HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 7 June 2000
(*Morning*)

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16th 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

THE FOLLOWING MEMBER ALSO ATTENDED:

Cathy Jamieson (Carrick, Cumnock and Doon Valley) (Lab)

WITNESSES

David Bookbinder (Scottish Federation of Housing Associations)
Andrew McKay (Port of Leith Housing Association)
David Orr (Scottish Federation of Housing Associations)
Hilary Spenceley (Margaret Blackwood Housing Association)

CLERK TEAM LEADER

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 7 June 2000

(*Morning*)

[THE CONVENER *opened the meeting at 10:01*]

Organ Donation

The Convener (Mrs Margaret Smith): Good morning. We will start with agenda item 1. Some committee members have been keen that work should be done on organ donation, focusing on whether we should keep the present system, in which people have to opt in to donate their organs after death, or move towards a system in which people opt out of donation. Opt-out systems are in use in other countries.

The Scottish Parliament information centre has prepared a paper for us. I would like some clarification on two or three points in the paper and some issues that arise from it to be taken a little further.

After last week's committee meeting, all members will be aware of the time pressures on the committee's business. I would, therefore, like to know what course of action the committee wants to take. There is a range of things that we could do on this important issue: we could simply note the paper; we could make suggestions as to how its research could be extended and then brought back to us at a later date; or we could decide to appoint a reporter.

Dr Richard Simpson (Ochil) (Lab): When the issue came up, I was quoted in a number of places. I have been taking the matter forward independently of the committee. I am going to London to meet Nick Palmer MP, who has introduced a bill under the 10-minute rule in the House of Commons. Two bills have been introduced in the House of Commons.

I have also had some discussions with the British Medical Association and corresponded with some of the transplant associations and societies. I am keen that the committee should consider the issue for inclusion in its programme of work for next year.

Mary Scanlon (Highlands and Islands) (Con): Before we get drawn into a discussion on transplants, I would like to know whether we are legislatively competent to do so. The SPICe note says that the Scotland Act 1998

"does not say whether organ donation and transplantation . . . is reserved or devolved".

Before we go any further, let us determine whether it is a reserved power or a devolved power. According to the research note, we

would follow the normal procedure in establishing the legislative competence of the Scottish Parliament.

Can we do that before we go further?

The Convener: That is one of the points of clarification that I understood from the research note. We need to know whether we have legislative competence. If we have, we must consider the impact of having one organ donation arrangement in Scotland and another in the rest of the UK.

Kay Ullrich (West of Scotland) (SNP): I agree. We must know whether organ transplantation is a reserved or devolved matter. We should, assuming that the matter is within our remit, note the research paper and discuss it at another time. A discussion on this would warrant the full committee and an evidence session. It is an important issue, but we must clarify whether Parliament is competent to legislate on it.

The Convener: At this stage, we shall seek clarification on whether we have legislative competence on the matter. If there are any other points in the research note that members would like to discuss with or have clarified further by SPICe, they should let the clerk know. At this point, we shall simply note the paper. However, members will want to return to the issue at some point. I know that Richard Simpson is already doing some work on the topic. We can probably pull in the information that he has gathered when we come, as a committee, to do further work on organ transplants. We shall put the matter on the agenda for a later date. As Kay Ullrich says, it would be beneficial to take evidence because we know that many reputable organisations in the health service and elsewhere have different opinions on the subject. Is that suggestion acceptable to members?

Members *indicated agreement.*

Community Care

The Convener: We should now move to agenda item 2, but we cannot do so, as the witnesses are not yet here. Let us move instead to agenda item 4.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Can you alter a published agenda?

The Convener: The alternative is to sit here until somebody arrives.

Margaret Jamieson: I think that we will have to do that. I know people who will want to be present for consideration of the petitions.

The Convener: We shall check whether everyone has arrived.

Margaret Jamieson: Some people will not be here until 11.30.

Irene Oldfather (Cunninghame South) (Lab): Is it the case that the people from the Scottish Federation of Housing Associations are not here? Is that why we cannot progress?

The Convener: Not all the witnesses have arrived yet. Half of them are here, so we can go ahead with those who are here.

Good morning and welcome to the Health and Community Care Committee. Thank you for taking part in our inquiry into community care. I believe that you will begin with a statement, after which I will open the meeting up to questions from members.

David Orr (Scottish Federation of Housing Associations): Thank you very much. I want to thank the committee for giving us the opportunity to give evidence to it. I am David Orr, the director of the Scottish Federation of Housing Associations.

David Bookbinder (Scottish Federation of Housing Associations): I am David Bookbinder, membership and policy officer at the SFHA, with responsibility for community care issues. As I have also recently taken up an internal secondment as the housing bill officer, the committee might see me in a different guise in a year or so.

Andrew McKay (Port of Leith Housing Association): I am Andrew McKay, secretary of the SFHA's housing and community care forum. Until recently, I was the community care manager with Hanover (Scotland) Housing Association. I am now policy manager with Port of Leith Housing Association.

Hilary Spenceley (Margaret Blackwood Housing Association): I am Hilary Spenceley, business development director with Margaret Blackwood Housing Association. I am closely involved in the SFHA's housing and community care forum. When we made a written submission to the committee, I was chair of that forum. I also spent a year on secondment to Scottish Homes and was involved in producing its community care policy.

David Orr: Andrew and I will make some short introductory comments, after which we will be happy to answer the committee's questions.

One of the key points that we want to make is that although community care is often perceived to be about specialist housing, we are increasingly delivering a service that is based on care. The service is provided to people who live in ordinary housing, rather than in specially adapted or specially built housing.

The shift away from institutional and residential care is welcome and it is gathering pace. Much more of what we do is about people living in their own homes. For such a policy agenda to be successful, a number of things are required. I know that this is not a housing committee, but there should first be a strong housing investment programme. We must be clear about where the housing component of the agenda comes from.

10:15

Secondly, there must be clear and well-defined relationships between housing bodies, the health service and social work agencies. There should be properly integrated, three-way planning, although there have been great improvements in that during the past two or three years. Housing used to be an add-on to community care planning. The situation has improved, but there is still an assumption that health and social work are the key planning bodies and that housing bodies are of secondary importance. If the system is to be effective, housing must be integrated from the start.

Thirdly, there should be a proper understanding of the components of the service. In our discussion today we must consider two of those components. The first is housing—I do not propose to say anything further about that. The second component of the service is support for people in managing their housing and their tenancies. Previously, that kind of support was funded primarily by the Department of Social Security. There is care support—members of the committee will know the various mechanisms by which the funding of care has been delivered in the past.

Major changes in the funding of tenancy support are being considered through the development of the supporting people agenda. As a result of those changes, responsibility would, through the Scottish Parliament, be transferred from the DSS to local

authorities. In that way, the money that the DSS spends on enhanced housing management—such as that which we are discussing—will be disbursed by local authorities. The small amount of revenue support from Scottish Homes—in the form of the special needs allowance package, or SNAP—will become part of the total funding that is available to local government through Parliament.

Both of the Sutherland commission's proposals on funding of care support are critical. However, until those matters are sorted out, there will be some short-term turmoil and uncertainty. A particular problem is the lack of a clear Government response to the Sutherland commission's proposals on paying for care. We are engaged in examination of the detail of the proposals for supporting people, but until we have greater clarity from Government about a general policy on paying for care, it is difficult to see how we engage in the debate.

In our view, the supporting people proposals are a clear attempt to rationalise funding structures. However, a number of key issues need to be incorporated for the proposals to be successful. First, the funding should be ring-fenced, so that when the Parliament disburses it to local government, the money is used for the purposes for which it was originally intended. To ensure that, there needs to be effective monitoring and tracking. However, members should understand that the money must be inflation-proofed. In standstill local government budgets, we are anxious about how to ensure that basic costs are inflation-proofed.

Given the nature of the programme, we advise that there is likely to be demand for its growth. We need to be clear not only about funding structures for years 1 and 2, but about what will happen in future years, so that there is a degree of certainty in planning.

We also need to be clear about what constitutes housing support and what constitutes care. If members wish, we can advise the committee of schedules that make the distinction between the two. In the agenda that is being developed for the Scottish commission for the regulation of care, the ways in which the various components are regulated will be critical. The work on separate housing support standards is particularly important and that will be carried out through a working group that the commission will establish in due course.

Those are the areas that we are particularly concerned about. Andrew McKay will discuss some of the issues concerning practitioners.

