HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 5 April 2000
(*Morning*)

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9th Meeting 2000, Session 1

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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)
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*Mary Scanlon (Highlands and Islands) (Con)
Dr Richard Simpson (Ochil) (Lab)
Kay Ullrich (West of Scotland) (SNP)
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*attended

WITNESSES

Jane Arroll (Greater Glasgow Primary Care NHS Trust)
Rosslyn Crocket (Greater Glasgow Primary Care NHS Trust)
Donny Lyons (Greater Glasgow Primary Care NHS Trust)
Dr Ken O'Neill (Greater Glasgow Primary Care NHS Trust)

CLERK TEAM LEADER

Jennifer Smart

ASSISTANT CLERK

Irene Fleming

LOCATION

The Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 5 April 2000

(*Morning*)

[THE DEPUTY CONVENER *opened the meeting at 10:04*]

Community Care Inquiry

The Deputy Convener (Malcolm Chisholm): I welcome our witnesses from the Greater Glasgow Primary Care NHS Trust to this Health and Community Care Committee meeting. This is our fourth evidence session on community care. We are particularly keen to find out what is happening on the ground and to investigate examples of good practice. You have given us a series of useful and interesting papers, although you have handed in two extra ones this morning, so members of the committee may not have had time to read them. Perhaps you could refer in particular to those papers on mental health and through-care services in your comments, although I understand that the latter one is an extension of the paper on enhanced home care.

I welcome Rosslyn Crocket, director of nursing; Jane Arroll, director of professions allied to medicine; Dr Ken O'Neill, local health care co-operative lead in the south-west Glasgow LHCC; and Donny Lyons, clinical director for mental health and the elderly.

Dr Ken O'Neill (Greater Glasgow Primary Care NHS Trust): My name is Dr Ken O'Neill and I am the chair of south-west Glasgow LHCC. In south-west Glasgow, we have strongly promoted partnership working with social work in trying to resolve some of the issues around community care. Our initial efforts focused on dementia. We started with some of the difficulties for people living at home. The perspective of patients was that there was poor information sharing between agencies, duplication of assessments and a lack of co-ordination—patients thought that the roles and responsibilities of the agencies were not always clear. We tried to address those issues by appointing a dementia care co-ordinator to examine needs assessment and the accessing of services across health and social work.

We were keen to extend that initiative to the elderly in general. Following our work with the project on co-ordination of assessment and resources in dementia, we developed a common assessment tool for the elderly, called CarenapE—care needs assessment package for the elderly. By a common assessment tool, we meant a tool that could be used by everyone, whether a social worker or somebody in health, so that one person could carry out an assessment that would be recognised by all the agencies involved in providing care.

The common assessment tool on its own is not enough, however, because it throws up other issues concerning, for example, a common understanding of our roles and responsibilities, as well as training. We felt strongly that co-location would be helpful, which is why we submitted a paper on it. Sitting down and working together improves our understanding of what we all do, because often we do not efficiently involve our colleagues—whether in social work, health or the voluntary sector—as we do not clearly understand what they can bring to a person's care. We felt strongly that training and co-location were fundamental.

If we are to meet the needs of elderly people living at home, it is important that there is a strategic vision for unmet needs in the area between health and social work. There must be partnership working and flexibility in the services that we provide. Sometimes I feel that the term lead agency is not helpful, because the issue is about partnership working. It is about partners sitting down, identifying unmet needs in an area, and trying to create flexible services to address those needs.

Those services will include respite care in the person's home or in a carer's home. Devolved budgets would help us to provide those services. With devolved budgets, there are issues of accountability and transparency. If we are working in a way that clearly identifies unmet need and allows us to create a strategic vision for how we respond to those needs across all the partnership agencies, there will be a need for transparency, responsibility and accountability.

Care of the elderly is a big issue. Much of our money is focused on institutional care, yet if we were to ask elderly people what they would envisage, most of them would want to be supported in their own home with a good quality of life. We have to take a leap of faith and, instead of having all our moneys poured into supporting people in institutions, we should move some resources into the community to provide flexible services and a reasonable level of rehabilitation, which will enable people to have that quality of life and support in their own homes. That is where, if we are honest about this, they will function maximally.

I have talked about common assessment tools and the strategic vision. A steer from the centre on

issues relating to information sharing in health and in social work would be helpful. The general practitioner administration system Scotland—GPASS—is the general practice computer system that is used in Scotland, while CarenapE has a software package that allows us to start aggregating assessments and considering aggregated unmet need. We need to consider how we can share information across the agencies—for example, with social work—and how far into each other's systems we can move without infringing on confidentiality. Such issues are beginning to be raised. Some central guidance on that would be helpful for those of us on the ground who are trying to take those issues forward.

When budgets and decision making are devolved, linkages are important. When I say linkages, I mean linkages with the board and with the trust. That can be about setting down basic guidelines and the flexibility to operate within them. We need to be able to make links with the voluntary sector and with initiatives such as the social inclusion partnerships. If we have that strategic vision locally and we develop a system of working, SIPs and similar projects will add to and enhance what we are trying to do, so that we are not a series of stand-alone projects.

The other important issue is charging. The social work budgets are predicated on a level of charging. For my colleagues and me in health, that can sometimes be difficult to work with. It is also difficult for people in their own homes, who find it hard to understand why they should have to pay for services. That is a major inhibitor to the progress of joint working.

At this point I will hand over to Donny.

10:15

Donny Lyons (Greater Glasgow Primary Care NHS Trust): I approach this issue largely from the point of view of a secondary care provider. I am a consultant psychiatrist and I manage mental health services for the elderly across Glasgow. I also have management responsibilities for other parts of mental health provision.

I wish to take members through the needs of somebody who suffers from a mental disorder. I have considered this specifically from the perspective of the elderly, but much of it is applicable to all care groups. I will refer to them and to the ways that we have found in which to address the issues, some of which are identified in the papers before you.

First, there is awareness and screening, and the ability of primary health care and other agencies to be aware of, pick up and refer people who have mental health problems. Screening procedures can be undertaken, perhaps as part of the over-75 health check. However, perhaps more important than that is a general need for increased awareness of major mental disorders—the symptoms, the signs and how to get help—at a primary care level and for information on that to be made available in public libraries, pharmacists and so on.

Accurate assessment and diagnosis, with clarity of responsibility for that at a local level, is important. Some of it can be done in primary care. The local health care co-operative that I work with, in the Eastwood area of Glasgow, has a protocol for identifying, investigating and diagnosing people who present with memory difficulties. There is a clear division of responsibilities between primary and secondary care, which is working well at the moment.

There is a need, following that, for accurate information support and advocacy. Greater Glasgow has an excellent advocacy service, of which I hope members are aware: Glasgow advocacy network, or GANET. Advocacy services must be independent and must be able to scrutinise how all agencies, including statutory and voluntary agencies, provide services. The advocacy service must be independent of those agencies and must be seen to be independent of those agencies.

There is a clear requirement for an assessment of need—we have good projects addressing that. Dr O'Neill has talked about that, so I will not reiterate what he has said.

The actual provision of care has to be properly managed. It is vital, in my view, that a care manager should have access to both health and social aspects of service. You have in front of you information on an initiative that we undertook with East Dunbartonshire social work department to ensure that we had a care manager who could access both health and social services. The project has been successful and we are hoping to replicate and expand it.

This probably goes without saying, but there is a need for effective therapeutic interventions. One of the problems is that the development of new interventions can sometimes outstrip the funding that is available for them. I refer in particular to new anti-psychotic drugs for schizophrenia, which are a major clinical advance on older drugs. The funding has to catch up with that and with new drug treatments for dementia and for alcoholism.

