HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 29 March 2000
(*Morning*)

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd, which is responsible for printing and publishing Scottish Parliamentary Corporate Body publications.

CONTENTS

Wednesday 29 March 2000

HEALTH AND COMMUNITY CARE COMMITTEE
8th 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

Billy Gorman (Association of Directors of Social Work)
Alexis Jay (Association of Directors of Social Work)
Margaret Wells (Association of Directors of Social Work)

CLERK TEAM LEADER

Jennifer Smart

ASSISTANT CLERK

Irene Fleming

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 29 March 2000

(*Morning*)

[THE CONVENER *opened the meeting at 10:02*]

Community Care Inquiry

The Convener (Mrs Margaret Smith): Good morning. Today, we will continue hearing evidence in our community care inquiry. With us this morning we have a deputation from the Association of Directors of Social Work, some of whom members of the committee have met before.

I welcome you to the committee. I hope that this will be a good experience for you. In the past few months, you have given us useful information, formally and informally. This morning, you will have an opportunity to put your thoughts on community care on the record. You can begin by making a statement, if that fits in with your plans, before taking questions from the committee.

Margaret Wells (Association of Directors of Social Work): We will introduce ourselves and then I will give a 10-minute introductory talk on our paper. After that, we will take any questions that committee members would like to ask. I am vice-president of ADSW in Scotland.

Alexis Jay (Association of Directors of Social Work): I am the convener of the community care standing committee.

Billy Gorman (Association of Directors of Social Work): I am a member of the community care standing committee.

Margaret Wells: I will try hard to keep within 10 minutes. In the first two thirds of the first page of our paper, we have given some of the background to ADSW's work on care in the community. We want to promote the vision of a just and caring society in Scotland, and we are committed to ensuring that older people and people with mental health problems receive care of a high standard that meets their needs and that goes beyond merely presenting them with limited options and lifestyles.

We focus on people rather than patients, although we recognise that being a patient may well have been an important part of the life experience of many people. We try to focus not just on the ways in which people are dependent and on the difficulties that they have with their health and abilities, but on the ways in which we can help them to be more independent and to deal with any disabilities and difficulties that they face. We want to focus on people's strengths as well as their problems. For some people, dependence is a real issue; but that should not mean that their choices should be reduced or that they should feel that they are regarded as second-class citizens. We want to work with them as equals and we want to enable them to have a fulfilling life. We very much support the notion of community and, within that, the place of the family and social responsibility. We are all citizens.

I would like to talk about the issues that you are addressing in your inquiry, starting with the issues that arise from the Sutherland report. We have highlighted what we describe as the considerable gap between needs and services. At times, the services that are provided to meet people's needs may not be exactly what they wish and may not offer them the lifestyle choices that they wish to have.

We are conscious of the difference between the amount of money that is available to pay for the care for older people and the amount available for people with learning disabilities. There is an evident inequity, arguably reflecting an agist approach. We are also conscious that, when working with people with mental health problems, it is important that we enable them to use mainstream services wherever possible, while meeting their mental health needs. We must try to ensure that any stigmatisation is minimised, and we work with people to overcome that.

On page 2 of our paper, we refer to needs and resources, and to the substantial gap that we see between them. There is a growing need for community care and support through a range of services; there are insufficient resources to meet that need and to satisfy the quite rightly growing expectations of people that their needs will be met.

We are conscious of the substantial contribution of the 500,000 carers in Scotland, and of how dependent we are on them. We must work in partnership with them, and we aim to support their role rather than take it over in any way.

The balance of long-term care services is still disproportionately tilted towards institutionalised care. Whereas intensive home care is provided for just over 10,500 people in Scotland, more than 30,000 people are in residential or nursing home care. If that balance is to be shifted, significant issues will need to be addressed, regarding both the services that are to be provided and the resourcing of those services.

We are conscious that there are 3,000 young

carers in Scotland and we need to work in partnership with education services to identify and support those young carers. Because of their caring responsibilities they can, from an early age, be denied the life choices and opportunities that we want young people and children to have.

The gap between needs and resources will, inevitably, increase because of the demographic changes that we face. There have been substantial increases in the population of people aged over 65 and the most significant increases have been in the population of the very old—those aged 85 or more. We are in the middle of another period of substantial growth in that population and many people in the older age group can experience severe and limiting disabilities and changes to their lifestyles. There is much to be done and many issues that need to be addressed.

Charging is an issue that we need to look at in a national context, although there might be scope—or a requirement—for local flexibility. We will work with health boards to provide seamless services, with health care being provided free. Aspects of social care services—home care, for example—are subject to charging. In endeavouring to provide integrated care, perhaps by one person, we are plainly faced with some difficult issues around the matter of charging. I know that the Deputy Minister for Community Care intends to address that in the joint futures group.

Moving on to page 3 of the document, we seek a framework of guidance for charging policies throughout Scotland. We have emphasised some of the inconsistencies and variable patterns of resource transfer among health, social work and local authorities throughout Scotland. We especially want to stress the importance of the recommendations of the Royal Commission on Long-term Care for the Elderly and the urgent need for adequate funding to implement those recommendations.

The difficulty is that the debate can become polarised—it becomes a debate between the health services and local authorities about whether beds are blocked and whether local authorities should have the means to free up beds for placements when, as the Sutherland report acknowledges, there are major issues about the overall level of funding for the system. We also support the proposal for a national care commission.

On co-ordination of health and local authority services, proper joint working and good co-ordination is needed at all levels, from strategic planning, through working at a local level with health care co-operatives, to working with individuals on their care assessment and provision of services to them.