Andrew McKay: I am sure that housing association practitioners are no different from the rest of us, in that we are concerned about the dignity of people who are affected by disability and frailty and about the choices that are open to them. We want people to be able to remain in their own homes, wherever that is possible and practical. However, that is often not happening, particularly with older people. The number of people who go into nursing care is still high and—from a practice point of view—we see a fairly confusing funding picture for people whose care is provided in their own homes. The provision of community care services varies throughout the country. We want a simple funding situation, in which care is affordable and available—preferably free—to all those who need it, regardless of whether the care is delivered in a residential home or people's own homes.

We therefore support the implementation of Sir Stewart Sutherland's recommendations and we urge that the costs of care, especially care at home, be taken into account, focused on and provided for—according to need—from the public purse.

We share a big responsibility in working with local authorities and others to co-ordinate what we do, for example in housing support, which will be covered by the supporting people initiative. We need to dovetail that in a meaningful way with personal care services. I hope that the practice examples in our paper show that we can do that and that co-operation rather than competition can provide cost-effective services that people will appreciate.

Kay Ullrich: Thank you for coming along today. You have highlighted the major problems that have been raised by other organisations. Implementation of the Sutherland report is, essentially, the way in which we can move forward on care in the community.

The emphasis always seems to be on residential and nursing care, but we know that what people really want is to remain in their own homes. You have also highlighted the problem of variations, depending on the local authority, in delivery and cost. Those issues simply must be addressed.

You also pointed out that the housing side has been the poor relation in the mix of community care professions—we tend to think more about health and social work services. You indicated that that situation has perhaps improved recently. How has it improved? Where there has been a merger in a local authority between housing and social work remits, has that improved the position of housing as a member of the team? Some places now have a director of housing and social work.

David Bookbinder: The merging of housing and social work is one of the reasons there is better co-ordination. There are obvious examples, such as the hospital closure programme, in

which—certainly in the latter stages—the commissioning of housing has been crucial. The teams that are responsible for re-provisioning for people who come out of the big institutions have had to liaise properly at a very early stage with housing providers—both the local housing authority and housing associations. The hospital discharge programme has improved relations, at least latterly. It has had to, because houses have had to be found for people.

There is other encouraging evidence of joint working. One example is where people, whether they are council tenants or housing association tenants, require adaptations to their property. That requires partnership between landlords and the occupational therapy part of hospital social work departments or local authority social work departments.

Increasingly, protocols are being developed between housing providers and the occupational therapy service to get assessments for people quickly, within an agreed time scale. That is another example of better co-operation.

Kay Ullrich: The provision of aids and adaptations has been an on-going problem for a number of years. I know from my professional background that the real problem is the shortage of occupational therapists and the consequent waiting times. Have you any evidence that the situation is improving?

David Bookbinder: It is patchy. There are areas where our members say that getting a visit from an OT is not a problem. There are other areas where members say that the OT service is far too hard-pressed and tenants wait quite a few months for a visit to assess their circumstances, never mind to apply for funding and so on. I wish I could say that there was no evidence of a shortage of OT services, but there are areas where our members tell us that it takes a long time.

Kay Ullrich: OT services in hospitals are crucial for moving people into appropriate accommodation after a hospital stay. What is the situation regarding assessments by hospital OT departments?

David Bookbinder: As far as I am aware, the worst problems are with social work occupational therapy teams, which are hard-pressed.

Kay Ullrich: Are those community based?

David Bookbinder: More often than not. The problem is not so much that hospital assessments are delayed, but that the housing solution may not be available. My colleague Hilary Spenceley may want to add something about that, because of the client group with which Margaret Blackwood Housing Association deals.

Hilary Spenceley: We have experience of acute hospital beds being occupied inappropriately by people for more than a year after they are ready for discharge simply because appropriately adapted housing is not available in the community. That goes back to David Orr's point about adequate capital resources for housing, whether for new-build, refurbishment, remodelling or adaptation.

Kay Ullrich: I have spoken about the merger in many areas between housing and social work. The other component is health. It has been said that relationships between housing and health have been problematic. What kind of difficulties have you experienced in your dealings with the health service?

Andrew McKay: There are no particular difficulties at practitioner level. What is sometimes lacking is the structures that let health colleagues meet housing colleagues regularly.

At another level, there are practical issues. Recently, for example, we reached agreement with the health trust to provide a community mental health service from one of our housing developments. For that to happen, there had to be an agreement from the district assessor about the rental that people were allowed to pay, which had to come to central services in Edinburgh. In structural terms, although the practitioners in the trust wanted the project to happen, it took a long time to go from them making the decision locally to the district valuer taking a view on what was essentially a simple problem about how much people should pay per square metre to the association in rent.

People are working hard to come together and some of the most innovative schemes involve community health linking with housing. In future, we will see services being delivered from housing developments. However, practical difficulties can still arise, as in the example I gave.

David Orr: There is a further structural problem to do with budgets and budgeting. There may be agreement in principle among three different agencies that a new service is necessary and on how it will be paid for, but come February, when the nuts and bolts of the budget are being debated, one of the partners will say, "We have had to take that out of the budget." Again, these are not practitioner issues. They are structural issues about priorities and lead to considerable uncertainty for the people who need to use the service and for the landlord, who might have a building developed on the understanding that there will be a care and support package only to find that a key part of it disappears at the last moment.

10:30

Dr Simpson: Have you been party to any resource transfer of funds from the health boards, or do you rely totally on it coming through the local authority?

David Bookbinder: A lot of the provision that housing associations make is as a result of resource transfer moneys from the hospital closure programme. That is quite widespread. Sometimes, general housing associations make available a few houses for people who have care services coming in.

Dr Simpson: Are those long-term contracts?

David Bookbinder: Yes. One of the key areas of concern that has come out of Professor Petch's recent work with Scottish Homes on the housing aspects of the hospital closure programme is that, while the decommissioning of hospitals might, for instance, result in four or five people with learning disabilities sharing a home together, no provision has been made for what might happen a few years down the line when one or two of them feel ready to move into a house of their own or with only one friend. There is a certain anxiety about short-termism and whether the funding that was available through resource transfer will be available when people have the confidence to move on.

Dr Simpson: Would the resources be held by the health board and released to you under contract? What happens with the local authority? As you know, the money is transferred and the local authority determines how it is used. Although the health board is, technically, still responsible, the Accounts Commission has told us that the health board is unable to see what happens to the money.

David Bookbinder: Day-to-day control of the money is the responsibility of the commissioning body, which is usually the social work department.

Dr Simpson: Would you like resource transfer money to go directly to housing associations on a long-term basis?

Andrew McKay: That might be appropriate. A number of things should work together to create a clear and transparent funding structure. It would be welcome if that involved resource transfer from health. We have got housing support elements that we have provided and that have been provided through housing benefit. Those will have to dovetail with the social services' personal care budgets that local authorities have.

I worked on one development where there was a contract based on the money that was transferred from health across to social work. That resulted in our getting a 10-year revenue contract with the local authority. The people for whom that money was transferred will have gone by the time that the 10-year contract is up. The future probably involves good-quality care at home. Complex packages that allow people to stay put should be developed. The thinking has moved on a little bit since the process was seen to be one of replacing a bigger institution with a slightly smaller one. Once that contract is up, we have to consider how to get money into good-quality packages at home.

That issue returns to the Sutherland recommendations about paying for care. Older people will not understand where the money for an intensive care package at home will come from. They might not understand what they and their family are expected to pay. That lack of knowledge makes it more likely that they will decide to move into a residential home, which is an inflexible and expensive resource.

Once we have provided housing that has perhaps been facilitated by resource transfer and by these contracts, we would like good, innovative packages to be put in place, in which the agencies work together. That would involve people deciding to stay in their own homes and being allowed to do so. If qualified practitioners such as ourselves find the current structure of funding confusing, how much more confusing must it be for people who are trying to make sense of it for their families at a time of stress?

Kay Ullrich: To clarify the situation, resource transfer kicks in where wards or hospitals are being closed. Mainly, it concerns people with learning difficulties and so on, but does not have an impact on elderly people, who are dependent on local authority funding to move from hospital to more appropriate circumstances.

Andrew McKay: I can only speak about the example in which I was involved. There was an accounting practice whereby money was transferred from health to social work as the beds closed. That money was then used to form a contract with a housing provider. Once the contract period is finished, one has to examine arrangements for the future. Six or 10 years on, the people who benefited from the transfer will perhaps have died. It is the people who come after who are important. There will be a generation coming after that, traditionally, would have gone into long-term hospital care. Through adapted housing and proper care, managed in suitable packages, we are trying to remove the requirement to choose a hospital or nursing home as the first port of call. We want clearly funded arrangements for care and good co-operation between housing, health and social work so that we can make that case to families and individuals.