It is important that clinicians on the ground are able to demonstrate cost-effective deployment of those treatments in clinical practice. We have been doing that in Glasgow with new drugs for dementia, measuring the benefit in terms of the improvement in the people who received those drugs.

We are embarking on a major piece of work in evaluating the clinical effectiveness and routine clinical practice of new anti-psychotic drugs. That work is in its infancy, but it gives members an understanding of what we are doing and what we feel is necessary in this area.

There is a need for effective provision of short-term hospital care, day care and home-based care, which must be co-ordinated and managed at source, as well as managed locally. There is still a need for long-term care. I agree entirely with Dr O'Neill that far too much resource has been piled into long-stay care, notably for the elderly, but such care is still a necessity—we cannot get away without it.

I promised my colleagues that I would not mention this, but we must know where we are going with long-term care. We must ensure that quality is good and that expertise is available. If long-term care is not being delivered within the NHS, as is increasingly the case, the expertise of specialists in psychiatry and medicine for the elderly must be made more widely available in residential and nursing homes. With the best will in the world, general practitioners are not necessarily experts in those areas. In Glasgow, we have a system of roving clinics in residential and nursing homes. That provision has been well received and has kept people out of hospital.

Elderly people and people with dementia have terminal and palliative care needs, which must be managed well and sensitively. I worry that such provision is often not as good or as sensitive as it ought to be. A pilot study in Glasgow has examined and reported on the palliative care needs of people in trust hospitals.

What I am looking for is the same as what Dr O'Neill is looking for. I want benchmarking and national standards to which we must adhere to provide for the patients whom we serve. Within that, I want a system of local management and accountability whereby we can provide what used to be called seamless—but I prefer to call joined-up—care. Those services must be scrutinised and be subject to feedback. The most important people to do that are the patients and care givers who use the services.

The Deputy Convener: There is a lot of ground to cover. I shall start with a couple of questions about LHCCs and pick up on mental health later. From the papers on the assessment model for enhanced home care, I note that there are also other areas that we must address. How many LHCCs are there in Glasgow? Are most of them developing the kind of joined-up working that you are talking about, or are you in the vanguard?

Dr O'Neill: At present there are 16 LHCCs in Glasgow—11 north of the river and five south of it. They vary in size and in the extent of their partnership working with the local authorities. We have been keen to ensure that CarenapE is not just a local model of working; if there is to be an economy of scale, it must cover populations beyond the LHCC. Some work has been done in the south-east Glasgow LHCC and in Pollokshaws LHCC, so people have started teasing out that agenda. The common assessment tool is only one part of the agenda, which broadens out into the whole joint working agenda of LHCCs and social work accessing one another's services. We must examine how to audit that and provide feedback about appropriate use of resources.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Do you think that your project provides a better means of linking primary care health professionals with social services staff?

Dr O'Neill: I do. CarenapE's common assessment tool was developed jointly between health and social work by the workers on the ground. Before that, the dementia project, which was a jointly managed project between health and social work, had started to tease out what each department understood about what we did. The dementia care co-ordinator undertook needs assessment, and we also used the community care assessment that the social work department used at the time. The social work department was asking for a CarenapD—for dementia—assessment as well; it was very keen on it. That was what encouraged us to develop CarenapE. It was a bottom-up approach; people were keen to develop that model of working.

Margaret Jamieson: Do you have that relationship only with social work, or does it extend to housing providers, whether housing associations or the council? How does that link in with the acute trust?

Dr O'Neill: In Govan, there has been a community care forum for some time, which housing providers attend. We have now started to engage with the voluntary community care forum in Govan. It is important to make those links. The voluntary sector can often bring a significant range of skills and resources to help to deliver our agenda. It is important that people do not go off at tangents and that we have a strategic vision to which we can all sign up and towards which we can all start working.

Margaret Jamieson: Do you have a community plan for the area that everybody has bought into?

Dr O'Neill: The honest answer at the moment is no, but we have an LHCC development plan for next year, which we put together at an open space event attended by many representatives, including the voluntary sector groups and community patients groups, both of which took part in the

open day at the Swallow Hotel. We asked people to start flagging up the issues; we have put together a development plan encompassing those issues. The model is still in its infancy, in terms of sophistication.

Margaret Jamieson: Have you examined other areas, running similar pilots, to see what they are doing, how they have forged relationships and whether you can learn from their experience, thereby sharing best practice?

Dr O'Neill: Awareness of best practice is always an issue for us. We need to roll that out. There are local directories. The Nuffield centre's "Community Care Works" resource is about examples of good practice of joint working. Resources are open to us that allow us to see what others are doing.

Margaret Jamieson: I am well aware of the pilot project. Mrs Crocket will remember from a previous life the Newmilns and Darvel pilot project in Ayrshire. A lot of good work took place there, which will now be rolled out. The project was in a rural area with small villages, so it is now going to be tried in urban areas. Have you gone beyond Glasgow to examine what is happening elsewhere in Scotland? I am aware that in Perth and Kinross health authorities and the council are working together closely. That is the type of best practice that I mean—not just closing the wall around Glasgow.

Rosslyn Crocket (Greater Glasgow Primary Care NHS Trust): It is interesting that you mentioned the Newmilns and Darvel project, because we discussed it in Glasgow on Friday afternoon. The primary care trust is actively looking at best practice in other areas.

On planning, the situation in Glasgow is that we have what we call planning and implementation groups, led by the health board. There is a planning and implementation group for frail elderly patients, and one for elderly people with mental health problems. The groups bring together at a strategic level all the different agencies, including housing and social services, that provide services for the elderly in Glasgow. A lot of good joint working is under way in those groups.

Further to Ken O'Neill's point, it is reasonable for the LHCCs to be at different stages of maturity. There is greater engagement at a local level with social services. Some of the LHCCs have a social work representative on their executive teams to consider the development plans and priorities for the forthcoming year. The overarching structure is in place.

At the macro level, the city is split into north and south; there is a south side planning and implementation group, which examines services for the elderly, and a north side group. There are distinct populations in the north and south of Glasgow; there are also fairly distinct health services in relation to our acute colleagues.

One of the late papers that we submitted was on the through-care project, which brings in social services, the primary care trust and the acute trust in Glasgow. That project, which was a pilot initiative to consider winter pressures, shows joined-up working in primary and secondary care in social work. In Glasgow, it was thought that patients were occupying acute beds when they could have been looked after quite comfortably in their own homes if there was a wee bit more care in the community. The through-care project was set up to find out whether there was evidence to support that thinking, and it has managed to do that.

10:30

A team of nurses works with social services to screen patients, to find out whether we can provide services to keep them in their own homes. Usually that means an intensive service for about three weeks, but that is sometimes supported by generic primary care services, such as the district nurses. The team also assesses patients who have gone into accident and emergency, orthopaedics or departments of medicine. If we think that we can bring the patients home quickly, we establish a care package to ensure that they have a comprehensive service at home.

The Deputy Convener: We will go into more detail on enhanced home care later.

Mary Scanlon (Highlands and Islands) (Con): The CarenapE pilot started in June 1999 and has been running for less than a year. You said that it has been generally well accepted and that it is proving useful as a catalyst for further development of joint working. Has there been any evaluation of such working? How does the pilot model overcome "professional territorialism"?

Dr O'Neill: When we carried out the pilot, the issues that emerged depended on the level of engagement between health and social services at the various sites. Inverurie LHCC had well-developed systems of joint working, but heard our presentation on CarenapE, thought that it was ideal and began to use it. There is an issue about the extent to which services are joined up locally. CarenapE forces people to consider what they do and how they work together. The tool can only do so much; what is important is the way in which people use it to access services across service boundaries.