Local authorities have a legal responsibility to ensure that the needs of individuals and their carers are assessed for care in the community. Working in partnership is central to the delivery of that. There are many good examples of joint working and the number of such examples is increasing. Social work's relationship with health services is generally good and is getting better all the time throughout Scotland, but there is, inevitably, a long way to go towards the delivery of seamless services and more integrated single assessments.

I will move on to page 4 of the document. We must move forward with health services and examine joint commissioning of services. It would be useful to see models of joint commissioning and joint management in Scotland being evaluated and extended. There are major training issues that must be identified so that there is common core training of, for example, community carers.

Considerable progress has been made in the co-ordination of service delivery. We would like to see less focus on such issues as who is responsible for bathing, although in many places that issue has been largely resolved. There must, however, be more focus on single access points to services and to shared assessments and co-ordinated service provision to individuals. There has perhaps been too much focus on some areas such as bathing, which can potentially divert from some of the more major issues that need to be addressed.

Our approach very much supports integrated services. We would like there to be national guidance in forming local agreements, more generic vocational training and common, recognised post-qualifying training for health and social care professionals. Much has been achieved by the national mental health framework, which translates into local mental health frameworks and action plans. We are beginning to see more integrated approaches to both planning and service delivery roll-out in mental health, a field in which much is needed.

10:15

In our submission, we discuss resource transfer. Some of the early work in community care has been characterised by time-consuming negotiation and bargaining, and patterns of resource transfer vary greatly across the country. In the third paragraph after the "Resource Transfer" heading, members will note the variation between authorities: from a resource transfer of £5,000 for each long-stay bed closed—with the care transferred to the community—to £23,000 per bed. That is an enormous variation, and some guidance introducing consistency to that process is needed, as is transparency in arrangements, if resource

transfer is to remain part of the picture.

In considering some of the figures—and we can go into them in more detail if that would be helpful—we are conscious that, over the period since community care was introduced, the sum that was apparently saved would more than pay for the people deemed to be blocking hospital beds because of a lack of adequate funding. That is a complicated issue, and we would be happy to discuss it further.

We have not listed specific examples of best practice. The Nuffield database lists 500 of them, and we are conscious that many examples of good practice are developing and are increasingly being shared across Scotland. We would urge more sharing of the things that work, and we would seek the Executive's promotion of that across Scotland.

We do not consider the status quo to be an option. We would like services to become more integrated, and we would like there to be much closer links between local authorities, with their democratic accountability, health boards and NHS trusts. We would like there to be links at an elected member level in the way that the various committees and boards operate, so that they become much more closely bound in their operation, from strategy right through to service delivery.

We do not advocate wholesale reorganisation and change; we are mindful of the need for stability and consistency, while recognising the need for some change to achieve what we are setting out in our submission. We have mentioned a programme of pilots. A partnership between the Scottish Executive, the Accounts Commission and the Convention of Scottish Local Authorities would be very welcome for taking the whole agenda forward.

There are some issues about boundaries for local authorities and some health boards. We find that some small authorities work with a number of health boards, and vice versa. Coterminosity may not be the answer to everything, but there are undoubtedly problems in some areas.

That is the position as we see it. We very much welcome closer working with health and community care; we would seek central direction, so that there is some consistency, while allowing room for local flexibility and for the determination of local needs; we would warmly welcome a national financial framework underpinning community care. That would enable the services to be provided to meet the expectation and needs of the people that we serve.

Kay Ullrich (West of Scotland) (SNP): Can you tell us what you consider the key management issues to be in regard to developing a strategic approach to providing community care services to the elderly?

Alexis Jay: It is important to get the strategic planning right, and a lot is being done at the moment in developing services between health and social care. There has been considerable movement in that area over the past few years, so we must ensure that the strategies involve all the stakeholders. The challenge for management is to listen to the end users of the service and hear what they have to contribute. There is much more involvement of service users and carers in the process, but there is still some way to go.

We need to get the planning right for the overall strategies for discharge programmes and the closure of long-stay beds, and to get proper agreements about the appropriate services that must be in place in the community. We must get the funding right for the alternative provisions and new services that need to be developed. Billy Gorman will say more about funding, which is a significant part of the process.

We must also ensure that the information systems are consistent. At the moment, they are not, and there has been little national lead in that area. It may seem a fairly tedious issue to some people, but it is important in ensuring that the health authorities and local authorities have compatible systems that reduce duplication and overlap. We should be able to trace right back to a person's first point of contact with the services. We can encourage nurses and social workers to talk to one another, but to ensure a speedy and responsive service, the information systems upon which it is based must be in place.

Work force planning presents a major challenge. Again, much has been done in the past few years to allow health staff and social work staff to share training and understand each other's roles and tasks. There is no comparison with the position only a short time ago. However, we must decide what sort of people we want in future to carry out those tasks. As the lines become blurred in some areas and some workers become interchangeable, staff must be equipped to take on those tasks.

Billy Gorman: The other issue that we must consider is the availability of resources that are currently invested in the provision of care for older people. Progress has been made over the past few years, and we are now willing to be more transparent about the resources that we have. Until the health authorities and local authority social work departments are transparent about their resources, any strategies that we develop cannot be realised. There must be more transparency.

Kay Ullrich: There have been changes in the way in which people think about best value. How

is that idea feeding into the strategic management process? We have heard evidence from other people who suggested that local authorities are putting people into their own residential homes before putting them into other homes. We know that local authority residential homes tend to cost more than voluntary, independent or private nursing homes. Where does best value enter the picture? Can you address that accusation?