Kay Ullrich: On resource transfer, it has been raised in evidence that there are huge differences between the health boards. A bed can be anything

from £8,000 to £32,000. Do you have any evidence of wide variations in the amount that is transferred? I see Hilary Spenceley smiling at that.

Hilary Spenceley: It is a question of scale and the number of beds that are closing. Is a whole ward closing? Are people being discharged as part of a big closure programme or on more of a drip-feed basis? It is right to say that resource transfer is patchy across the country.

I would like to address the issue of capital funding, because resource transfer is all about revenue funding. Some health boards have been very flexible in the use of capital funding to make things work and have been willing to put money on the table to allow housing providers to be flexible and get projects off the ground. Other health boards have not been so flexible.

Essentially, we want good joint working and joint use of budgets. To pick up on what Andrew McKay said, it is important that once money is transferred, it is ring-fenced and can be used flexibly so that provision can change over time. Quite a bit of residential provision is still being developed. It is possible that large institutions are being replaced by smaller institutions, which, unfortunately, may have to close in five or 10 years. It is important that revenue funding should be available in future and that it can be used flexibly.

Irene Oldfather: I am very sympathetic to your suggestions about ring fencing, but I am also aware that local authorities and health boards do not like money to be ring-fenced. What are your views on that?

David Orr: The starting point for us is that the money that is currently paid in housing benefit through the Department of Social Security and the money that is paid by Scottish Homes in the special needs allowance package is specific. We know exactly where that money will go and it is all tracked and traceable; indeed, many housing associations complain about the amount of bureaucracy that is involved in tracking that money. It would be very unfortunate if that money, which is already insufficient, were repackaged and delivered in such a way that there was a possibility of leakage. We are aware of the pressures on local authorities and the demands made on their resources, but when there is a clear resource transfer from one organisation to another to deliver the same service but to do so in a more coherent way, that needs to be identified as clearly as possible.

Irene Oldfather: Thank you. It is helpful to put that on the record. My question is about the barriers that housing associations face in the provision of housing for people with special needs. Your introductory remarks and the comments that you have made have pointed us in the direction of a number of issues, such as structural and planning issues, joint working between agencies and the effect that that can have on inflation proofing and ring fencing of moneys. Are there other issues that you have not already covered that you want to draw to the committee's attention in relation to barriers?

Andrew McKay: The main barrier is that the funding for people who wish to stay at home in a tenancy-based situation is complex and needs to be sorted out. I hope that from the examples in our submission we have shown that we can help through sitting down with local authorities and managing the process of who does what to make sure that the support that people need in housing developments is efficient and effective. We have a responsibility to do that, as do local authorities.

Sometimes you can ensure that things are done better, and in that way you can make savings on costs that are not just savings on price. You can make sure of that by working together more closely, but to do that, you need a commitment to the partnership from both the local authority and the provider. There are a number of examples in our submission that show that that is possible. It happens at the moment through working round the complex funding structure. It would be much more effective if we could draw on a clearer funding arrangement.

Irene Oldfather: I appreciate the appendices that you provided, which give good examples of joint working and partnership. Do you have any examples of failures in the system when that has broken down? One of your colleagues mentioned someone being inappropriately placed in care for a year. Do you have any other examples? For instance, you provide housing. Do you find that sometimes the care package falls down once people are rehoused?

Hilary Spenceley: That has been an issue. If you like, I am sure that we could produce some illustrative examples.

Irene Oldfather: That would be helpful for the committee.

David Orr: We can do that, and put together a little package of some of the details behind the issue as well.

The Convener: That would be helpful.

Andrew McKay: When capital is available from Scottish Homes and when we are able to work jointly with local authorities, it seems like those who get allocated houses are the lucky ones. We are well aware that the failures may be the many who are not lucky enough to get allocated to the success stories that we have highlighted. There are still people who end up going into large-scale

nursing homes who might not choose that, or who go into hospital when it is not appropriate. Perhaps we should look at those if we are looking at failures.

Irene Oldfather: For most elderly people, their aspiration is independent living in their own home, but that will only work if you have the additional care that is required as well as the housing. I am aware that you have established a good reputation in your housing associations for providing those special needs houses, but that has to be pursued in partnership with care. It would be interesting for us to know about examples that have worked well, but also to know about examples where there have been difficulties and barriers.

David Orr: Okay.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I would like to address the proposals for supporting people. That was an important part of your presentation and you have covered it in some depth already. I agree with you on ring fencing, but I wish to explore it further. Ring fencing seems to have been going on for a long time. I remember being in committees and discussing this issue straight after the 1997 election, and now we have a date of 2003. What has happened in the transitional period? I know that you said then that there was housing waiting to be occupied and that it would no longer be able to be occupied. Has that happened, or have you had protection in the interim period?

10:45

David Bookbinder: One key step that has happened in the past few months is that from 1 April this year the transitional housing benefit scheme has come into being. It is a three-year tideover until the money is transferred to local authorities in 2003. That has the potential to end what was, as you said, ineffective and a blight as providers were unable to make new provision, because the money was not there for the tenancy support that they might have wanted to provide. It is now fundable if, for example, an organisation wanted to set up a visiting support service for young, formerly homeless, people who are in their first tenancies and might be struggling to keep those tenancies going. That sort of service could be established and funded by the transitional housing benefit scheme. In 2003, the money will be transferred to the local authority. That has been a welcome step.

That is the first thing that has happened. Secondly, we are in negotiations with the Executive to develop the long-term proposals for the transfer of grant. It is a joint working effort with the local authority bodies, Scottish Homes, housing associations and the voluntary sector. The aim is to ensure that the transition in 2003 is as smooth as possible so that it does not worry or cause undue distress to people who receive tenancy support services—whether in supported accommodation or ordinary housing—and ensures that there is no disaster on 1 April 2003 that means that someone's funding ends on that day. Steps are being taken to ensure that that does not happen.

Hilary Spenceley: There is the same issue about planning blight on the horizon in 2003, unless growth funding is addressed in the supporting people scenario.

Malcolm Chisholm: I was going to ask about that. In a sense I agree with you about ring fencing, that growth is what is required, but are you confident that there will be no leakage, as it were, so that by the time it is transferred everything that was covered by the previous regime will be covered by the transfer? I suppose that the immediate question is whether the interim arrangements cover everything that has been lost so far.

Andrew McKay: The interim arrangements are fine and have been welcomed. We have moved from a situation where an individual's right to the money through housing benefit has been replaced by a system of a specific block grant. Any growth caused by the aging population, increase in disability and so on will have to be taken into account by the new grant, because of the different mechanism. There will be opportunities, when the money is transferred, to move towards a more simple funding mechanism, but there will also be threats in that the total pot might be less and may be shrinking.

There will be an onus on us to work responsibly and sensibly with local authorities to make the best use of that money. While we are doing that—and as David Bookbinder said, we are working closely with the Executive to make the transition smooth—at the back of our minds is a concern that the overall pot that is available might shrink, because of the way that supporting people funding will become a specific grant. Local authorities will have to examine that. An incremental increase for us in staff costs, for instance—the cost of living can easily take us to an increase of 2, 3 or 4 per cent—and what looks like a generous increase in overall grant can result in services being constricted. We have that concern, but a simplified funding structure is what we are asking for. We think that supporting people has the potential to do that, if we can work with it.

Malcolm Chisholm: You are worried about a shrinking pot. Obviously this relates to how housing budgets are going but, in that aspect of the housing budget, would you say that it has not been a shrinking pot over the past three years, or

would that be going too far?

Andrew McKay: We have welcomed the guidance on the tasks that have entitlement for the eligibility for the transitional housing benefit. That has included most of the tasks in housing support that we have been carrying out. The protection has been there.

Malcolm Chisholm: So everyone is getting the support that they had before. What about the number of people who are getting support? Is that the issue if the pot shrinks? Would it mean less support or fewer people getting that support?

David Bookbinder: We are confident that everyone who is currently getting tenancy support in one way or another will carry on receiving that support after 1 April 2003. No changes are likely to be made to the support that people receive until the local authority has carried out a full review of that service. There will be protection mechanisms. Our real worry is about what will come after.

For example, earlier we talked about hospital closure programmes. There will be cases where four or five people have been living in a care home, receiving about £300 a week each in care funding. If they move on to their own tenancy, the care funding is unlikely to follow them. What they might need is a much more modest amount of tenancy support, say, £70 or £80 a week. They may still need care, but that extra input of tenancy support would be sought through the supporting people programme. That would be growth, which is clearly needed, although not clearly available.