Mary Scanlon: Are we still talking about a pilot study that started nine months ago, or has this been evaluated before?

Dr O'Neill: CarenapE came off the press only in

May last year. A report is being written and will go before the planning and implementation group at its next meeting in Glasgow.

Mary Scanlon: Do you have checks, performance criteria and performance indicators? Will there be a report on whether the model is successful?

Dr O'Neill: Yes. A report is being written for the planning and implementation group meeting, which will be in the next month.

Mary Scanlon: So the model has not yet been evaluated.

Dr O'Neill: Yes. The report is being written.

Mary Scanlon: What is described in the submission is a good working model, which sounds very positive. However, we do not have anything that would prove that it is working.

Dr O'Neill: We can send you the evaluation report.

Mary Scanlon: In your submission, you say that CarenapE pilots in the Elderpark clinic were to be evaluated in February and March. However, you are still talking about what this scheme will do—for example, it will be required to care manage, it will gate keep and manage budgets, and it will be responsible for training. That sounds more like a wish list—like pie in the sky—than a tried and tested model.

Dr O'Neill: When CarenapE was developed, people were keen to use it. Last year, we held a conference with all the local health and social workers, who were very keen for a common assessment tool to be developed as a means of facilitating further joint working. An assessment has been undertaken that examines the tool itself and focuses on the issues of validity—whether the tool does what it should, whether it measures unmet need in a rigorous and robust way, and so on. Consistency on the part of those who are rating the tool is also considered. That exercise has now been completed, the report has been compiled and the indications are that the tool is absolutely fine. However, there are many assessment tools around. It would be easy to say that we have developed a tool and that we hope people will use it, but people may just put it on the shelf, where it would stay forever. The key is whether people use the tool. Its use throws up other issues regarding access to services. Debates on matters such as whether a health care worker can access home care services from social services have only just begun.

Mary Scanlon: You seem to be answering my question and saying that although the model looks good, we still do not have the information that would allow us to say that this is a top-class successful project and an example of best practice that should be implemented. I hope that it is, because it sounds good, but we are not quite at that stage.

Dr O'Neill: No. We are beginning to tease out the issues. That is why I was making a plea for devolved budgets.

Mary Scanlon: You mentioned devolved budgets in your opening statement. Are devolved budgets necessary to make the model work?

Dr O'Neill: I think that they are.

Mary Scanlon: What do you mean by a devolved budget?

Dr O'Neill: I mean a protected budget for the area teams, so that they have money that they can utilise.

Mary Scanlon: Are you talking about local government ring-fencing money for social work? I thought that you were talking about your budget.

Dr O'Neill: There is no reason for there not to be a protected resource from health and from social work. At the moment, one of the difficulties in social work is that there is a budget for residential care and a budget for flexi-care, which covers local services. The problem is that those two budgets stand alone. People can be overspent in their flexi-care budget—which, it could be argued, might well be good practice because it helps to support people at home—and underspent in the residential budget, but still be penalised. That is what I mean when I talk about a devolved budget.

Mary Scanlon: I thought that you were talking about a devolved budget in relation to your LHCC. What would you do if you were given a devolved budget within your LHCC to help achieve joined-up care?

Dr O'Neill: We would work with our colleagues in social services to arrive at a strategic vision about what we are going to provide in response to the needs that we identify on the ground. For instance, we would decide what services are required for the elderly and what we could provide between us. Both groups would jointly commit to that.

Margaret Jamieson: In relation to devolved budgets, is there no use of the joint investment fund in Glasgow for pilot projects?

Dr O'Neill: That fund was designed with primary care and secondary care organisations in mind.

Margaret Jamieson: Is the situation that rigid in Glasgow? I understood that the arrangements were relaxed and could be designed to fit.

Dr O'Neill: One of the difficulties has been identifying the resource that is involved.

The Convener: We have a great interest in the joint investment fund, but we will return to the issue of assessment.

Irene Oldfather (Cunninghame South) (Lab): I am impressed by the theory of the project. Like Mary Scanlon, I think that it reads well on paper; if it works well, it could enhance the quality of life of our elderly people.

Could you tell us something about barriers to joined-up working? There is much duplication in social work and health. How could professionals be persuaded that joined-up working could improve services to patients? Are jealously guarded professional boundaries the problem, or is it to do with difficulties in delivering services?

Jane Arroll (Greater Glasgow Primary Care NHS Trust): A practical issue that highlights the problem is equipment. Someone who lives at home and needs a piece of equipment does not ask whether that equipment would be defined as nursing equipment, physiotherapy equipment or occupational therapy equipment. On occasion, we have discovered that several professionals from a range of agencies have gone to the person's house to assess the need, provide the equipment, train the person in the equipment's use and so on.

We attempted to develop a protocol that would enable the equipment needs to be assessed by any professional; that raised issues about whose budget would be involved. Also, issues were raised about whether highly specialised training would be required if the piece of equipment were specialised. We discovered that a significant proportion of equipment, training and skills were generic across the professional groups and agencies. That meant that the professions and agencies could be confident that we could provide jointly the bulk of the assessment and training to clients and their carers.

That exercise has reduced significantly the number of people visiting an individual's home and has speeded up the process, but there are still problems with budgets. We are investigating the possibility of a joint store that would help us to resolve such problems. However, the Parliament must also examine such issues, as we can do only so much on the ground; some of the problems are linked to statutory requirements about who provides what services.

10:45

Irene Oldfather: Is the process working? Are occupational therapists working for both health and social work services, or is there still a separation between health occupational therapists and social work occupational therapists?

Jane Arroll: The issue is not about a division between health OTs and social work OTs: a social work OT can access health equipment and a district nurse can access social work OT equipment. That said, four or five years ago, health OTs were working only in the mental health and learning disabilities areas of generic community services; we have since developed health OT posts for the care of frail elderly people. However, we do not want a separate health OT and social work OT, especially in primary care. In two of our LHCCs, we seconded a member of staff from the local authority and another from an acute hospital to take on roles with responsibility for both health and social work services. Both posts are coming to the end of their evaluation period.

Furthermore, we have undertaken work with East Dunbartonshire Council to bring together acute services, social work services and primary care services; however, that report is not due until the end of the year. There is a lot going on, but we are not yet able to propose any final models.

Irene Oldfather: It seems to have taken us so long to decide on simple measures that would improve matters enormously.

Dr Lyons, you mentioned that too many resources have been put into long-term institutional care. I recognise that, but do we have the breadth and range of services outwith such institutional care to support elderly people in the community? An elderly person might have a low period—through arthritis or some other illness—but might not need long-term institutional care; indeed, they might not even need medical care, just respite nursing care. Are enough resources put into that?

Donny Lyons: The quick answer is no. Although it is possible to get 24-hour home care for short periods to help someone through a crisis, such services are subject to great variation geographically. Unlike Dr O'Neill, my remit is for the whole of Glasgow, which has 16 LHCCs and six different local authority social work departments, never mind different offices. On top of that responsibility, I also have a day job treating patients.

As I said, it is possible to institute short-term 24-hour care for someone by providing extended periods of day-care and a night-sitting service at home. However, that is very expensive, and it is sometimes cheaper to take an individual into residential nursing home or hospital care for a short spell. Unfortunately, a stay in such care tends to deskill people, particularly those whose intellectual functions have diminished slightly, and often they cannot be rehabilitated and returned home.

The Deputy Convener: As we are moving into the next section of questions, I want to finish off

the section on assessment. Hugh Henry will then lead off our questions on enhanced home care. Did Duncan Hamilton have a question about assessment, or—

Dorothy-Grace Elder (Glasgow) (SNP): I have a question about budgeting.