Margaret Wells: Best value is increasingly at the heart of the way in which we work and of the scrutiny to which we subject our services and their costs. My authority and a number of others recently took part in the Accounts Commission's study, "Care in the Balance". Some local authority costs, although they were higher than those in the private sector, were certainly lower in some instances than costs for voluntary sector provision.

We found that it is not always the case that local authorities cost substantially more. The report found differences between some terms and conditions of staff in the private sector—I do not criticise many of the services in the private sector—and those of staff in local authorities. I was disappointed that, in the public reporting of the report, the fact did not emerge that, although the private sector had low overall costs, the turnover of staff and the continuity of care were at the other end of the spectrum in that sector. I do not wish to overdo that point, but it was evident in the report.

Alexis Jay: The Executive recently produced tables—not quite league tables—showing occupancy levels in local authority homes, independent sector homes and nursing homes in each local authority area. The figures indicated that occupancy was no lower in the independent sector than in local authority homes. Of course, occupancy was very high in nursing homes. Average occupancy in all the sectors ranged between 88 per cent and 95 per cent. We are under directions to offer people choice and that is the usual social work practice, where choice exists; in some areas only one establishment may be available, and the alternative may be some distance away. There are restrictions to choice that are outwith the control of the provider.

Kay Ullrich: The question that has arisen is whether there is a conflict of interest, in that local authorities place clients and are also providers of service.

Margaret Wells: I do not have the precise figures with me, but I can provide information later, if that would be useful. The data that we have gathered show that there has been a gradual reduction in the number of people in local authority residential care. Our corner of that market is declining. There are successes in care in the community, and across Scotland we are increasingly able to support frailer people in the community for longer. Therefore, it tends to be the case that people who require residential care go into the nursing home sector.

Kay Ullrich: Yet bed blocking is increasing all the time. In under a year, the figures that we have received from the Executive show that the number of blocked beds has risen from 1,800 to 2,400, so I do not know how much success there has been in placing people in the community.

Dr Richard Simpson (Ochil) (Lab): I have a couple of supplementary questions. First, on Kay Ullrich's question, at the moment local authorities purchase services, provide services and, either jointly with health boards or independently, provide inspection, registration and quality control. Is it appropriate for local authorities to carry out all those functions, even if, as we have heard, there are Chinese walls between them?

We have heard evidence that the fact that local authorities carry out those three functions causes considerable concern to the private and voluntary sectors because those sectors feel that they are unable to protest to local authorities about anything, as those local authorities may also purchase services from them. Would you address that point in strategic terms?

I am surprised that your document, which is seven pages long, does not mention voluntary or private organisations. In strategic terms, the voluntary and private nursing and residential home sectors, and voluntary organisations as suppliers of service, are partners. That was not mentioned once in your document or in your introduction.

I do not agree with what you say about occupancy rates. There is a 3 per cent to 4 per cent difference between your figures and those in the Accounts Commission document. You did not mention the fact that, although the turnover in voluntary and local organisations might be higher, the sickness rates are two or three times as high in the local authorities.

The issues are obviously quite complex, but I would like you to address the main points that I have made.

10:30

Margaret Wells: I agree that the issues are complex and that they merit detailed examination.

With regard to the local authority rules, I am sure that members are aware that the inspection and registration function will be transferred to an independent body when the bill is enacted next year.

You raised a point about inequity and local authorities' responsibility for assessment,

placement and procuring. That was examined in detail by the Scottish Affairs Committee, which reported in March 1997. The concern that you outline was not—as I am sure you are aware—upheld by the findings of that committee. There are issues about the size of the market in relation to the private sector. Even if I could find a place for everyone in my local authority area who was awaiting care—notwithstanding the fact that not all those who are awaiting care are doing so because of a lack of funds—there would still be almost 200 unoccupied beds in the private sector. The issue is the level of provision within that sector and the level of need. We work closely with the private and voluntary sectors and partnership is very much at the heart of our work.

Dr Simpson: Are there regular strategic planning meetings that involve the health board, yourselves and private and voluntary organisations?

Margaret Wells: That is happening at the most senior levels, but it might not be the case throughout Scotland.

Billy Gorman: The pattern varies—it is not true that in every local authority area the providers of voluntary and private residential facilities are involved in strategic planning at the top table.

The responsibility for community care planning has been given to local authorities. We are the lead agency and we plan in partnership with the boards, trusts and with organisations such as Scottish Homes.

We work mainly with providers at a delivery level, rather than at a planning level. We discuss our spending intentions and the budgets that are available to local authorities. We aim to promote closer dialogue about provision of services between local authorities and the voluntary and private sectors.

We become closely involved with potential providers when we consider a reduction in the number of NHS continuing–care beds and the commissioning of alternative services in the community for patients who have been discharged from hospital. We work closely with providers to examine the quality of care that is being asked for and the price that will be paid for that care. We must also bear in mind the difficulties in finding someone to represent the voluntary and private sectors.

I come from Renfrewshire, where there must be about 40 or 50 private and voluntary providers. I have worked with them and have asked them to meet to decide who they want to represent them. That has proved difficult. It is, therefore, difficult to decide whom we invite to the talks about strategy.

Dr Simpson: Those providers have national organisations and co-ordinating groups—the committee recently heard evidence from three of them.

We talk about partnership, but we do not talk about all the partners. I will not declare all my interests again, but I am involved in a nursing home operation in Manchester. There, the local authority has undertaken a joint risk assessment with the private and voluntary sectors, so that they will have some idea of what the lead organisation's view of the future is. In that way, the private and voluntary sectors can plan ahead, perhaps to decide that there is no point in making additional provision. There is evidence that there have been individual commissioning arrangements when there has been retraction of care, but that has often been done at the expense of existing accommodation. The providers of the existing accommodation do not know where they stand and occupancy is declining.