David Orr: The key problem is that, at present, housing benefit is an entitlement—if a person fits the criteria, they get the benefit. That means that if there are 10 people who are entitled to housing benefit this year, at a cost of £100, that is the amount of money that goes to the local authority. However, that is to become a grant; it will become a fixed sum of money. That means that it will be £100 next year, even if there are 15 people who require support, whereas currently, if 15 people required that support, they would get the money because they were entitled and housing benefit is not cash limited.

The transfer from a system that operates as entitlement to benefit to a system that operates as access to a grant may mean that a cap is put on the total amount of funding. That would not reflect projected need, but would simply reflect the amount of money that was being paid in the year in which the transfer took place. I am anxious that, in due course, there will be a squeeze on the amount of funding available for new projects of the kind that David Bookbinder has been talking about and, more generally, as demand grows. We have had standstill local authority budgets for the last two or three years. Growth in the context of a standstill budget is difficult to deliver. There are some important unanswered questions about how any growth in demand might be met under the new arrangements.

Malcolm Chisholm: That was very helpful.

Kay Ullrich: I am a wee bit concerned about the security of tenure for people who are moved into housing because they have special needs. They will have contracts that are nothing like tenancy contracts and which may stipulate that they should be out of bed by 10 o'clock in the morning and so on. Could you explain why they do not have the same security of tenure?

David Orr: Increasingly, such people have the same security of tenure. There are some restrictions. However, the advice that SFHA gives its members is that everyone should have a proper assured tenancy agreement, or its equivalent. There are particular circumstances where that is not the case. I can go into detail on that if you like. However, there is an increasing use of proper tenancy agreements, rather than occupancy agreements or other, less formal arrangements.

Kay Ullrich: Could you put something in writing on that matter?

David Orr: Certainly. It is quite a detailed issue.

Kay Ullrich: That would be very helpful.

Dorothy-Grace Elder (Glasgow) (SNP): Just before I go into question 5, I would like to say that I was pleased to hear what David Orr had to say on housing benefit and the possibility that there will be no automatic benefit entitlement in future. That was a key point that the lenders who appeared before the Social Inclusion, Housing and Voluntary Sector Committee made in connection with the Glasgow housing stock transfer. They pointed out that 80 per cent of Glasgow tenants are on benefits and that, if anything happened to threaten those benefits, the deal might be threatened.

The Convener: All right, but can you move on to the question?

Dorothy-Grace Elder: Yes, I will—but that issue is crucial to sheltered housing, too. Could the witnesses outline any recent developments in design that are relevant to the housing contribution to community care? Could they also comment on the location of sheltered housing? To boost schools, some authorities have a policy of encouraging only young families into certain areas—areas that may also be near shops, for example. Older people are rather cut out.

Andrew McKay: We have increasingly seen the building of barrier-free housing—we have come to call it very sheltered or extra-care housing—which can be used by people who are even more frail

than people in sheltered housing. Such barrier-free housing is characterised by wheelchair-accessible bathrooms with wet-floor areas and showering so that people can, with the help of community nursing and personal care, stay put. Helping people to stay put has been a key issue of late in sheltered housing. In the past, people have had to move on because there was not enough personal care and because certain aspects of the design were not appropriate. The vast majority of the sheltered housing that has been built in the past 10 or 12 years has been barrier free and appropriate for people as they develop physical disabilities.

Your point about proximity to facilities and shops is well made. Associations that build sheltered housing always try to get sites that are close to bus routes and shops so that people are encouraged to stay mobile and so that their families can visit.

Dorothy-Grace Elder: That is not so easy in certain authority areas. Some authorities have policies for areas into which they want to bring young couples to boost the schools. That is perfectly natural. However, areas with a lot of shops and facilities are absolutely ideal for the elderly.

Andrew McKay: Those are prime sites.

Dorothy-Grace Elder: The elderly have fewer cars, which causes fewer problems.

Andrew McKay: I agree.

The Convener: David Orr said that there were variations across the country in the funding system and support for capital investment. Could our witnesses give us some more information on that variation and on the support for adaptation projects and capital investment across Scotland? Where is the money coming from?

David Bookbinder: One of the key pieces of feedback that we get from members—I suspect that my colleagues may wish to supplement this—is that the provision of housing, and especially new housing, in any one area is very patchy. A lot of the community care programme uses existing housing, which is fine, but there will always be a need for new housing—not least because the new housing provided by housing associations is generally built to barrier-free standards. Inevitably, the capital resources that we would all like to see are not available through the Scottish Homes programme. That means, for example, that people who come out of hospital do not always find that there are developments in the areas that they come from and would like to go back to. That has held up the chances of people moving to where they would like to move. I know that that is a problem that the Margaret Blackwood Housing Association has come across.

Hilary Spenceley: There are conflicting priorities across the country for funding from Scottish Homes. Much of that funding is going into urban regeneration, which is not necessarily the best location for housing for people with particular needs. Scottish Homes recognises that there can be provision of such housing elsewhere. However, priorities must be balanced and those of us who are especially involved in community care are not always seen as a priority. It is welcome that Scottish Homes has agreed to give priority to funding adaptations, but the theory and the practice differ around the country.

11:00

David Orr: May I put this issue in context? At the time of the 1997 general election, the forward-planned housing budget in Scotland was about at its lowest, in real terms, since the war. Last year, the development programme of Scottish Homes was the lowest in the 10 years of the organisation's existence—it is marginally higher this year. Public sector investment in housing generally is at historically low levels, although some additional investment has been made in housing, through the new housing partnership programme predominantly and in one or two other areas, such as the very small increase in the development programme.

That situation has consequences, one of which is that, in each area, local authorities and Scottish Homes are considering how to divvy up a relatively small cake. Specialist housing, aids and adaptations must take their place in the queue. Each of the five Scottish Homes regions is responsible for its own budget for aids and adaptations. That budget may be small in some areas and considerably larger in others, depending on how the regions assess the local priorities. Likewise, local authorities determine their aids and adaptations budgets and—inevitably and absolutely understandably—those budgets tend to focus on local authority housing stock. Accessing money to provide aids and adaptations is a genuine problem, because the basic capital funding is not in place, even though those items do not cost much and could make substantial long-term savings.

The Convener: From the anecdotal evidence of people at surgeries, or from letters and so on, we know of situations where people are being kept in a hospital bed for the want of a stairlift or adaptations made to a bathroom, which involve relatively small amounts of money. A hospital bed for one week can cost more than the adaptation that is needed to get people back into their own home and with their own family.

You talked about funding from Scottish Homes and the situation in which local authorities find

themselves. I concur with your comments that local authorities will, understandably, tend to put money into their own housing stock.

What is the private take-up of aids and adaptations? Is that a growing issue? Are people realising that, unless they pay for those items privately, they will not get them?

David Orr: I think that the answer is yes, although—

The Convener: Is there a hidden issue? Are people paying for items privately because they do not think that they could get them from Scottish Homes, local authorities or other sources?

David Orr: I suspect that the answer is yes, although I do not know whether my colleagues have any evidence to support that suspicion.

David Bookbinder: There is certainly some supporting evidence from those of our members that operate care-and-repair projects. As committee members may know, those projects are aimed primarily at older people who own their own houses. There is some evidence that the chances of getting adaptations money from local housing or social work departments are poor. That is particularly the case where, because of the authority's hard-pressed resources and the balancing act that it must perform, there is a greater tendency for it to prioritise funding adaptations for its own tenants, rather than those of private owners, as David Orr said.

Lack of awareness may be an issue in some cases, although I think that care-and-repair projects are good at highlighting where people can get help. There is some evidence that there is not enough money to fund adaptations for private homeowners.

Ben Wallace (North-East Scotland) (Con): I have visited the care-and-repair organisations—there is one in Aberdeenshire, one in Glasgow and one in Perth. Could you expand on the value of broadening that service? From what I have seen, the provision of care and repair is too patchy. Some local authorities use it, whereas others do not—in some authorities it does not exist. Is there a role for care and repair to play in the future, perhaps within a larger, more co-ordinated organisation?

David Orr: Yes, care and repair could play an expanded role. A national strategy has begun and the wish has been expressed that there should be at least one care-and-repair service in every local authority area in Scotland. We are getting closer to that, although we are not there yet.

The structures that care-and-repair organisations have set up could be used more widely. The decision of the Executive and the Convention of Scottish Local Authorities to set aside care-and-repair funding—I think that the term "joint priority" was used—and to ensure a degree of tracking of care-and-repair funding has been helpful. There has been some growth and care-and-repair services could be expanded further.

Dr Simpson: So there are separate pots of money for local authority tenants, housing association tenants and private tenants.