The Deputy Convener: Sorry, Dorothy-Grace. Was your question about information technology, Duncan?

Mr Duncan Hamilton (Highlands and Islands) (SNP): Yes.

Dorothy-Grace Elder: I thought that I was next.

The Convener: Duncan has been next for a while, followed by Dorothy.

Mr Hamilton: I have been queuing patiently.

I want to pick up on one or two of your comments about the system. Members would support the joined-up thinking and working that you are trying to promote, to which the free flow of information is central. What is happening on the IT front? Even in the Parliament there is institutionalised resistance—among colleagues who are over 40—to getting involved in IT. That does not apply to all people who are over 40, but certainly to some. Are the barriers to the free flow of information the result of the input of information, or of the use of information at the other end?

My second question concerns the establishment of IT links and the progress that is being made on them. You said that a steer from the centre would be useful on that. Would you like to unpack that and tell us what you mean by a steer from the centre?

Dr O'Neill: I share your thoughts on IT. I am not an IT buff, but I am convinced of the advantages of a proper IT system. CarenapE allows the software package to aggregate the unmet need. The assessment can be kept on the computer.

When someone contacts the social work department—or a secondary care agency—it needs to know immediately whether that person is known to any of the relevant agencies. Often, an elderly person who lives alone is admitted during the night, and it can be difficult to find out whether services have been visiting them, whether somebody is care managing them and whether they have a social worker. As an aside, we are keen for a copy of the assessment to be kept by the person in their home, so that that information is available.

We need to consider the possibility of storing the information electronically, so that social work services can simply key in a name and go straight to an assessment, but confidentiality is an issue. How much information should be legitimately shared between the health service and the social work department? I am not sure. Common sense might dictate what is practical. However, there may be episodes in someone's past—20 years ago, for example—which should be treated with sensitivity and should not be in the public domain.

Mr Hamilton: Are you saying that there may be a limit to how far the sharing can go? What does that mean for the great plans that we have for joint working?

Dr O'Neill: In principle, nobody has difficulty with sharing. We, and our colleagues from social work services, recognise sensitivities on both sides. We need to share certain fundamental information, and the assessment of an elderly person is mainly concerned with functionality. Can that person get out of bed? Can they toilet independently? Can they dress independently? Are they on medication? However, they may have been involved in incidents 15 or 20 years ago, which were known to health or social workers, and that information does not need to be shared. We should respect people's privacy.

The Deputy Convener: Several members want to speak, therefore I must ask for relatively short questions and answers. We are due to finish at 11.15, but we may have a little extra time.

Dorothy-Grace Elder: Thank you for all the information that you sent us. Unfortunately, we have not been able to read through the two papers in full, but we understand the principles.

My first question concerns the home help service in Glasgow. Given that there have been cuts in that service, how much involvement does it have in your plans? My second question concerns payments. At the beginning of Dr O'Neill's statement, he spoke about charging. He said that social work budgets are predicated on a level of charging and that the elderly find it hard to understand why they should pay for services. I also find that hard to understand, because services are provided in the home in order to keep people out of a free hospital. What sort of charges are people hit with?

I would be grateful if you would answer the question on home help first.

Donny Lyons: I will pick up the home help question.

We would all like home care services to become much more generic, providing both basic domestic care services and health care services. Rather than having six, seven or eight people a day running in and out of someone's house, there would be as few as possible, as one person would be able to perform a variety of tasks. Getting that idea across is a tough battle, because people tend to say, "This isn't that person's job."

I do not need to tell you about the bathing

service—

Dorothy-Grace Elder: The fact that someone is unable to change a light bulb might mean that they have to go into hospital. Sorry—on you go.

Donny Lyon: Absolutely.

The other silly argument, with which you will be familiar, is about bathing services, when people ask, "Is that a health bath or a social bath?"

Dorothy-Grace Elder: Have the cuts in the home help service affected your plans?

Donny Lyons: The threshold for access to the home help service has risen, so that people who need intensive home care input receive it. There does not appear to be a problem with that, although there is a problem with the burden of care being placed on people who perhaps need help from home care services once or twice a week for some of the bigger, more difficult tasks. That burden falls on relatives or friends, while the person who needs care is left in a situation where their quality of life is not being maximised.

The Deputy Convener: Can I bring in Hugh Henry—

Dorothy-Grace Elder: So cuts are affecting you then?

The Deputy Convener: Could you finish on that point, Dorothy? When Donny has answered it, Hugh will lead the questioning on enhanced home care.

Donny Lyon: Yes—

Dorothy-Grace Elder: But I have a budget question about people being reluctant to pay and unable to understand why they should have to pay, given that they are being kept out of hospital by those services. Would you comment on that point, Donny?

Donny Lyon: Perhaps you should ask other witnesses to comment on that question as well.

I dislike charging for care services. If I had my way, the attendance allowance would be scrapped; in its place, I would implement a voucher system, whereby a person's needs would be met by that person having some sort of purchasing ability, or someone purchasing services for them, with vouchers for a certain amount of care. That might be a better way of providing the service. The attendance allowance is provided to cover those services, but I am concerned that sometimes the attendance allowance is not used or targeted properly.

The Deputy Convener: Are there any other comments on that point before I bring Hugh Henry in?

Jane Arroll: We are also considering having extended home care workers, but that issue is linked to paying for services. Currently, if a district or auxiliary nurse is providing health care, no cost is involved, but if home care is provided through a joint service, the person will be assessed.

How does one differentiate between social care and health care? In our pilot schemes for extended home care workers, the person who requires care will be assessed as usual and if an extended home care worker is sent in, the cost will be included for all services, including the extended health care services. To balance that, we have made available additional nursing services, in order to put more intensive elderly nursing services into that same population group. However, we cannot address that issue at a local level, where we are clear that we want joint, extended care workers, but we are unable to get over the charging issue.

The Deputy Convener: Dorothy, you can make further comments later.

Hugh Henry (Paisley South) (Lab): A couple of points have been made that influence the question that I wanted to ask. You raised a point about attendance allowance. Many people regard that as part of their weekly income, so switching to vouchers could cause significant problems for people on restricted incomes. Nevertheless, I understand that the purpose of attendance allowance is to help people to receive extra care. When we consider our final recommendations and the Sutherland report, we may wish to comment on how people with specific needs are assisted.

11:00

On the question of who provides what in a home, you are right that we do not want six or seven people going into a patient's house, but there are management issues, from which flow budgetary and accountability issues. Something that has arisen in previous meetings leads us to think that a debate is needed about who should have financial responsibility and who should manage specific services, and about whether it is sensible that critical services in the community should be managed by completely different organisations. We will want to return to that issue.

Given some of the tasks that you have identified in your paper, which range from practical home care to medical care, how do you ensure that the roles are not blurred and that people understand who should do what?

Jane Arroll: That was certainly a major issue with the extended home care worker and there was a lot of discussion about it. The arrangement that we have come up with is that, although care is managed and financially managed through social work, clinical supervision is carried out through

health. We spent a lot of time identifying who would take responsibility and considering how, after an assessment was done, we would agree on the package of care and the supervision of care.

The day-to-day management and supervision of the worker is through the social work department, which employs them, but we have a link nurse for any professional or clinical issues. That was only possible after huge training issues were addressed. This is a complex area, which is hindered by some of the boundaries. However, the fact that those boundaries existed meant that we did not rush in, as we had to spend a long time thinking about supervision to ensure that there was a clear pathway and clear lines of responsibility, and to flag up significant training issues. Sometimes such tension can be useful as it ensures that we put in place something that is robust.