The Convener: Richard, I have been told that you must declare your interests again.

Dr Simpson: I am the director of a nursing home company, which manages nursing homes in England, but not in Scotland, although its principles are the same. I am also a member of some voluntary organisations that are service suppliers, such as the Scottish Association for Mental Health. I am concerned about the lack of involvement of that group.

Billy Gorman: I do not want to repeat myself, but the local authority is the lead agency for planning community care—it is not the lead agency for management of the social care market. Joint community care plans are published to which health boards, trusts and local authorities are signatories. Each plan will indicate the needs of the local population, the intended provision of services for three years and unit costs. Any provider can get a copy of the plan and can examine it along with the local authority audit of resources. They can then decide whether there are gaps and whether they want to fill them.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): What are the typical arrangements for joint working between social work, housing and health provision?

Margaret Wells: I will begin and my colleagues can add their comments.

On housing, there are a growing number of joint housing and social work services throughout Scotland. I am director of one such joint service—they are a good arrangement for developing joint working between social work and housing.

Most typically—although this is at a different stage of development in different parts of Scotland—there is something that is akin to a joint

committee on community care. That committee would include elected members of the local authority and non-executive members of the health board and the NHS trusts. Local authority membership could reflect a range of services including social work, housing and education. One could argue that there is a role for transportation and roads departments in relation to disabled people. We are broadening our scope.

Representatives of primary care—perhaps a GP—would also be at that table, but the voluntary and private sectors might not be represented at that strategic level. Senior officers of the various authorities would be there as advisers to the board, which would set strategy, determine the plan and oversee its implementation.

After that, a group of senior officers from various bodies—such as local authorities and trusts—might co-ordinate development of strategy and operations and link with locality planning to do so. I hope that such a group might contain representation from both the voluntary and private sectors.

Locality planning should involve different professions and interested bodies from the voluntary and private sector, as well as input from users and carers. We also hope to develop that on more strategic levels. However, locally, we would draw together information from different professional groups, local groups and user forums to assess local needs. We would then feed that information into the strategic process to ensure that strategy is not a top-down arrangement.

We are hoping to introduce more flexible budgets and to develop much more integrated local arrangements with multi-professional teams of staff. That is not easy when the budgets are committed in every sector. We want better co-ordinated care planning and delivery—the more we support people with complex care needs in the community, the more finely tuned and sophisticated our care co-ordination and delivery must be. Some aspects of such care need to be changed daily.

Margaret Jamieson: Although that detailed response covered several of my questions, it did not clarify at what level decisions can be made. You have described a very rigid structure in which service users are involved only at a certain level. At what point in that structure are decisions made about the direction of funding?

Alexis Jay: That is a key question for service users, as it affects the responsiveness of local authorities and health services. As Margaret Wells said, in most cases we are managing scarcity not surplus. After a social worker does an assessment, the senior social worker will usually decide how to allocate funding for home care or placements. Any such decision would be referred to a higher level only when placements cost significantly more than the average, or when a package of care costs more than a certain amount.

Margaret Jamieson: Can you give a ballpark figure?

Alexis Jay: It would be approximately the cost of a nursing home place, which is £325 a week at the publicly funded rate or, perhaps, £327 with the uprating. Any long-term package of care whose weekly costs are more than that might require approval from elsewhere.

Margaret Jamieson: In your answer to Kay Ullrich, you talked about best value. I was amazed to hear that you understand best value as relating only to cost. Best value does not mean looking only at cost. Quality of care, the effects on individuals and a range of other factors need to be considered. This morning, however, we have heard about nothing but costs. I would be extremely concerned to find out that you view best value only in terms of cost.

Margaret Wells: Quality of care is a major issue.

Margaret Jamieson: I thought that it would have featured heavily in your submission.

Margaret Wells: It is a major issue—no review of best value can focus exclusively on cost. However, it would be very misleading of us to suggest that cost is not a major factor in the present climate. We regret that and find ourselves faced with increasingly difficult decisions and choices—resources are inadequate to meet need.

We do not want simply to provide people with well-serviced lives or basic physical care—such as food and drink—but with quality of life. Increasingly, the level of need that we are faced with in the community and in residential and nursing homes forces us to make cost a central consideration. If we did not do that, we would be providing an excellent service for some people and—potentially—no service for many others.

10:45

Margaret Jamieson: I am well aware of the difficulties that you and your staff face. However, we have to deal with the other side of the coin—the carers and relatives of those who are cared for inappropriately in the health service. I have constituents who have for nearly two years been waiting for your colleagues in social work to provide them with a place. How can you balance cost and quality when making judgments about best value?

Margaret Wells: It is extremely difficult.

People's health care is of great interest to us, as is the need for a proper living situation. Who wants to live in a hospital for two years if they do not need to be there? We would like to be in a position to do something about that. I can only refer back to the detail in our submission on what has happened since community care arrangements were introduced and on the levels of resource transfer. I know what pressures the health service is under and I am not arguing that that is the only solution. However, I am obliged to tell the committee if that is part of the picture. I want to emphasise again the importance that we ascribe to the findings of the Sutherland committee and its recognition that there is simply not enough money in the system to provide the amount of care that is needed to the standard that is required.

The Convener: Before we move on to grant-aided expenditure, I will take questions from Malcolm Chisholm and Kay Ullrich.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I want to ask briefly about joint working. In your submission you refer in passing to the new primary care trusts and local health care co-operatives. Some of us hoped that those would allow social work to engage with health in a new way. To what extent is social work involved in primary care trusts and local health care co-operatives throughout Scotland? Do you feel that you have been able to make progress through involvement in those new structures?