David Orr: Care-and-repair funding is local government money that is agreed with the Executive and channelled through care-and-repair agencies to provide assistance to elderly owner-occupiers. Aids and adaptations funding for housing association tenants and local authority tenants comes from elsewhere.

Dr Simpson: That is the point that I wanted to make. Do you think that, rather than our having different pots from which funding is issued, the priority should be assessed need, wherever the person comes from? In my constituency, last year, although there was money left in one of those pots and demand in another area, there was no possibility of transferring the money. People were waiting on one list and not waiting on another list, but we could not get the money into the right place. Is there not a crying need for the different areas to be jointly assessed and for the care-and-repair budgets to be channelled through a joint grouping or a single fund?

David Orr: There is no doubt that there must be improved co-ordination, although I am not sure whether a single fund is the best mechanism. The responsibility of landlords to maintain their stock is different from the responsibilities that a local authority has to provide grant support to elderly owner-occupiers. More work needs to be done on the specific delivery mechanisms. You are correct to say that, on occasions, one pot is empty and another is overflowing, but there is no coherent way of putting the two together—that is nonsense.

Dorothy-Grace Elder: Could I make an additional point, convener?

The Convener: No, we must move on. Margaret Jamieson will ask question 7.

Margaret Jamieson: I am aware of some of the innovative planning work that is being undertaken by housing associations. In my constituency, Horizon Housing Association, the local health board, the primary care trust and the local authority have designed housing that will open up channels for a significant number of individuals with special needs by allowing them to be discharged from hospital. That has long been in the pipeline in Ayrshire, but the level of barrier-free in that development has not been replicated throughout Scotland, as far as I am aware. Could we replicate that template throughout Scotland?

Should we also encourage private house builders to start thinking about where they position sockets and light switches, and about the height of toilets, so that in future less adaptation is necessary if someone becomes disabled or their dependency increases? That way, budgets for aids and adaptations would no longer be necessary. I know that I have covered a number of questions, but I thought it worth raising these issues together.

Hilary Spenceley: There have been welcome changes to the building regulations that will require new housing, except in exceptional circumstances, to be visitable.

Margaret Jamieson: I knew that there was a word, but I could not remember it.

Hilary Spenceley: Those changes may not go as far as some of us would like. Margaret Jamieson makes the important point that barrier-free housing is not adequate for the needs of some people. There is no doubt that more specialist housing needs to be designed so that people who use wheelchairs can make full and independent use of it—so that they can cook, bathe and so on.

David Orr: I remember having a discussion with the sales director of a major building company in Scotland about barrier-free design. That person told me that, if the company spent £500 on installing a kitchen, it could add £1,000 to the cost of the house. If it spent £500 on making accommodation barrier free, that money was lost, because it could not add anything to the cost of the house. From the company's perspective, that is a problem, but it is also a ridiculous situation. The reason that barrier-free costs more is that it is deemed to be non-standard. If it were standard, it would not cost any more. We need to ensure that barrier-free becomes a standard house design. If we do that, it will not cost any more and life will be much easier, not just for people who use wheelchairs, but for the mother with a double buggy trying to get in. It is ridiculous to have doors that are not wide enough for a double buggy.

Margaret Jamieson: Or too heavy to open.

David Orr: Exactly. Some basic things could be done that would not cost money, if we could only change attitudes.

Margaret Jamieson: Can your associations provide an alternative model of provision to the traditional method of residential and nursing homes? I know that you have small pockets of such provision, but can they be widened?

Andrew McKay: Yes. In one of the appendices to our submission there is an example of people moving, with the help of the local community council and local families, from an existing well-loved residential home that was due to close into new tenancies where day care and community health services are provided on site. That means that people have gone from being looked after to having their own tenancies and all the rights and responsibilities that go with that. The association has helped people to become tenants once more, and the local authority is providing the care.

However, as we have heard, Scottish Homes provides housing associations with a limited amount of money. To prioritise a scheme of the sort that I have described, the council has to put on hold its programme for family and other types of housing for the area concerned. Not all councils have the money to make a strategic decision to move people from an existing residential home that is seen as aging and unsuitable, and may not be people's first choice, into lovely little tenancies that are barrier free and have all the facilities that we have talked about. If all housing were being built to barrier-free standards, such tenancies would not go only to the lucky few, but to the many. However, there are a number of good examples of smaller projects similar to the one that I have described.

Margaret Jamieson: Are there no other ways in which they could be financed, such as through a public-private partnership?

Andrew McKay: For housing associations to build housing with rents that are affordable, they need grant from somewhere. If they did not get that, they would have to charge a market rent. Increasingly, however, housing associations are using their own resources and are resorting to creative ways of raising money through lenders—building societies and banks. About a third of the funding for the scheme that I described came from the association, a third came from Scottish Homes and a third came from the council. That is how progress can be made.

11:15

Margaret Jamieson: Is there no opportunity to educate companies such as Barratt, Wimpey and Stewart Milne about what the needs are and what can be provided?

Hilary Spenceley: Several associations, including mine, are working with builders to adapt standard house designs. We would like houses to be provided in the private sector, so that owner-occupiers can have a suitable house and can access flexible care packages. We also want house builders to provide rented housing in partnership with housing associations.

Mary Scanlon: Mr Orr, could you clarify the difference between housing support and care?

David Orr: There are detailed schedules to

explain that but, basically, housing support covers the things that enable people to manage their tenancies. That includes understanding budgeting, paying the rent and other basic housing management issues. Most of us manage those things on our own without any support, but some people require external support to be able to cope. What we call care covers more personal care support services.

Mary Scanlon: On page 1 of your submission you make three points, the first of which concerns the provision of housing and making arrangements for care with another agency. The second point concerns housing and related services, where care is provided by social workers. The third point, as I understand it, covers provision of housing support and care. Some housing associations provide care, have staff who provide care and extend that to provide care services in the wider community. What would be the advantage of a tenant having a housing association that provided care staff and care services? Do you feel that it is better for the client, the patient, or whatever we call them, to get those services from you instead of from others?

David Orr: A small number of housing associations in Scotland have developed as housing and care agencies and have the necessary expertise in delivering services. They are able to provide the complete package and they provide a good and supportive environment for people to live in. A larger number of housing associations have real expertise in housing and housing-related support services but do not have expertise in providing care and do not wish to develop that expertise. They prefer to contract with the local authority or other care agencies to provide that care.

The most important thing is that the necessary expertise is available—whether that is directly from the housing association or through a contract is less important. Where it is possible to provide the whole package, there is a co-ordination of approach that works well.

Mary Scanlon: I knew about housing support, but I had not thought of housing associations as providing care services. Is there an example of good practice in that in Scotland?

Andrew McKay: There are several. The Craw Wood dementia project in the Borders, run by Eildon Housing Association, is a good example of joined-up care and housing. It was provided when a long-term psychiatric ward for older people was closed. There are other examples throughout the country.

The trend is towards separating housing and care, with housing support, housing management and accommodation being provided by a housing provider. The people in that accommodation get their care from a number of sources—it could be the local authority, their own or another housing association, or a third party. Some people think that that is a better arrangement, because the individual can sack their care provider without putting their tenancy under threat. They therefore have more choice. Although that is a good idea where it works well, there are advantages in having housing and care together, as you point out.

Mary Scanlon: On the theme of partnership, are any of your housing associations involved with the local health care co-operatives?

David Bookbinder: That is a developing area. The only evidence that I can currently give you is that some of our members have found that local health care co-operatives have become involved in local housing and community care forum meetings about adaptations or a new-build project. However, it is still early days for such relationships and I do not have any firm evidence.

Dr Simpson: I want to ask a supplementary. As you know, my concerns centre mainly on joint working. In the example of the Eildon Housing Association, staff were transferred from Dingleton hospital; I was glad to see that you received advice on the matter from the dementia centre at the University of Stirling, which is in my constituency.

My concern is that, although in the past there have been superb developments of sheltered or support housing, the primary care sector has not been advised of such developments until well into the scheduling. There was no recognition of the fact that, sometimes, there has been a significant impact on primary care and community nursing. For example, there are some very good Margaret Blackwood housing developments in my area; however, after the first was built, we suddenly realised that we should have considered the issue earlier in the process. Is there a requirement on the local authority as part of the planning process, or on the housing associations as part of their development, to consult the area LHCCs—or what were primary care teams—to ensure that there will be support for developments and that it will not simply be assumed that they are part of the normal primary care resource?

Hilary Spenceley: Although I am not aware of such a requirement, it sounds like good practice. We have experienced such situations throughout the country. As tenants choose their own general practitioner, a development's location might mean extra calls on a doctor's surgery, health visitors and district nurses. As a result, local authorities have talked about community occupational therapy.