Hugh Henry: There are increasing tensions. Indeed, there are tensions within local authority social work departments, which, I know, have had to revise what home helps do. We have moved to a completely different model, in which more intensive support is given to people with greater needs. It is probably a better use of resources than existed in the past. How do you determine whether a bath is a medical or a social requirement? How do you determine whether changing a dressing needs medical support? How do you decide whether a home help should carry out such tasks?

Who ends up paying? Many of us would share your reservation about charging. Equally, we all know that somebody has to pay for the service. If you do not charge the individual and do not use the attendance allowance, is it the local authorities, which have restricted budgets—there are issues over local government finance—or taxpayers generally who pay? Should we increase taxation? Even at your level, with your finite budgets, who ends up paying when there are arguments, for example, about whether a dressing should be changed or whether a bath should be given?

Rosslyn Crocket: We determined what a health input, a nursing input and the role of the enhanced home care worker were by getting together with colleagues from social services and groups of district nurses. It was very difficult for us to iron out the specific criteria for making definitions. Responsibility for the provision of a bath, by social work or by a district nursing service, was particularly difficult to identify. The same applies to the other tasks that we feel home workers can now carry out under the supervision of a qualified nurse. A joint process was agreed and criteria were developed, specifying who could do what. The key to that was the supervision mechanisms that were put in place.

That is the situation, but that does not answer your question, Hugh, about charging. If the joint assessment of a patient says that an individual can be looked after at home, and if the enhanced home care team is put in place, that means that a range of services can be provided under the supervision of a qualified nurse, if that is expected.

There is currently a charge levied through social work for that range of services. There are a lot of difficulties with that. One of the basic difficulties is that that charging has had an impact on the contribution by nurses to the assessment. I believe that that situation is moving on. Initially, nurses found it very difficult to relinquish to extended home care workers some of what they felt that they could continue to provide. We as a profession have never said that patients will have to pay for something. The nurses themselves found that very difficult.

That does not answer the question about why someone should be expected to pay for an element of care that they might otherwise not have paid for under the old system.

Hugh Henry: But it is not just about the client being expected to pay; it is about disputes between you and the social work department about who pays. You both work on finite budgets, and want to manage them.

Rosslyn Crocket: When the services that we provide now, including that of the enhanced home care worker, were first piloted, new moneys came into the system or were transferred from Greater Glasgow Health Board because of all the closures and continuing care beds. The money coming into the social services budget to provide the service was new. That was all agreed throughout the city's planning and implementation groups.

Jane Arroll picked up on one of the positive aspects of the service from a health perspective: with the enhanced home care worker, we have demonstrated that we have been able to keep people at home who would otherwise have been admitted to institutions.

The evidence that we have now is largely qualitative, and has been acquired by talking to the patients and their carers themselves. The patients are extremely happy that they have been able to stay at home. That allows us to utilise our district nurses in other areas, and that helps develop their skills and expertise in other areas, but we are still able to look after our elderly population in their own homes as well. There has been a knock-on effect.

Donny Lyons: Day care is also affected. Our day hospitals provide day care free. Someone

comes to our day hospital for a short space of time, gets assessed and rehabilitated and needs on-going day care, but finds that that is charged for by the social work department. On finding that they get charged, they say "No, thank you very much. I don't receive a service." That is a problem.

There is also a problem with resource transfer because that money sometimes falls into a black hole, by making up deficits in nursing home budgets, for example. That experience is not confined to Glasgow—it happens everywhere. When one tries to use resource transfer to get more care in the community, that is not necessarily where the money ends up going. I would make a plea for a budget pooled between health and social work, which is jointly and effectively managed and where it is specified on what services the money should be spent.

Hugh Henry: Convener, at some point could we investigate whether resource transfer money is being used to supplement expenditure on nursing care rather than on care in the community?

The Deputy Convener: That is something that we should investigate. We will touch on mental health and the more general question of pooled budgets at the end.

Irene Oldfather: I want to return to the role of the GP in the community care package. There seems to be a need for respite or convalescent care. The German health system makes extensive use of that and Germans expect convalescent care if they have gone through a major illness or a particularly low period.

Can you explain where individual GPs fit into the system? Although we are talking about joint assessment and so on, there are cases where elderly people have been discharged from casualty on the basis that they need respite care, which should be arranged by the GP. Is joined-up care working?

Dr O'Neill: It falls to me, as a jobbing GP, to answer that question. There has been a move away from general practitioners working in primary care teams as management units towards groups of GPs working together, with a population focus. That gives us an opportunity to resource the issues mentioned by Irene Oldfather. The economy of scale is crucial to that. It will be far easier to provide such services across a population than in individual general practices.

There has been a big problem because there has been a substantial lack of resources for providing a service in the community for elderly people. Part of that problem relates to the principle of divide and conquer—because general practices were individual primary care teams, it was difficult for general practice to get a cohesive voice. We hope that LHCCs will enable general practitioners to come to the fore and seek a strategic vision on the services that ought to be provided in the community.

Irene Oldfather: That goes back to the point that Margaret Jamieson made about the acute trusts. At the moment, the casualty department will discharge patients without taking responsibility for them. There must be liaison between the acute trust and the GPs. If that does not happen, the whole system will break down. I know of cases where that liaison is definitely not happening.

Dr O'Neill: You are probably right. If someone breaks their wrist and goes to casualty, it is possible that their situation might be managed at home. However, somebody has to go home with the patient to see how safe they are and to decide whether that patient can stay at home. Community staff should follow people in and provide advice on getting out of hospital.

Dorothy-Grace Elder: Have you any particular concerns about elderly people who are carers—people who might be in their 80s, but who are still caring for an adult son or daughter with a severe mental health problem? Has there ever been a budget projection on how much the NHS might save in hospital costs, if your scheme is successful in the long run? Again, I am returning to the question of people having to pay for those home services to keep them out of a free hospital.

11:15

Donny Lyons: On the elderly carer question, one of the situations that I often come across is a frail elderly carer looking after a confused elderly partner. It is almost as if between the two of them they make one functioning person: one of them has the legs and the other has the brain, if you want to look at it that way. That is a precarious situation. It does not take much to upset that, and crises and disasters do happen. Despite the Carers (Recognition and Services) Act 1995, the needs of carers are not adequately recognised, provided for or funded across the board. I see that my colleagues are nodding in agreement. I agree that there is a big problem.

Dorothy-Grace Elder: And sometimes both elderly people end up in hospital. If the carer goes first, that is it.

Donny Lyons: Yes. The frail carer becomes so physically unwell that they have to be taken into hospital, and the confused person is left in a vulnerable situation on their own at home and ends up in care. It is a difficult situation to anticipate. Even when you know what will happen, sometimes there is not a lot that you can do about it.

Dorothy-Grace Elder: What about the budget?

Are there any projections for how much the NHS might be trying to save, or able to save, on hospital care?

Donny Lyons: I can only talk about the modernising mental health services strategy that we have in Glasgow, which looks at how much money we can take out of continuing care and re-invest elsewhere. As I am sure you know, there is a difficulty, because bridging funding is required. Services have to be available in the community before you can cut back on long-stay beds. Bridging funding, which was a reality for a while in the 1980s and early 1990s, is not a reality any more. That causes us the greatest difficulty.

The Deputy Convener: We are in extra time now. We have to stop by 11.30, because we have a large number of statutory instruments and petitions to deal with.

Margaret Jamieson: I would like to go back to what Irene Oldfather said about an individual being discharged from accident and emergency with a broken wrist, and how no thought was given to whether that person could be sustained in the community. If an elderly person has a broken wrist, they will have difficulty if, for example, they want to make a cup of tea. There seems to be a divide. The individual may be fit to be discharged from accident and emergency, but no thought is given to how they will manage over the weekend, for instance.