Alexis Jay: Unquestionably, they have made a big contribution to the development of joint working. Although some co-operatives were slow to get off the ground and to involve social work, we now have clear evidence from throughout Scotland that local social work managers and teams and the people who control resources are fully involved in health care co-operatives.

That has been an encouraging development, out of which have come all sorts of new ideas about different ways of working, especially in GP practices and health centres. There has even been significant movement in the past year. I have worked in one area and moved to another, and that experience has been mirrored throughout Scotland following the emergence of the primary care trusts. Much more has yet to emerge from that, which will be helpful in progressing joint work.

Mary Scanlon (Highlands and Islands) (Con): I want to ask about the attitudes and the egos that are at the centre of this. Throughout your document, you say that, although joint working should work, the division between health and social care is contentious, and that there is "attitude professional preciousness". You say that integrated assessments remain elusive and that seamless services remain distant. Unless we overcome such attitudes, we will not get anywhere. We received a submission from SAMH, which spoke about cultural incompatibilities. Given that the system has been in place for about 10 years, what is your problem?

We must move forward because there is a serious problem. We know that there are 2,400 blocked beds. The patient is nowhere near the heart of the service. Can you explain the attitude of your submission?

The Convener: In answering Mary Scanlon's question, I would like you to comment on the training and deployment of community carers, and on the interchangeability of staff and professional barriers in the nursing profession.

Margaret Wells: I will begin, and then refer to my colleagues. I will not begin by saying what our problem is—if we are perceived to have one.

Mary Scanlon: Those are your words, not mine.

Margaret Wells: We have set out some of the issues and realities on which we are working. No attitudes or views—including ours—are set in tablets of stone. I said at the outset that our relationship with the health service is generally good. The only complaint that I receive from GPs is that they would like more of the service that we provide. Because people come from different professional backgrounds, the ADSW is talking not only about professional social workers, but about a wide range of social work and social care services.

Mary Scanlon: What does "attitude professional preciousness" mean? Can you explain that phrase?

Margaret Wells: When there is any suggestion of joint working, there is evidence of division on both sides. Whenever we start to talk about joint working—saying that something is not only a health or social work matter—people who have had single-service professional training might feel threatened. They might feel that roles could become blurred. There is still a need for specialism and differing inputs, but there are significant grey areas in which people in the health service and social work could be more trusting of one another's assessments.

Mary Scanlon: How can we believe that you can make that right in future, if you have not been able to work together for 10 years? There is still a division. How can we have faith in all the words that you are using, such as "joint working", "partnership" and "co-ordination"? How can we believe that you will put your differences behind you and work together in the interests of the patient?

Margaret Wells: Many of the 500 examples of good practice in the Nuffield database refer to joint working. I attended a conference in Edinburgh on Friday at which new examples of joint working

were suggested. NHS trust chief executives stood up alongside local authority chief executives to show their commitment to making joint working successful.

Mary Scanlon: Why is your paper so negative? If you can sit there and tell me that joint working can work, why do you point out its problems?

Margaret Wells: There is still a long way to go. If the impression that has been given is that the situation is all bad and that it will not get better, I would like to correct that.

The Convener: We are asking you what you can do to make things better, but part of the task also falls to us. We have to supply the framework and the funding to make it happen. What could our review say that would improve the situation, in terms of joint working?

Margaret Wells: We would urge that the recommendations of the Sutherland report be given urgent consideration. As a member of the joint futures group, I know that some of those issues are being addressed, but an urgent Government response is needed.

As page 4 of our submission states, it would be helpful to have a programme of work that was jointly agreed by the Scottish Executive, the Accounts Commission and COSLA, to evaluate some good local experiences and replicate them nationally. To promote the sharing of evidence-based practice, let us see what works and put more of it in place around Scotland. We would ask the Executive for a national financial framework for funding community care and for clarification of resource transfer or whatever means is used to provide adequate funding.

Kay Ullrich: The message that is coming through loud and clear—not just from your evidence but from other submissions—is that it all seems to boil down to funding, or the lack of it. Before I move on to grant-aided expenditure, I want you to consider another question. Does the current balance in community care delivery tend towards being resource-led rather than needs-led?

Billy Gorman: You will appreciate that local authorities have to watch their budgets carefully. At the same time, however, they have to take strategic decisions to target those budgets towards those in greatest need. In the majority of cases, we are needs-led when making assessments, but we are often budget-led in terms of provision. We have to change that balance. Most local authority expenditure on community care is devoted to supporting people to live at home. That should be increasing; that is one of the Government's objectives and we are committed to it. The number of people who receive home care for more than 10 hours a week is far smaller than the number of older people who are in residential or nursing care.

Kay Ullrich: Is that in terms of cost?

Billy Gorman: That is in terms of both number and cost, but mostly cost, and we must change that. Any survey shows that the majority of older people want to remain at home. We must devise ways and means of developing joint services between primary care and social work departments to make that happen. We must transfer our budget expenditure away from institutional care and towards supporting more people at home.

Kay Ullrich: A previous witness from ADSW gave us a briefing; it was not George Irving—

Margaret Wells: It would have been Andrew Reid.

Kay Ullrich: That is right. He indicated that evidence suggests that local authorities are not adhering to the indicative GAE allocation when it comes to community care. Why is that happening and what can be done to rectify the situation? I know from my own background that the answer for the criminal justice service was ring fencing. Do we need ring fencing to get social work departments to spend their indicative amount on community care?