Dr Simpson: That point applies to all areas of community care. Although residential homes are the same, there needs to be more joint planning on the allocation of resources to ensure that tenants are given adequate support from the health service as well.

Andrew McKay: I agree. In specialist associations such as the Hanover (Scotland) Housing Association development in Moray—which is mentioned in the appendix—there will be a steering group with places for a primary care and nurse care manager. Such provision has been valuable. Although it can be very difficult for doctors to attend, it is important for the practice nurse care manager to attend steering group meetings and to keep people appraised of what is happening.

Mary Scanlon: Can you offer an assessment of the value-for-money implications of different arrangements and partnerships? What would offer the best value for money and quality of service?

David Orr: It is difficult to say that one form of service delivery automatically, because of its structure, provides better value for money than another. Although a housing association with the expertise to provide care might provide very good value for money, if we said that that association provided the best model, that might lead to other associations without such expertise trying to develop it and providing a poorer-quality service with poorer value for money as a result. It is important to develop local solutions that bring together various properly planned components that are delivered by people with the appropriate expertise.

Mary Scanlon: I appreciate that, but we, as the Health and Community Care Committee, are considering the national, rather than the local, picture. We are looking to you to give us a lead on the best quality provision, the best working partnerships and the best value for money.

David Bookbinder: As housing providers, we are perhaps reluctant to comment on what is best value for money; it should be the users who do that. Take the example of five or six people with learning disabilities, who are living together following a hospital closure; it would be more expensive to provide three small flats, in each of which a couple of them live with a friend, than one group home. If, however, some years into their tenancy in a smaller, self-contained flat, you were to ask them what value for money means for them, they would say that it means the independence and empowerment that they get from having their own tenancy, rather than what sometimes happens, which is that after a hospital closure, people find themselves pushed into living with five or six others.

Irene Oldfather: Does the federation feel that flexibility and adaptability would be appropriate? Elderly people in particular can be on a plateau for quite some time, but can then take a bit of a dip. Flexible and adaptable provision could take account of that dip, and would mean that they would not have to move home because their accommodation could cope with their needs. If their arthritis got worse, they could still take a bath and so on. Would you find such principles useful?

Andrew McKay: Yes, very much so. I draw your attention to appendix 3 in the examples. Fifteen flats were provided to replace equivalent provision in a long-stay residential home that was costly and needed to close. Provision of the flats produced significant cash savings at the end of the day; that reflects your point. Not everybody needed the high level of intensive care that was available all the time in the home, yet the way in which the home was staffed and structured meant that the care was there all the time.

In the flats, there was housing support, which could activate a more intensive care package when someone required it. That support could be deployed elsewhere when it was not required. That is an example of doing things smarter rather than cheaper. That is what we have to aim for—working with the care providers, housing providers and colleagues, to take costs out of the system. It is not just about driving down price.

Hilary Spenceley: The terminology we are using now is person-centred as opposed to top-down. Our approach is built around the individual.

Mr Duncan Hamilton (Highlands and Islands) (SNP): This is an appropriate point to ask about best practice. You have described the need to have local solutions and flexibility. Presumably, that diversity does not mean that there are no minimum benchmarks against which the housing association's performance can be measured. I see the examples of good practice in the appendices—that is useful. The committee would be interested to know about the internal performance management of the housing associations that are involved in community care.

In your submission, under the section entitled "The Standards to which Housing Associations Deliver", the first point is

> "Performance Standards against which Scottish Homes assesses associations with sanctions for poor performance".

Will you comment on the specific targets or standards that are set with regard to the provision of community care? Do you think they have been successful? If not, what would you propose to add to those standards? What are the sanctions?

David Bookbinder: I will start by making two

comments about the standards. Last year, the Scottish Federation of Housing Associations, in conjunction with Scottish Homes, issued standards on the provision of supported accommodation and housing with support to all housing associations. One part of those standards dealt with the tenancy arrangements that we expect to be in place when making provision with particular support needs. The arrangements should generally not be inferior to those that any person who does not have support rights gets as tenancy rights.

11:30

We have all accepted that, where care provision, as opposed to housing provision, is made—a minority of housing associations are involved in that—and the care is independent and not provided in a registered setting, there has been a gap in regulation. That makes the forthcoming arrival of the regulation of home care, for all types of home care providers, very welcome. There was certainly a gap there.

We have issued detailed standards on supported accommodation. If a Scottish Homes performance auditor found—during a regular audit of an association's performance in a supported accommodation project—that the tenancy arrangement was not the maximised arrangement that it could be, and if an occupancy agreement was being used where the accommodation was long-term or permanent and we believed that an assured tenancy could be in place, we would expect Scottish Homes to exercise its range of sanctions. Ultimately, that could affect the association's funding. There are more drastic sanctions that would probably not be appropriate in that example, but funding is one of the key sanctions. If an association gets a poor grading, that can affect its funding.

Mr Hamilton: What exactly is the status of the guidelines? Are they simply guidelines, or to what extent are they enforced or monitored?

David Bookbinder: Minimum standards are clearly set out at the beginning of the guidelines that we produced last year. We would be delighted to send the committee a copy of those guidelines. The minimum standards are not for negotiation, and those are the minimum standards that Scottish Homes performance auditors would be considering. Thereafter, it is partly a simple matter of good practice.

Mr Hamilton: Thank you; that was useful. On a related question, what mechanisms are in place for the sharing of best practice information? There is a sense in which too much diversity can lead to a fractured system. Are the right mechanisms in place for discussion and a forum?

David Bookbinder: The federation's housing and community care forum plays a key role. The forum involves regular meetings not just of housing associations, but of a range of voluntary sector providers, such as the Richmond Fellowship Scotland and Penumbra, which is involved in supported accommodation, local authority housing departments or social work departments, and Scottish Homes people who are involved in the delivery of community care.

A few weeks ago, we produced an occupancy agreement for use in very short-term supported accommodation. The agreement gives people the minimum rights, even if they are staying somewhere for only two or three months. We have taken steps to get that agreement out to all kinds of voluntary sector providers, and to local authorities, which run short-term accommodation, rather than keeping it within the housing association movement.

Community care is so multi-agency. The involvement of as wide a range of other bodies as possible is very important.

Dr Simpson: Is stock transfer likely to have an impact on the general availability of housing for community care needs? Are there any other general housing developments that are likely to impact on the ability to respond to community care needs? I know that you have covered some of that on the capital side.

Hilary Spenceley: There are huge opportunities with stock transfer. One of the reasons behind stock transfer is to allow properties to be refurbished and brought up to a good condition. It is a great opportunity to do something about community care at the same time. I am concerned that that opportunity may be missed if the issue does not come higher up the political agenda.

On the wider picture, and on resources in general, there have been Scottish Homes programmes and local authority programmes; there have also been a number of challenge funding initiatives, including new housing partnerships and the empty homes initiative. However, I do not believe that enough has been done—although there are notable exceptions—to provide for people with particular needs through those initiatives. We need to bring the whole picture together.

Specific working parties are examining homeless people and what will happen after the transfer of stock from local authorities. It is important that we also address community care.

Dr Simpson: Are you saying that there is not a group looking at that at the moment?

David Bookbinder: Latterly, as well as looking at how homeless provision will be looked after

post-stock transfer, the federation has worked with local authorities to draw up a model contract for local housing authority community care responsibilities after stock transfer. For example, if a local authority is in the habit of making available 20 houses a year, scattered throughout the authority, to a particular voluntary organisation, so that that voluntary organisation can provide for people with learning disabilities, will that agreement be respected post-stock transfer? If such arrangements were to lapse after stock transfer, that would be a major blow for housing provision for the community care programme. We are looking at model contracts, which would tie the recipient landlord into respecting and, I hope, expanding such arrangements.

Dr Simpson: You have both referred to expansion. I agree entirely that the stock transfer provides an opportunity through a new refurbishment programme to upgrade standards of accommodation by, for example, using ground-floor flats to give proper access to people with disabilities and people in wheelchairs. That has not been tried before. Do you need a further mechanism? Do you need us to recommend anything to push that forward?

David Orr: There is a fundamental shortage of capital investment for new-build housing. Stock transfer and the new housing partnership programme, which involves some new build at present, will help by improving the quality of the stock, but that is not sufficient. There will be occasions when new build is required. Until we are able to increase the basic amount of funding going in, we will continue to have difficulties.

Andrew McKay: Receiving landlords will have to outline their plans for homelessness. It would be helpful if they were asked to prepare an equivalent statement about community care and people with disabilities.

