am sorry, Duncan, but that comment was just too good to miss.

Subordinate Legislation

The Convener: The next item on the agenda is consideration of the Food (Peanuts from Egypt) (Emergency Control) (Scotland) Order 2000. There is a bit of everything on this committee.

This instrument is under the negative procedure. No motion has been laid 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. As a result, I suggest that the committee has no recommendations to make on the instrument. Are members agreed?

Members *indicated agreement.*

Petitions

The Convener: The next item on the agenda is consideration of petition PE92 from Mr Frank Harvey, which calls for the Scottish Parliament to hold a public inquiry into, first, staffing and waiting times in accident and emergency departments in Scotland and secondly, the number and type of beds available in NHS hospitals in Scotland. As a member of the Public Petitions Committee, I know Mr Harvey very well—I believe that he is currently responsible for 20 per cent of the petitions that have been submitted, so he is keeping all the Parliament's committees very busy.

The Public Petitions Committee's recommendation is that this committee should simply note the petition. Are members agreed?

Members *indicated agreement.*

The Convener: The next item on the agenda is consideration of petition PE93, again from Mr Frank Harvey, which concerns the incident at Falkirk royal infirmary involving a patient with body dysmorphic disorder. The Public Petitions Committee recommends that we simply note the petition. Are members agreed?

Dr Simpson: I am concerned about simply noting this petition. As you said, this particular gentleman has been responsible for 20 per cent of petitions to the Public Petitions Committee. I think that we should find another term that means less than noting.

The Convener: Your point highlights our difficulties when an individual overindulges the public's ability to access a Parliament that we pride ourselves on being open, accountable and accessible to all.

Kay Ullrich: The same could be said of the amount of questions lodged by some MSPs.

The Convener: We all agree with that.

The clerk of the Public Petitions Committee has already said to Mr Harvey that it might be more fruitful if he concentrated his efforts on a smaller number of petitions.

12:15

Dorothy-Grace Elder: I know that we receive petitions from people who go on a bit, but Mr Harvey's ideas are perfectly sensible. Without wanting to make it illegal, I am sure that the committee agrees that healthy limbs should not be removed unnecessarily. I say good luck to Mr Harvey.

The Convener: The Executive has asked the chief medical officer to write to all the trusts, to find out what their response would be. We might return to the issue at some point in the future, but the Executive is obviously acting as a result of what happened at Falkirk royal infirmary.

Dr Simpson: That is a good example of a total waste of time.

The Convener: The more we pursue it, the more it becomes a waste of time.

Dr Simpson: For the chief medical officer to write to every trust, asking them to set up committees to determine policy, is a waste of time in the system. That is totally wrong.

The Convener: Let us not waste any more time, and move on.

Joint Investment Funds

The Convener: Agenda item 5 concerns the issue of joint investment funds. It arose after conversations that we had in one of our informal budget meetings, at which we noted that there is not much evidence to suggest that joint investment funds are being used at all. It is suggested that we ask the Executive to provide the committee with information on the management and operation of joint investment funds in all health boards and trusts. That information should give us an idea of how successfully those funds are operating.

Ben Wallace: I have written to every health board, and have received replies from 80 per cent of them, on the number of joint investment funds in operation. To date, that number is one. We might well be talking about a theory.

The Convener: Can we leave that discussion to a future meeting? I will liaise with Ben Wallace on that issue, and we might write to the remaining 20 per cent of health boards.

Dr Simpson: I suggest that that item should be on the agenda for the next meeting at which one of the ministers will be present. The system is clearly not working, and we have the information to support that assertion.

The Convener: I agree, but the committee will be in a stronger position to question the ministers if it has received evidence from all the health boards and trusts in Scotland which suggests that the system is not working.

Dr Simpson: I suggest that the committee should appoint Ben Wallace as the reporter to complete the study that he has already started, rather than have it undertaken again. He should be given the authority of the committee to write to the boards that have not responded, to say that he is now officially approaching them on behalf of the committee. We can then pursue the study, rather than begin collecting evidence again.

The Convener: That seems a fair suggestion.

Mr Hamilton: I do not have a problem with Ben doing that. However, the situation should be monitored continuously. I would like the Scottish Executive to be involved, so that monitoring happens not just once, for this committee, but on an on-going basis. There is no reason why we cannot take the evidence that Ben has collected and appoint him as the reporter to pull it all together. However, we also need a central collation of statistics to inform us about what is happening.

The Convener: Does the committee agree to appoint Ben Wallace as the reporter, as he has already done the bulk of the work, to return to the 20 per cent of boards and trusts that have not responded? Once that information has been received, we will proceed in the way that Richard Simpson and Duncan Hamilton have suggested. Are we all agreed?

Members *indicated agreement.*

Mr Hamilton: May I make one more point, in reference to a related issue?

The Convener: No. I will leave you frustrated, Duncan. Agenda item 6, on contacts from outside organisations—

Mr Hamilton: It is a genuinely important point, about the budget. At the same meeting, we asked for a note on capital charges, which I would still like to see. Can we ensure that that note is received?

The Convener: Okay. No problem.

Outside Organisations (Contacts)

The Convener: We now move on to item 6—if I can find my papers. A series of items have been sitting on our agenda for a while. [*Interruption.*] I have some notes that I am trying to find. I am sorry. Bear with me, while I find my papers.