Margaret Wells: I suspect that COSLA might be better placed to answer that question, but I do not mean to avoid the question, so I will respond.

There are variations across the country in the level of spend on community care. As part of the picture of total funding of social work services, our association's analysis has shown a drop in real terms, especially in the funding of children's services. There is no facility to offset some of that substantial decline through charging policies, whereas that facility exists for community care.

There are also concerns about the choices and decisions that local authorities have to make about priorities and relative need. That complicates the picture, but the indicative spend tends not to take account of the income that is generated through charging. Charging is a concern because it is applied so inconsistently across the country. There is scope for some local variation, but a framework to underpin charging is required.

Kay Ullrich: And on ring fencing?

11:00

Margaret Wells: It is difficult to argue strongly in favour of ring fencing—it must be thought through, and I would be reluctant to say off the top of my head, "Yes, that's the way forward."

Ring fencing can complicate decisions and affect the flexibility with which authorities are able

to determine how they meet differing levels of need.

Kay Ullrich: Social work departments have statutory duties on the protection of children and families, which will always be the priority. However, they also have statutory duties on the care of the elderly. Will it come to judicial review proceedings and individual cases going to court? We know that a number of cases have started to go down that route, but so far—funnily enough, for the individual concerned—the money has always been found to provide the service that the individual wants. I do not want local authorities to be trailed into court by individuals, nor do I want individuals who are already in stressful situations to have to go through that process.

Margaret Wells: Perhaps the most objective view that I can give is that of the underdevelopment of mental health services. I forget when the mental illness specific grant was introduced, but it brought about significant developments in the field for people who have mental health problems. That may be worthy of consideration as—

The Convener: You referred to the need for some sort of financial framework and for central guidance on charging policies, rather than ring fencing. Is that a fair reflection of your views?

Margaret Wells: Yes. Perhaps ring fencing would merit more detailed consideration, but it is the extent to which—

Kay Ullrich: I used it as an illustration.

Billy Gorman: We have some examples of ring fencing. Through the grant aided expenditure settlement, the modernising community care action plan identified a sum of money for each local authority that must be spent on meeting the objectives of modernising community care, principally by supporting more people at home. Local authorities cannot spend any of that ring-fenced money on institutional care. A recent Scottish Executive development on carers means that certain money allocated to local authorities must be spent on supporting carers. Those examples involve only small amounts of money, but they are clear examples of ring fencing, as local authorities must spend the money in specific ways.

Allied to that is another measurement, through statutory performance indicators, whereby we can indicate by our spending where services are being delivered. For example, over the past few years, each local authority has increased progressively the number of frail older people who receive more than 10 hours a week of care in the home. That is another way in which we can indicate that our spending is meeting targets.

On the national financial framework, our submission refers to the variation in rates that local authorities receive through resource transfer, which is quite extreme. We must consider seriously, at a national level, why that is the case. The difference between local authorities and neighbouring health boards is not at the margins. Some local authorities have great difficulty in negotiating realistic resource transfers to provide the alternative services that are required in the community.

Kay Ullrich: Resource transfer certainly should not vary by the amount that is described in your submission. Resource transfer is still happening, but in many ways the horse has bolted, because fewer and fewer closures of geriatric and long-stay mental health wards are taking place.

Billy Gorman: Not necessarily. There is a long way to go with learning disabilities, mental health and services for frail, elderly and psycho-geriatric patients in certain areas of Scotland. It is not too late. Lessons can be learned.

Kay Ullrich: I did not mean that it was too late, rather that a lot has happened and that as we reach the end of resource transfer, local authority funding for community care will be the ultimate issue.

Billy Gorman: Yes.

Dr Simpson: The Accounts Commission said that it is increasingly difficult for health boards to see where the transferred resources are being used, even though they are still responsible for that element of the budget. Do you support my view that any resources that are being released by a process of retraction in the elderly, mental health and learning disabilities sector should be the subject of joint agreement? It should not be simply a negotiation about the element to be passed to the local authority. Several health boards have used the money for the acute sector, rather than for jointly planned services to replace the retracted ones.

Alexis Jay: I agree absolutely. That transparency has not been evident in the past, especially in relation to internal resource transfer to trusts and how the trusts intend to complement social care services. There is evidence that open discussion is taking place in some areas, but that is not the norm. We need to have joint discussions about the necessary community nursing services and community-based health services to ensure that the right packages are available.

Dr Simpson: Two psychiatric units have closed in Aberdeen and the capital is being used to build a children's hospital. That may be the priority in Aberdeen, but was it set by the health board and the local authority? What is happening to the mental health services for which that capital

should have been released? A decision was made somewhere, without the overall strategic aim being taken into account. We must stop that before it goes any further.

Mary Scanlon: In your submission you referred to the desirability of bringing health, social work, housing, education, planning and other statutory functions under a democratically controlled local government structure. Could you explain that proposal?

Margaret Wells: I referred to that in my introductory remarks. We would like a structure that would bring local authorities and health provision closer together. As I said, we are not advocating a wholesale restructuring, but we would like places on the boards of trusts and health boards for local authority members. There might be arrangements for joint committees to govern and take joint policy decisions—

Mary Scanlon: Your submission suggests bringing them under a democratically controlled local government structure. That is not the same as a place on a health board.

Margaret Wells: The association feels that the principle of local democratic input and control is important, not just for local authorities, but in relation to health. We are not prescribing a certain model, but there is a need for a structural or formalised arrangement to bring the two closer together.

Mary Scanlon: Does that mean that you are not talking about changing the structure, or taking any aspects of health care into social work?