I am also aware of how that can affect an individual with a mental health difficulty: whether it is a profound difficulty or a short-term one does not matter. How do you, as mental health professionals, link into the accident and emergency services in Glasgow? How does that relate to LHCCs? I am interested to know if you have thought about generic mental health workers, an idea which I support and think should be expanded. I am aware that some accident and emergency departments now have consultant psychiatrists attached to them, because like everyone else, they are taking account of clinical governance.

Donny Lyons: I was hoping that nobody would mention clinical governance.

In relation to the frail and elderly, the accident and emergency department ran a successful winter project, details of which you have before you. It concentrated on people with physical frailty who present in accident and emergency departments.

Accident and emergency departments in hospitals that have a mental health unit have an on-call psychiatrist. Glasgow's long-term strategy is to co-locate mental health in-patient units, which have 24-hour duty psychiatric cover, and accident and emergency departments in the same hospitals. That is not the rule everywhere. There is a bid in place within the framework of modernising the mental health service to have experienced psychiatric nurses available. I think that that is a good approach, if not better than having an on-site mental health unit.

To support the mentally ill person, we have a network of community mental health teams that are available from 9 in the morning until 9 or 10 at night. We also have a 24-hour crisis service. If someone with mental health needs presents at casualty at night but does not need to be admitted to hospital, they can be supported at home by the crisis service and passed on to the community mental health team in the morning. Mental illness is a 24-hours-a-day problem. Mental health services have to be there 24 hours a day as well.

Mary Scanlon: Halfway through Margaret Jamieson's question I indicated to the convener that Margaret was asking the question that I wanted to ask. I hope that I do not cover the same ground now.

Before I start, I want to speak up for the over-40s and say that we are not all technophobes.

When thinking about care in the community, we tend to place a lot of emphasis on the elderly. You mentioned the mentally ill, however. I was concerned by what you said about the lack of awareness and the accuracy or otherwise of diagnosis. I am concerned about the integration of services. Do you work closely with the LHCC, Dr Lyons? Is there a core requirement for an LHCC to have input from a mental health service specialist? I know that a pharmacist cannot be on the board of an LHCC.

Donny Lyons: The LHCC that I work with has a general practitioner who is the LHCC mental health lead. That is the person that I talk to when I have ideas about mental health development. He helps in the dissemination of information.

Mary Scanlon: Your concerns are being fed into the process, then. Is that happening throughout Scotland?

Donny Lyons: I do not know. Ken O'Neill could probably tell you better than I can.

Mary Scanlon: We would be seriously concerned if the issues that you raised were not being addressed in the joined-up working scenario.

Donny Lyons: In Glasgow we have, coincidentally, 16 LHCCs and 16 general adult community mental health teams. It might be possible to make them fit together. Would that not be nice? Common sense would dictate that that is a good idea.

The issue about which you are concerned arises

in relation to speciality mental health disorders such as addiction disorders, eating disorders, elderly mental health care and child and adolescent mental health care. It is not possible to have one person from each speciality linked to an LHCC. The model works well with general mental health but not with speciality mental health disorders. There is a need for organisations to operate on a macro level when dealing with speciality mental health disorders, as well as on a local level when dealing with mainstream mental health services.

A tension exists between the views of mental health in primary care and secondary care. Secondary care mental health services focus, rightly, on severe and enduring mental illness. Primary care focuses on people with what we regard as minor mental illness and psycho-social problems. That takes up a lot of the time of GPs. Our job is to deal with the really ill people.

Mary Scanlon: In the new joined-up working package, do you work closely with the police? Is your relationship with the police integrated into your thinking on joined-up working?

Dr O'Neill: There is a new directive in the city around joined-up working with the police in the approach to mental illness.

Mary Scanlon: So that is part of the package that you are putting forward to us?

Dr O'Neill: Yes.

Mary Scanlon: That is good.

The Deputy Convener: That was a useful discussion on mental health. We may want to come back to our witnesses on that, because we know that there is a lot of good practice in Glasgow on mental health.

We are out of time. I had the first question, so perhaps I can tie up the session with the last. Dr Lyons indicated his support for pooled budgets. I would like an indication of whether the other witnesses think that such budgets are the way forward. To sum up, what do you think is the single most important factor in enabling successful cross-agency working?

Donny Lyons: One word—coterminosity.

The Deputy Convener: Do the other witnesses want a last word?

Dr O'Neill: Joint training and joint understanding.

Jane Arroll: Joint working is also about looking at the different care groups and acknowledging different needs.

Rosslyn Crocket: There has to be a real willingness at every level, in the health service and in the local authorities, and a commitment to breaking down the territorial boundaries that sometimes still exist. That has to be a consistent message from the bottom up and from the top down.

The Deputy Convener: Thank you. Both your written and oral evidence was very useful. We could easily have gone on for another hour and a half, but the committee has other business.

I propose a five-minute break, during which members may wish to read the letter from Argyll and Clyde Acute Hospitals NHS Trust about the petition.

Meeting adjourned at 11:26.

11:37

On resuming—

Subordinate Legislation

The Deputy Convener: We move now to a series of statutory instruments, all of them under the negative procedure. We will go through them one by one.

The first is the National Health Service (Dental Charges) (Scotland) Amendment Regulations 2000 (SSI 2000/44). The Subordinate Legislation Committee has said that the Parliament's attention need not be drawn to the instrument and the recommendation is that this committee take no further action. Are we all agreed with that recommendation?

Members *indicated agreement.*

The Deputy Convener: The next instrument is the National Health Service (Optical Charges and Payments) (Scotland) Amendment Regulations 2000 (SSI 2000/45), which again is not controversial. Are there any comments? If not, are we all agreed that we should make no recommendation on the instrument?

Members *indicated agreement.*

The Deputy Convener: The next instrument, the Health Technology Board for Scotland Order 2000 (SSI 2000/47), is slightly more controversial. The Subordinate Legislation Committee has drawn the attention of Parliament to certain vires issues in relation to the instrument and the Scotland Act 1998. Given that it has done that, and that there do not appear to be any health issues, are we agreed that we should make no recommendation?

Members *indicated agreement.*

The Deputy Convener: The next instrument is the National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2000 (SSI 2000/50). Again, there is nothing controversial about the instrument. Are we all agreed that we should make no recommendation?

Members *indicated agreement.*

The Deputy Convener: The next instrument is the National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000 (SSI 2000/54). The Subordinate Legislation Committee has drawn the attention of the Parliament to a vires issue, but I do not think that the committee needs to do anything more. Is it agreed that we should make no recommendation?

Members *indicated agreement.*

The Deputy Convener: The next instrument is the Meat (Hygiene and Inspection) (Charges) Amendment (Scotland) Regulations 2000 (SSI 2000/61). The recommendation is that we do not need to draw the attention of the Parliament to it. Is that agreed?

Members *indicated agreement.*

The Deputy Convener: The Subordinate Legislation Committee raised some drafting points about the Food Standards Act 1999 (Transitional and Consequential Provisions and Savings) (Scotland) Regulations 2000 (SSI 2000/62). Is there anything more that anyone wants to say about that? Is it agreed that we make no recommendation?

Members *indicated agreement.*

The Deputy Convener: No motions are lodged against the Scotland Act 1998 (Agency Arrangements) (Specification) Order 2000 (SI 2000/745). We are the secondary committee to the Transport and the Environment Committee on that. Is it agreed that we should make no recommendation?

Members *indicated agreement.*

Budget Process

The Deputy Convener: The next item of business, on the budget process, is more substantial. Members will remember that, at the end of a previous meeting, we discussed the timetable, the list of witnesses, and the possibility of having a special adviser.