Several organisations have contacted us, offering information, presentations, possible inquiry topics, visits and so on. Two members of the committee have responded, to say what they think ought to be done.

Dr Simpson: Three.

The Convener: Sorry, three members have responded. Two members' responses are included in the paper that we have in front of us.

We have had offers of information from the Office of Public Health in Scotland, and from the Scottish Directors of Public Health. Public health is not being considered directly as part of our on-going work load and agenda, but bearing in mind its importance to the overall health agenda, it might be worth while to find time for a presentation. Do members agree?

Irene Oldfather: We will have to be very disciplined. The paper contains many suggestions for presentations, invitations and so on. I am aware that—

The Convener: I will just run through the paper and say what I felt. I thought that we would value a presentation on public health.

We had a meeting with the Royal College of General Practitioners on the on-going support and information that it can give to the committee. The college is now in contact with our researcher in the Scottish Parliament information centre and will give information from time to time.

Other organisations have offered to do presentations for us, but some are area specific and some concern matters that would arise at specific times.

Dr Simpson: We could short-circuit this discussion if the convener, together with the party spokespeople, came up with a set of proposals for specific presentations, as opposed to information, on the basis of members' responses. Perhaps members could have another 24 hours to respond by e-mail.

The Convener: I am concerned that contacts from outside organisations have been on the agenda for some time, but because of other work, we have not made progress. If the party spokespeople agree with Richard Simpson's suggestion, I will discuss the matter with them.

Dr Simpson: We should make a decision.

Hugh Henry: Is this paper an exhaustive list? I made some suggestions to the clerk, but I do not see them—

The Convener: This is a list of suggestions from outside organisations, not from members. Are you referring to possible witnesses for the community care inquiry?

Hugh Henry: Yes.

The Convener: There is another list for that. The list that we are discussing is—

Hugh Henry: The list mentions visits. I remember that when we talked about the Perth and Kinross—

The Convener: That is on the community care list.

Hugh Henry: Is it on this list as well?

The Convener: No, but some items are on both lists. We are considering a list of representations, from outside organisations, which were made to the committee without our going out and soliciting them. Early in the process, before we started to decide where we wanted to go and what we wanted to do, we might have received letters suggesting visits. We can now include such suggestions in our community care inquiry. If we can clear up the list one way or another, that will give us a clearer programme.

Are we agreed that we will delegate that task to the convener and the party spokespeople?

Members *indicated agreement.*

Irene Oldfather: I thought that you also wanted members' recommendations. Is that correct?

The Convener: Yes.

Forward Work Plan

The Convener: Agenda item 7 is our forward work plan. The paper sets out our proposed agenda for the coming weeks.

Malcolm Chisholm: I have raised this point before. I am worried about two things. First, will what happen to the community care inquiry in April and May? Secondly, we have started on that inquiry—eventually—but I am still worried about its structure and direction. Will we do a big report in a few months' time, or will we try to break up the inquiry and report on interim progress?

The immediate problem is that there appears to be a two-month gap, during which community care will be on the back burner, if not off the cooker altogether.

The Convener: I have had an initial discussion meeting with the advisers—Alison Petch and Gordon Murnoch—and they are working through a number of aspects, such as other people from whom we should take evidence, members' suggestions on visits and so on. Those things are being worked on and will come back to us.

The budget process is almost an imponderable. Until we have had our briefing on that, it is difficult to know the number of organisations from which we will want to take evidence. This year, the committee might decide that it wants to hear from the minister and one or two other people, but that it does not want to go into the process in great depth. The sessions that have been set aside for the budget proposals might not be taken up in full.

I am waiting for further suggestions on the timetable for the community care review from the advisers, who have been on board only since the beginning of last week. We will have more information on that at next week's meeting.

Mary Scanlon: I am not clear about our input to the budget proposals. I asked about that before, and you said that you would seek clarification. What is our exact role in the process?

The Convener: We are having a private briefing on the budget process next week. That will tell us what our role is.

Mary Scanlon: Therefore, we will be told exactly what we can and cannot do.

The Convener: That is right. We will be told what our role is. Once we have been told, we will have to decide how we want to perform that role.

Irene Oldfather: I am a bit concerned that every Wednesday morning in April and May seems to be booked. When we book weekly slots, we always seem to be able to fill up the meeting. Once we are clear about the budget process, I would welcome a review of what the proposed meetings will be about. I am not in favour of booking every Wednesday morning, then trying to fill it. We must be disciplined about how we tackle our work load.

The Convener: However, if we do not pencil in the meetings, problems can arise with the availability of rooms if we decide later that we require another meeting.

The weekly meetings have been included in the forward plan, but next week we will find out exactly what our role is. Once that is clear, we must decide exactly what we want to do. Some committees might take the view that they do not need to have much involvement in the budget process, but we might take a different view because a substantial health and community care budget is involved. It would not be fair to pre-empt next week's discussions by saying, "Let's not bother doing this," or, "Let's do something else." If we need to use all the proposed meetings for the budget process, that is fine, but if we do not, we will have some spare mornings, which we can use accordingly.

We can simply note the forward work plan for the time being; it will firm up during the coming week. Are we agreed?

Members *indicated agreement.*

The Convener: That brings the meeting to a close.

Meeting closed at 12:27.

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Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178