Dr Simpson: That is helpful. Thank you.

Dorothy-Grace Elder: I assume that you are talking about mass housing stock transfer, not the usual transfer of fewer than 3,000 houses, which Scottish Homes would have handled in the past. I assume also that you are aware that a considerable number of people, in places such as Glasgow, are very concerned about the deal and think that it might be a disaster for the homeless, as well as possibly affecting care in the community—15,000 houses are likely to be demolished under the Glasgow plan alone, which happens to be the biggest one.

The Convener: Can we have a question, Dorothy-Grace?

Dorothy-Grace Elder: Are you looking at any alternatives to mass housing stock transfer, or are you totally committed to and enthusiastic about it, without studying the alternatives? Local authority control would save at least £200 million in VAT up front, which this deal will not.

The Convener: The question basically is, are there any viable alternatives to the stock transfer programme?

Dorothy-Grace Elder: The mass stock transfer programme.

David Orr: We have looked at lots of different ways of bringing as much investment into housing as we possibly can. The transfer programme creates an opportunity to bring in investment, which no other programme would allow us to do. If we try to separate the politics out of it, and consider the pragmatics, the stock transfer programme could lead to an investment of £3 billion or £4 billion in poor quality Scottish housing. To that extent, we are supportive of it.

However, SFHA does not have a policy line that says that mass stock transfer or partial stock transfer is the only way. Our view is that transfer, where it provides enhanced housing solutions, is worth examining, exploring and taking further. Because we recognise the impact of some of the transfers, we are looking with COSLA and the Executive at detailed model contracts on a whole range of different areas—allocations policy, the provision of housing for people with particular support needs, the way that housing benefit is managed and so on. There will be six or seven such contracts.

We are trying to put in place an infrastructure that will take the expenditure and the development of the quality of the housing stock, and support within that the other housing programmes, which need to be supported.

The Convener: Okay. Kay Ullrich has another question.

Kay Ullrich: Will this be the final question?

The Convener: There will be a supplementary to it.

Kay Ullrich: My question concerns nimbyism, which is always a problem when housing for people with special needs is being established. Are there any measures that may help that you would like to be implemented?

David Bookbinder: The extent of nimbyism should be reduced as the number of large projects reduces. For instance, where people with a history of mental illness are being housed in scattered tenancies, one would not expect the community to be involved. Often, communities focus on the areas in which a visible project is being built, and their opposition is less accentuated where there are ordinary tenancies.

The legislation states that, where the provision is

for a couple of tenancies or a small house for fewer than four or five people, there is no requirement to consult the community. That does not mean that the providers will not undertake some behind-the-scenes work with neighbours. However, the fact that consultation is not necessary for scattered tenancies is welcome. There has been some reduction in nimbyism, although there is evidence that some of our members still have to deal with it.

Kay Ullrich: It is essential that there is consultation that involves the neighbours and the community. You said that there could be behind-the-scenes work for the small developments and scattered tenancies. What is your practice? Do you have a standard practice when you put anybody with special needs into a community setting?

David Bookbinder: We put the emphasis on working quietly and using the care-providing agency. The care-providing agency often has expertise that the housing provider would not pretend to have in dealing with such matters, and works behind the scenes with neighbours instead of having a large public meeting. Such meetings do not create the right kind of atmosphere.

Kay Ullrich: The large public meetings are usually held as a result of a lack of communication and consultation.

David Orr: It is difficult to get the balance right. We work on the assumption that people deserve the opportunity to live in an ordinary house in an ordinary neighbourhood. Before I move into a new neighbourhood, I do not expect to have to consult the neighbours. The rights of the people who are moving in should be considered, as well as the rights of their neighbours. I do not believe that there should be an automatic right to consultation.

When a facility has been opened that provides an ordinary home in the community for two or three people who have special support needs, the experience of living in that community is never as bad for the neighbours as the fantasies suggested it would be. A major consultation programme can provoke fears that are completely irrational and will not be realised. If there is a large-scale development, of course the neighbours will be aware of it, involved in it and educated about it. There are, nevertheless, occasions on which it will be more appropriate for the local care agency to carry out some of the groundwork without undertaking full public consultation.

Malcolm Chisholm: What do you mean by a large-scale development?

David Orr: The kind of development that we think will generally not be required any longer.

Malcolm Chisholm: I asked only because, at a recent public meeting in my constituency, I learned of the problems that had arisen because of a lack of consultation. I understand what you say about small developments but, from my recent experience, I am aware that it is better to inform and engage local people if you want to make such developments a success.

I want to ask about involving people with special needs in the planning and implementation of housing and support.

11:45

David Bookbinder: Some of the developing examples involve groups of current tenants. For example, Key Housing Association, which operates nationally from a Glasgow base, has a range of tenant forums where people with learning disabilities feed in information on the types of housing support and care support that they receive. That is infinitely more successful and positive than any complaints system. Generally, complaints systems do not produce that kind of feedback. Key Housing Association uses the information in the development of its newer housing support services and housing provision. It uses as its base existing tenants. It is certainly more difficult to identify a more amorphous kind of population. Most associations harness the views, knowledge and expertise of people whom they already house.

The Convener: Thank you, not only for the answers that you have given to the variety of questions that we have asked, but for your written submission. We will probably address some of the other points that you have raised and ask you for further written evidence to back up what you have said today.

11:47

Meeting adjourned.

11:55

On resuming—

Petitions

The Convener: We have a number of petitions this morning. The first is from Mr Bill Welsh regarding measles, mumps and rubella vaccination. Committee members have received a detailed submission from Mr Welsh on behalf of a number of organisations, which raises several questions. This is an area of great sensitivity. We must discuss this case and decide on a course of action. The options are: to simply note the petition; to appoint a reporter to investigate and report back to the committee, and possibly do further work at that point; or to hold a full inquiry and take evidence, which would have to be done at a later date, given our work schedule.

Kay Ullrich: We are grateful to Mr Welsh for the detail in his petition and for his subsequent letters to us. The issue is causing concern, and I feel that it is worthy of an inquiry, but I am well aware of the time limitations that are on us; we could not undertake an inquiry until at least after the recess. However, my recommendation is to have a full inquiry and take evidence from all concerned parties.

Dr Simpson: A number of issues are involved. There are concerns about the MMR vaccine, although the evidence is anecdotal, and there is almost certainly a rise in the number of individuals suffering from a disorder within the autistic spectrum, but whether those two are linked is not clear. Establishing a causal link between two rising trends is extremely difficult on occasions. However, there has been sufficient concern about vaccines and vaccination over a sufficient number of years that this is not a petition that we should simply note.

Given the committee's heavy work load, I suggest that we appoint a reporter to undertake some preliminary work for us over the next few months; a lot of information would have to be gathered, with the assistance of our clerks. That would allow us to focus any subsequent evidence-taking sessions, if we choose to have them, in light of the reporter's findings.

Mary Scanlon: Following on from that, convener, the letter from Bill Welsh to the clerk says:

"Mrs Smith informed me that this application/appeal to have informed scientific evidence presented to the Committee will be on the agenda within the next four weeks."

According to an article published last month in *The Lancet*, Andrew Wakefield from the Royal Free hospital said that the MMR vaccine should be withdrawn, a claim

"not shared by his co-investigators".

Alan McGregor of King's College London concluded that

"there had been no new evidence to suggest a causal link".

In a letter to *The Herald*, Dr Peter Christie from the Scottish Centre for Infection and Environmental Health wrote:

"the current accusations against the MMR vaccine and its supposed links to autism and Crohn's disease are not even supported by the published research which the anti-vaccination lobby quote so vociferously. Nor is there any evidence anywhere to suggest that single-component vaccines are safer than MMR".

I am not a medically qualified person, but what I am seeing is conflicting information. Whatever procedure we use to progress the petition, how can we make decisions about whether one academic piece of research is more correct than another? When I asked a question on this subject in the Parliament, Iain Gray, to his credit, said that the Executive would be willing to fund research to clarify the potential link between MMR and autism. Before we start to use committee time to deal with the nitty-gritty of opposing academic positions, I suggest that we get hold of some conclusive evidence.

12:00

Malcolm Chisholm: Given the massive agenda that we have, I would be concerned about our getting into this kind of area. The Health Technology Board for Scotland is the body that should be looking into this. The board prides itself on the fact that, unlike its counterpart in England, it will not be told by the minister what it should examine; that may or may not be a good thing. When there is an issue of major public concern, is there some way in which the Health Technology Board can be encouraged to take it up? There is one medical expert on the committee, but it does not seem to me to be appropriate for a body such as this to deal with a subject about which there is conflicting scientific evidence. When we receive petitions, can we at least flag up to the Health Technology Board for Scotland that there are issues that it might want to consider?