We will deal first with the timetable and the list of witnesses. The proposal is that we have three meetings, on the first three Wednesdays after the Easter recess, and that in the first meeting and the first half of the second witnesses will give oral evidence. The witnesses will be the chair of the health boards chief executives/general managers group; a representative—I hope, the chair—of Scottish Directors of Public Health; James Dunbar, medical director of Borders Primary Care NHS Trust; Charles Lind, associate medical director of Ayrshire and Arran Primary Care NHS Trust; and last but not least, Pat Dawson, of the Scottish Association of Health Councils. It is proposed that the witnesses in the second half of the second meeting will be Scottish Executive finance officials, and that in the third meeting we take evidence from the two ministers. Are there any suggested changes? I think that there was general agreement about that at our previous meeting.

The outstanding issue is the matter of the special adviser, which we will deal with in private at the end of the meeting.

Mr Hamilton: On the budget process, we considered various areas in which the committee might require greater explanation and a more detailed breakdown of the figures. There are a number of points that I wish to raise, although not necessarily today. It should be noted that we will want a breakdown, not just to ensure that the figures are given in real terms, but because many issues arise from Gordon Brown's budget relating to funding priorities that are not reflected in the figures. The committee will want to return to the detail and the way in which the figures are presented.

The Deputy Convener: That point was raised last week. Obviously, before the first meeting, we will want to discuss the questions that we will ask.

Petitions

The Deputy Convener: There is likely to be more discussion about the first petition than about the second one. Petition PE129 calls on the Scottish Parliament to

"initiate an enquiry into geriatric provision and the continuation of local health services in the Oban area".

Duncan Hamilton has an interest in that, so I am sure that he will want to talk to us about it in a moment. Is Mary Scanlon also involved?

Mary Scanlon: Jamie McGrigor is handling it.

The Deputy Convener: More generally, we must consider what our role is with reference to local service decisions. In the case of Stobhill and Stracathro, we decided that we would examine procedural issues. It could be said that we have already done work on how consultation should be conducted, but we have been careful not to get involved in the decisions themselves. We should bear that in mind when making a decision on this petition. We should probably hear from Duncan Hamilton first, as he has been involved locally, before other members comment.

11:45

Mr Hamilton: I would like to draw the committee's attention to the *Official Report* of the meeting of the Public Petitions Committee of 14 March, at which I made precisely the point that the convener has just made. I am acutely aware that this committee will not examine specific local issues. At the meeting of the Public Petitions Committee, I emphasised that the Health and Community Care Committee was likely to want to examine this issue because it is symptomatic of a wider problem in the health service, which was evident also at Stracathro and Stobhill, and would help inform our discussion.

I am not pleased with the way in which matters have been handled. I understand that Argyll and Clyde Acute Hospitals NHS Trust sent the letter last night that we received this morning. I do not think that that reflects a spirit of openness, particularly when the letter relates to the petitioner, a councillor in Oban, who does not have an opportunity to respond to it. It would have been more courteous and useful if we had received the letter in advance, so that the petitioner, who was invited to attend, could have decided whether he wanted to do so.

Some of the points that are made in the letter are self-explanatory. It addresses the issue of the CT scanner at Lorn and Islands Hospital, which was referred to at the meeting of the Public Petitions Committee and about which there has

been much public concern. The trust has now accepted the offers of support, and the scanner will be provided. That has taken the matter forward.

However, there are three outstanding issues on which the committee might want to focus any inquiry or report. First, there is the issue of consultation, which the Public Petitions Committee addressed. The letter suggests that no decision has been taken and that there are plans for extensive consultation. That is a very different story from the one that people have heard locally. I attended a public meeting at which the chief executive of the trust indicated that a decision had been taken. At the very least, there is some confusion as to what is happening.

It is important to note that the consultation exercise has been bolstered by the role that this committee has assumed. The fact that we have examined the Stracathro and Stobhill situations in such detail is one reason why Argyll and Clyde Acute Hospitals NHS Trust is taking this forward. It might be trying to learn from our earlier reports, which is useful. However, people are still unsure about whether consultation will be effective, and I ask the committee to consider monitoring it.

The second issue is the potential confusion over resource transfer from health board to local authority. There is real local concern about what will happen in future if the ward in question shuts; that will involve resource transfer. So far, there is no agreement on what should happen—no plan and no sense of direction. Again, that is a more general Scottish issue that we might want to take this opportunity to consider.

Thirdly—and perhaps most important—there is the issue of the split between rural and urban health provision, which the petition gives us the chance to examine. As we know from our deliberations on the Arbuthnott report, Argyll and Clyde Health Board covers both very urban and very rural areas. If you remember, convener, we made a recommendation based on the fact that the rural areas in Argyll and Clyde had not been dealt with adequately. That is why the Scottish Executive has said that Arbuthnott will revisit the issue of funding for such split health boards.

It would be useful for the committee to take the opportunity to consider whether the current structure of health boards is inhibiting, or permitting, the adequate provision of health care. If the current set-up is not to the advantage of areas such as Oban, we should ask the Scottish Executive to monitor the set-up much more closely, with a view to introducing changes. The community has a real fear that it is being bypassed in favour of other areas. I appreciate that that happens in many communities, but I feel that this particular case highlights a structural problem in the NHS in Scotland.

The Deputy Convener: There were three points there: consultation, which we have considered before; resource transfer, which we are also considering as part of our general inquiry; and the urban-rural split, which is a new element.

Margaret Jamieson: I saw the petition only this morning, and I am concerned that every change that is mooted will end up in this committee. That will be a problem for us.

I do not share the view of Duncan Hamilton and his party that we have had cuts because of bed numbers. Significant advances have been made in the treatment of patients, with the result that people often do not have to stay overnight. The public have not grasped the fact that not having a bed does not mean not having a service. The service is being provided in a different way.

I share Duncan Hamilton's concern about resource transfer. We should give more consideration to that in our investigation into community care. The situation in Argyll and Clyde will not be any different from the situation that I have experienced in Ayrshire and Arran, where the health board has not transferred all the moneys from long-stay closures to allow the appropriate level of service to be maintained in the community. I would be happy if we could do something about that. However, I would not be happy for us to say that we had to have an input every time that a ward closed in a hospital. That would not be the best use of the resources of this Parliament or of this committee.

Hugh Henry: I agree with Margaret Jamieson. As we go through the acute services review, a number of communities throughout Scotland will feel aggrieved at local decisions. We cannot substitute ourselves for the local decision makers. We must ensure that the guidelines that are established by the Parliament—which we expect the Scottish Executive to accept—are being implemented. If procedural matters are being ignored against the express wishes of the Parliament or of the Scottish Executive, we have a legitimate role to play. However, we are not a local forum that can consider all local decisions.

There will be understandable local concern, but the three elements that Duncan Hamilton mentioned in response to the petition can be dealt with by the committee. On consultation, we can draw the attention of the trust to the conclusions that we have already reached and to our expectation that trusts and health boards will undertake proper consultation in local communities. We should draw the attention of the Scottish Executive to yet another area in which concerns have been expressed, but go no further than that.

On resource transfer, Margaret Jamieson is absolutely right. The matter is being addressed. Following the discussion this morning, I look forward to getting more information on how money from resource transfer is being used. That information will form a substantial part of our community care deliberations. That is the proper way for us to proceed, rather than considering everything issue by local issue.

On the rural-urban split, as Duncan Hamilton said, we have made a recommendation that expressed our concerns about the implications for areas such as Argyll and Clyde. We have expressed a view, and we can remind the trust, the Executive and the petitioner of that view. Duncan admitted that our views had been accepted by the Executive. It would not be appropriate to examine the consequences of the rural-urban split in specific communities. We have already considered the general issue and there is not much more that we should do on the petition.