Margaret Wells: Some anomalies need to be considered further. I suspect that, at a local level, joint management arrangements between local health care co-operatives and social work management might involve discussions about care and accommodation of the elderly, bringing in the housing dimension. It is important to have some measure of flexibility in bringing them together.

Mary Scanlon: You are not talking about additional functions being brought under the democratic structure of local government?

Margaret Wells: At the moment, if people need publicly funded nursing care in nursing homes, that care is purchased by local authorities, whereas the district nursing service at local level is provided by the health service. There are some anomalies that should be thought through. I am not saying that it necessarily needs to go one way or the other, but there should perhaps be a formal joint arrangement, rather than it being down to local choice and opportunity.

Mary Scanlon: Could that not be done by working with the local health care co-operatives in a more integrated way? Is that not where you are heading?

Margaret Wells: We are heading in that direction—there is national support for closer joint working.

Mary Scanlon: How would you respond to the suggestion that social care services should be brought under the umbrella of the national health service? That would be an integrated package.

Margaret Wells: We see the local authority social work services as being in the right place. We need to work jointly with the NHS and we feel that the services should be accountable to the people in the area that they serve.

Mary Scanlon: We are considering a model that will overcome the difficulties that we all recognise, such as funding problems and attitudinal problems. Are you saying that we now have the perfect structure with which to move forward?

Margaret Wells: Perfect structures can be quite difficult to achieve.

Mary Scanlon: Do we have a structure that will address the problems?

Margaret Wells: We may need greater support for more integrated arrangements between local authorities.

Mary Scanlon: Is that not a bit woolly? We are looking for strong conclusions—we are spending time on this because it is a problem.

The Convener: I am going to be strong: we have five to 10 minutes left for this discussion. I want to bring in Malcolm Chisholm, and Richard Simpson had some other questions.

Malcolm Chisholm: You referred to the balance between institutional and domiciliary care. In your opening statement, 10,000 and 30,000 were referred to—I think that the 30,000 referred to people in institutional care—but later you said that there had been a reduction in residential care. How does that relate to your earlier figures? The key question is what you think would bring about a real shift in the balance of care between institutional and domiciliary settings. It would be helpful if you could also clarify your two earlier statements.

Alexis Jay: There are a number of reasons why the shift has not taken place, one of which relates to funding. We will not go into that at the moment, but 24-hour care and support at home is extremely expensive. However, other issues are involved. One important issue is that carers and medical practitioners in particular need to be convinced that care at home is a realistic and viable option. They have to have confidence that packages of care that involve care and support at home will work and that people will not be at risk. We are now working together far more closely. District

nurses in particular are influential and play an important role in ensuring that people have confidence in the packages that are put forward. An improved approach is evident, but we must engage in a longer-term process to convince carers who feel that their relative or friend would be safer in a residential setting than in their own home.

We are developing a range of support services, and increasingly sophisticated technological approaches have much to offer. There is a question about whether 24-hour support at home is available and financially viable—generally at the moment it is not available on a long-term basis.

We need to convince carers and the medical profession of the practicality of care at home as an alternative for much of the population.

11:15

Dr Simpson: Several committees, including the Finance Committee, have discussed pooled budgets. What are the advantages and disadvantages of pooling budgets? How do your agencies regard pooled budgets and how do you envisage that they will function?

Margaret Wells: If pooled budgets were transparent and if both sides put all the resources—for example for services for the elderly or for people with mental health problems—on the table, such budgets would allow health and social work to know the total resource that is available, to determine joint strategies for commissioning services and to achieve resource shifts. It is difficult to develop new services without development moneys, but spaces might be created in existing services, which could free up and develop other moneys. Pooled budgets would enable greater joint working, but they would not solve the problem of competing priorities, which is evident in the NHS between the acute sector and primary care services.

Another question is how one can achieve the flexibility that is being sought. As well as having flexibility in strategic decisions about budgets, we must devolve budgets to front-line staff at the point of service delivery. That is happening in some places. Front-line staff can then deploy those resources flexibly, within spending guidelines, to meet the needs of the people whom they are assessing; that breaks the frustrating chain whereby staff have to seek a decision elsewhere on how they spend and secure care for the people whom they assess.

Devolved budgets need to be backed by careful systems of commitment accounting and by well-trained staff, who understand how the activities that they undertake relate to the finance.

Dr Simpson: So you think that there should be pooled budgets at different levels, right down to the front-line care person. In the original community care discussions, it was envisaged that social workers, community care workers or even nurses would have access to pooled budgets. Is there evidence that that is happening?

Margaret Wells: It is happening—extensively in some areas. There are examples of social work staff being able to commit health service resources, and vice versa. The care manager is the most appropriate professional in the multi-profession team to assess need and co-ordinate care arrangements.

Some arrangements are working successfully. In mental health, there are reductions in the number of crisis and detention admissions. In dementia, work is being done in rural areas to support people and their carers locally, and the number of admissions to large central hospitals some distance away is tailing away to virtually zero.

Dr Simpson: Is that process empowering the staff? Do they feel that the quality of their job has improved?

You mentioned the Nuffield database of best practice. What else should be done to ensure that best practice is spread more rapidly? Publishing lists of best practice is not a recent thing—almost every report for the past five years has had elements of that. There is also evidence, which is disconcerting to say the least, that projects are dropped following an evaluation period, even if the evaluation has been successful, although that has not happened in this particular field.

Billy Gorman: The whole ethos of community care was, eventually, to empower front-line staff. Increasingly, front-line staff will have to have power—working among colleagues, taking the appropriate decisions that put in place quickly the quality services for those who need them. The only way to do that is through professional training, experience and having access to budgets.