Mary Scanlon: This is an example of bad practice. People in Oban and the islands are not so naive as to think that one needs a hospital bed in order to get treatment—there is as much day care going on there as anywhere else. I am concerned that a lack of trust will become a lack of confidence. The whole thing gathers momentum and undermines people's faith in the health service. That stems from bad management, poor consultation and poor participation. That is a problem and we should acknowledge the bad management of the health board. Councillor McIntosh said that the petitioners would rather be part of the Highland Communities NHS Trust, because they feel that it covers a large area and recognises island and rural needs. The petitioners feel that their health trust is not listening to them.

Duncan Hamilton mentioned that the issue is in the public arena. It is a bit like Stracathro, where the patients and staff read about what was happening to their local hospital in the *Brechin Advertiser*. There is talk about closing the maternity unit and people have raised issues about breast cancer screening and treatment. It is a fair trip from Tiree or Oban to Paisley or Greenock and that adds to the trauma of needing to undergo such treatment.

We should recognise the fact that bad management, such as that in Oban, undermines faith and trust in our health service.

Irene Oldfather: I agree with what has been said on consultation. The committee undertook a useful exercise in relation to Stobhill and Stracathro. I hope that we have sent out a clear message on consultation, although I do not think that it has got through to health boards yet. I am concerned that every decision might come back to the Health and Community Care Committee for endorsement. In my constituency, there is a petition that has more than 3,000 signatures, and I am worried that all members could bring such petitions before the committee. We must send out a clear message about consultation.

The Deputy Convener: I should have said that the petition asks us to

"initiate an enquiry into geriatric provision and the continuation of local health services in the Oban area".

I do not think that that should be the role of the Health and Community Care Committee. The Public Petitions Committee said that the committee might want to consider the approach taken by Argyll and Clyde Acute Hospitals NHS Trust in relation to public consultation on its proposed reduction in services. Hugh Henry has suggested that we draw the trust's attention to the work that we have already done on consultation.

Mr Hamilton: We are not that diverse in our opinions. I take the point about local issues being taken to the parliamentary committee. That is why I began by referring to previous comments. I am not attempting to push a local issue at the expense of the rest of the committee's timetable. The matter is symptomatic of problems in the wider NHS. There is scope for inquiry on the matter.

It has been said that we do not want to duplicate our work on consultation. I completely agree with that. Now that Argyll and Clyde Acute Hospitals NHS Trust has said that it is at the beginning of the consultation process, what you have said is right: we should draw its attention to the matter and hope that the consultation is followed through.

12:00

Two other points are worth considering as they relate to different points in the process. The first is whether there will be any closure, which is the central concern. Although we addressed resource allocation in our discussions on the Arbuthnott report, that is very different from my current proposal. There is complete distrust of the decision-making process and the daily and strategic management of Argyll and Clyde Acute Hospitals NHS Trust. Do people feel, as a rural community, that local needs and concerns are being adequately addressed by that trust? I feel that that is more of a national issue.

Secondly, any closure will raise the issue of resource transfer. We would examine replacement provisions only if the ward were closed down and, in doing so, would need to investigate the interaction between the health board and local authorities. That secondary consideration flows from the first decision.

Although I take your point about the Public

Petitions Committee's recommendation on the petition, it is merely a recommendation and does not rule out the possibility of the committee conducting an inquiry with the terms that I outlined.

The Deputy Convener: We all agree that we should draw the trust's attention to our conclusions about the consultation process. However, Duncan Hamilton's other points are a matter of disagreement. Perhaps it is fair to say that he is taking the committee beyond the wording of the petition.

Mr Hamilton: That might well be true. However, events have moved on since the petition was submitted.

The Deputy Convener: We might have to vote on the matter. Do any other members want to comment on Duncan Hamilton's proposal?

Mary Scanlon: My concern is that, where there is already a lack of trust, one problem can gather momentum and the whole partnership can collapse. I can see that the matter has moved on.

The Deputy Convener: We are agreed that we will highlight our conclusions on the consultation process to the trust. I will have to put to the vote Duncan Hamilton's proposal to do further work on the issues of resource transfer and the rural and urban nature of that particular health board.

Mr Hamilton: Before you do so, it might be helpful if I clarified my proposal. Any further work would examine whether the structure of Argyll and Clyde Acute Hospitals NHS Trust adequately addresses Scotland's urban-rural split. I want to take the threat to Nelson ward as an example of that.

The Deputy Convener: Are you not including the issue of resource transfer in your proposal?

Mr Hamilton: Indeed. That is the second issue.

Margaret Jamieson: We already have the petition. However, because Duncan Hamilton is involved locally, we have received additional information that would not have been available if the hospital had been in another area and the MSP were not a member of the committee. We can deal only with the terms of the petition. Although Duncan's information is helpful, it is not part of that petition.

The Deputy Convener: Although that tends to be my view, I think that we should just put Duncan's proposal to the vote.

Mary Scanlon: Is Duncan seeking a review of the health boards throughout Scotland?

Mr Hamilton: No. I am merely taking Argyll and Clyde Acute Hospitals NHS Trust as an example of where the urban-rural divide has not been adequately addressed. The committee can then decide whether the trust's decision-making process gives enough balance to the rural communities. My other point concerns resource transfer between local authorities and health boards.

Mary Scanlon: Although I am sympathetic to Duncan Hamilton's proposal, I do not want the committee to take on any more work. Could we tell the health board that concerns have been raised with us and ask what is being done to address them?

Hugh Henry: No, because that presupposes that the committee has reached a consensus on the matter. We cannot infer anything about the attitude or decisions of the trust from an individual's comments. If we are going to do that, I would want a more fundamental investigation, to give everyone concerned the opportunity to express their case. Duncan Hamilton is taking us 100 miles away from the petition's terms, on a fishing expedition of momentous proportions. Although I can understand the politics behind the proposal—

Mr Hamilton: No—

Hugh Henry: We are not stupid.

Mr Hamilton: I am not suggesting that you are.

Hugh Henry: Now that I understand what the proposal involves, I think that Duncan is trying it on just a wee bit.

Mr Hamilton: First, no one is suggesting that anyone is stupid. I am not playing political games; the Parliament has to show some flexibility on the issue. Ten thousand people in Oban have signed a petition expressing their public concern about the lack of transparency on the part of the trust and their confusion about the future of a ward in their hospital. They want to know what the Parliament is going to do about that.

I am suggesting that, because events have moved on and in light of the fact that the consultation exercise has been undertaken in a different review, we should use this situation as a prime example to get to the root of the problem in Oban, which is all about whether the decision-making process gave enough weight to Oban and the rural areas. That is it.

The Deputy Convener: We have agreed to address the issue of the consultation process, which is the recommendation of the Public Petitions Committee, and I am sure that we will come back to resource transfer on many occasions over the next few weeks.

The question is, that the committee investigate the management structure of Argyll and Clyde Health Board together with the question of

possible resource transfer. Are we agreed?

Members: No.

The Deputy Convener: There will be a division.

FOR

Hamilton, Mr Duncan (Highlands and Islands) (SNP)

AGAINST

Henry, Hugh (Paisley South) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)

Motion disagreed to.

The Deputy Convener: The next petition is from a certain Mr Frank Harvey, whose name I seem to recognise, asking us to take urgent action on various pension payment issues arising from hospital stays. The recommendation is that we simply note the petition. Is that agreed?

Members *indicated agreement.*

The Deputy Convener: That ends the public part of the meeting. We will discuss advisers for the budget process in private.

12:06

Meeting continued in private until 12:22.

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