The examples that are coming through include the local care partnership models, one of which is in my own patch. It is a rapid assessment team, in which an occupational therapist and a social worker work together; they have access to a pooled budget, and they take the decisions on spending that budget, based on the assessed needs of older people living in the community.

The care programme approach for mentally ill people demonstrates that social work staff are coming together with community psychiatric nurses and are trying to meet the needs of those people who are most vulnerable, who are either doing harm to themselves or to others. They try to prevent such people being admitted to hospital

unnecessarily.

There are good examples of staff being recognised for using their judgment in an appropriate way, and being empowered as a result.

We should also develop good practice models through joint training. There is scope for local authority social work staff, housing colleagues and health colleagues to come together much more for joint training, which could possibly be done at the pre-qualification stage, and certainly at post-qualification. The time is ripe for all of us to begin to work with a programme under which we can come together, overcome some of the problems—such as those that were identified by Mary Scanlon—and equip ourselves for the new culture. Joint training would allow us to do that; there are a few opportunities, but there should be more.

Dr Simpson: Should that be achieved through an opportunity fund? I am not that keen on challenge funding, beacon funding and all those things, but they are fine if they get things going.

Billy Gorman: If there is one thing that I am jealous of, with regard to the health service, it is the management development group within the management executive of the national health service in Scotland. The MDG is a well-resourced and sophisticated outfit, which supports professionals on the health side. We lack that, to an extent, on the local authority side. We must equip our future managers through joint training. There is room for the committee and the management executive to examine the opportunities and decide how they could be resourced and funded.

Dr Simpson: Do you have any evidence of undergraduate joint training? I lectured in social work for 19 years and tried to establish joint training between general practitioner trainees—or registrars as they are now called—and social workers, but I found it extremely difficult.

Given the generic, inflexible working that you mentioned earlier, is there room for joint nursing-social work training? Should we be doing that, given that nurse training is all carried out in the colleges now?

Margaret Wells: There is a need for a much greater coming-together in that training, certainly in core training. If that happened, perhaps people could diversify later, depending on the specialism that they wanted to pursue.

It has always struck me as remarkable that we train people very separately and somehow expect them to combine and become joint beings when they come out of training.

I encountered an example of that recently—although it does not link with medicine—at Robert Gordon University's school of pharmacy. A virtual-reality pharmacy department has been set up, in which there is scope for occupational therapy students as well as social work students to learn. A qualified GP is involved, and the department provides a real opportunity for a multi-professional experience. It would be excellent to see such a model coming to the fore in more areas.

Billy Gorman: We have been concentrating on professionals, but non-professionals make up the largest group of care providers, particularly at local authority level. We need to consider the changing role of home carers and home helps, together with auxiliary nurses in the community. There is scope there too for joint training that would allow the minimum number of visits to a patient's home; one person could be trained, equipped and supported to deliver both a personal service and some health care. A large army of people out there are doing that task for us.

The Convener: I mentioned community carers earlier and had planned to return to that point to consider the possible way forward and some of the problems. Moves towards joint training can come up against professional bodies, in particular in nursing, but from what you have said, such an approach to training seems a good idea.

Could you give us some further thoughts on that in writing? A few other points have not been covered, because we did not have enough people or enough time to ask the questions. I know that Mary Scanlon was keen to take the issue of local democratic control a bit further.

If you agree, we will present our outstanding questions to you in writing; your response would be very useful to us.

Margaret Wells *indicated agreement.*

The Convener: I thank the witnesses very much for coming along this morning, for their input into our review and for giving us the benefit of their expertise.

Meeting closed at 11:26.

Members who would like a printed copy of the Official Report to be forwarded to them should give notice at the Document Supply Centre.

Members who would like a copy of the bound volume should also give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the bound volume should mark them clearly in the daily edition, and send it to the Official Report, Parliamentary Headquarters, George IV Bridge, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Monday 10 April 2000

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Central Distribution Office, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

DAILY EDITIONS

Single copies: £5
Annual subscriptions: £640

BOUND VOLUMES OF DEBATES are issued periodically during the session.

Single copies: £70

Standing orders will be accepted at the Document Supply Centre.

WHAT'S HAPPENING IN THE SCOTTISH PARLIAMENT, compiled by the Scottish Parliament Information Centre, contains details of past and forthcoming business and of the work of committees and gives general information on legislation and other parliamentary activity.

Single copies: £2.50
Special issue price: £5
Annual subscriptions: £82.50

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £2.50
Annual subscriptions: £80

Published in Edinburgh by The Stationery Office Limited and available from:

The Stationery Office Bookshop
71 Lothian Road
Edinburgh EH3 9AZ
0131 228 4181 Fax 0131 622 7017

The Stationery Office Bookshops at:
123 Kingsway, London WC2B 6PQ
Tel 0171 242 6393 Fax 0171 242 6394
68-69 Bull Street, Birmingham B4 6AD
Tel 0121 236 9696 Fax 0121 236 9699
33 Wine Street, Bristol BS1 2BQ
Tel 01179 264306 Fax 01179 294515
9-21 Princess Street, Manchester M60 8AS
Tel 0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
Tel 01232 238451 Fax 01232 235401
The Stationery Office Oriel Bookshop,
18-19 High Street, Cardiff CF12BZ
Tel 01222 395548 Fax 01222 384347

The Stationery Office Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0870 606 5566

Fax orders
0870 606 5588

The Scottish Parliament Shop
George IV Bridge
EH99 1SP
Telephone orders 0131 348 5412

sp.info@scottish.parliament.uk

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178