Ben Wallace: I agree. Given the committee's work load, to launch into a specific scientific investigation would be counter-productive. I want to pick up on Mary Scanlon's point about what the Deputy Minister for Community Care said he would be willing to do. Perhaps we can write to him to request that he expand on his commitment and provide us with a concrete plan or timetable for research. Once he has responded, we can

move forward from there. It is not for this committee to carry out a scientific investigation into this issue.

Mr Hamilton: I agree with what Ben Wallace has said. A distinction needs to be drawn between the sort of inquiry that Richard Simpson carried out, which was about consultation and local accountability—an area in which the committee has, if not expertise, at least a strong interest—and a scientific investigation. Frankly, the committee is not qualified to make a judgment on the issues at stake here. That is not to say that it would be a bad thing to take a morning's evidence on the matter. That would flag it up and provide a time frame for the Executive to come back with a briefing document setting out its conclusions, which the committee could test. I am perfectly comfortable with that. However, it is not for the committee to provide the sole momentum on this issue.

Margaret Jamieson: I agree with Ben Wallace. We should inform the minister that we have received this petition and that research into this subject should be commissioned. However, to return to what Malcolm Chisholm was saying, we should test the Health Technology Board and ask whether it would look into this issue on our behalf. Clearly, it is a matter of concern. There is a trend in the number of children being presented for inoculation and it is decreasing; that is worrying. We are coming at it from two or three different angles. Given the work load, it would be better for us to have the research conducted first. As Duncan Hamilton pointed out, that would give us an informed basis for a decision.

The Convener: We said that we would write to the minister on the issue. If we write to him, we could ask for his initial comments on the petition. We could also ask what research the Executive is undertaking or plans to undertake and request a commitment on the time scale. At the same time, we could write to the newly formed Health Technology Board to ask whether this is an issue that it is planning to consider and whether it is something that would fall within its remit, if we recommended that it consider the matter. We could come back to the issue, having ascertained the answers to those questions.

Kay Ullrich: We need the information, but let us not close the door.

The Convener: Not at all. We could follow that up.

Dorothy-Grace Elder: I was interested in Richard Simpson's suggestion that somebody should try to prepare a preliminary report. If that report found out even what we do not know, it would be useful. There are so many things that we do not know, particularly in relation to autism. We do not even know the prevalence of the condition in the British Isles. A preliminary investigation would be valuable. Over the last 20 years as a journalist, I have held the view that we must consider anything that the Department of Health has told us with scepticism. The department has been found out on many issues. We must have an independent mind in Scotland.

The Convener: Let us not prejudge anything. There are some general concerns about the issue and we have had anecdotal evidence from parents who are concerned. It is part of the committee's job to allay any fears that we can. However, we must take on board the fact that we are not medical experts and therefore perhaps not the best people to do all the work on our own, although we may have a part to play.

Irene Oldfather: It is important that we do not try to reinvent the wheel. I recall from some of the information presented in the petition that there is a congressional hearing on the matter. It would be useful to draw together some of the conclusions reached in that and to consider what the US Food and Drug Administration is going to do, rather than to conduct the whole hearing again in this committee. I am very conscious of what Malcolm Chisholm said about the committee's work load, but I also agree with Kay Ullrich's point, which is that we should not close the door entirely.

The Convener: As well as writing to the minister and the Health Technology Board for Scotland, we will give members access to the congressional hearings information and evidence. We will also ask the Scottish Parliament information centre to provide a background note. That would not be closing the door on the issue.

Dr Simpson: Without wanting to add to your personal work load, convener, perhaps you could take that matter forward. You might raise the issues that you have outlined with the Joint Committee on Vaccination and Immunisation, which approves vaccines in the UK. We should be asking that committee for its view. At this point, it is important that the committee does not send out the message that it is an unsafe vaccine—it is a vaccine that saves lives. It is fundamental that we do not get into the sort of nonsense that we had over the triple vaccine 20 years ago, which resulted in substantial worsening of health, with people getting whooping cough and children dying because the wrong messages were coming out of committees.

The Convener: We all agree whole-heartedly with that, Richard.

Kay Ullrich: I had a phone call last week from somebody who is so concerned about what is being said about the triple vaccines that they want to find out in which country they can buy the single

vaccines across the counter and administer them themselves. Obviously, I counselled strongly against doing that, but I am concerned by the messages that are being put out. Until we have the evidence and facts, people will, naturally, be very concerned, as this concerns their babies and children. I cannot stress enough the need for us and the media not to whip up a frenzy about this, because, like the person who phoned me, people will look for a do-it-yourself solution. That would be child abuse, as I informed them.

The Convener: You are absolutely right. We must handle this issue with great sensitivity. Even Mr Welsh's submission says that, over the past 20 years, there have been all sorts of other insults, as he calls them, to the human body, such as pollution and additives to what we eat. As Richard Simpson says, it is difficult to establish a causal link between one impact and another. There could be other reasons, but there is definitely concern among parents of children who have autism. As Kay Ullrich has said, there is also concern among parents who are coming to the point at which their children must be vaccinated. We should treat this matter with sensitivity, but find a sensible way to answer some of those questions.

Mary Scanlon: Apart from sensitivity, there is also urgency about this issue. In four health board areas in Scotland, take-up of the MMR vaccine is now well below the 90 per cent required to avoid an epidemic. I stress that this matter is urgent. We must get a clear message out to parents; we cannot leave this on the back burner.

The Convener: I shall recap on some of the points that have arisen from our discussion. We shall write to the minister on the issues that we discussed and to the Health Technology Board. We shall ask SPICe to write a research note and we shall get copies of the evidence given to the congressional hearings in the United States last month. We shall also pick up on Richard Simpson's point about the Joint Committee on Vaccination and Immunisation. At a later date, we shall discuss the issue again when we have all the information to hand and decide what is the best course of action.

Dorothy-Grace Elder: We should also write to the various societies concerned with autism.

Margaret Jamieson: We are trying to find out about medical research; we must have that information before we can do anything else.

Dorothy-Grace Elder: The autism organisations might have a view on the subject.

Margaret Jamieson: They may have a view, but it will not be based on medical research.

The Convener: The main point is that when we return to this matter with all the information that we have garnered, we must decide whether to instigate a full inquiry or whether to appoint a reporter. If we decide to go down either of those two routes, we will obviously have to take evidence. At the moment, we are not closing the door on this matter. We will get further information and make use of it to decide what is the best and most constructive way forward. At the end of the day, the answers may come from an inquiry by this committee. However, putting a little bit of pressure elsewhere may get a better result, because others will have more expertise than committee members have as lay people, however excellent you all are.

Do members agree that that is how we should proceed?

Members *indicated agreement.*

The Convener: We have before us four petitions that relate to Greater Glasgow Health Board's plans for health services in Glasgow. Three petitions are from Mr Frank Harvey and one is from Mr J McNeil.

Margaret Jamieson: These petitions should be noted. Greater Glasgow Health Board's consultation has just been extended. Following the committee's inquiry into Stobhill hospital, the health board embarked on a meaningful, frank and open consultation process. It would be inappropriate for the committee to intervene at this stage.

12:15

Ben Wallace: I agree that it is important that we do not influence that unduly, but there is a great deal of concern about Greater Glasgow Health Board's plans—I have had letters from members of the public and professionals that demonstrate that. The committee should keep an eye on the situation.

Dorothy-Grace Elder: I agree. The consultation period has only recently been extended to September after considerable pushing from Unison and Glasgow MSPs. That is a brief consultation period in which to deal with almost all of Glasgow's major hospitals. A primary concern of mine is the siting of a large number of facilities at the Southern general hospital without the ambulance service being consulted. That issue is serious with regard to the Clyde tunnel, football matches on that side of the city and the two children's hospitals. We should consider at least one of Mr Harvey's petitions.

Margaret Jamieson: The people in Argyllshire, Lanarkshire, Argyll and Clyde, the Forth valley and Edinburgh use the tertiary services that are available in Glasgow. This is not just a Glasgow issue. There will be full and frank consultation with

all the health boards in Scotland. We need to ensure that we are examining health care provision, not dilapidated buildings.

Mary Scanlon: We were justifiably critical of Greater Glasgow Health Board's approach to Stobhill. We have to be mature about the situation and assume that it has learned from that experience. We should allow the health board to go through the consultation process, on which Richard Simpson worked so hard. We should not pre-empt that. Like other members, people have contacted me with regard to the health board, but I think that it would be inappropriate for us to jump the gun on the issue. After September, if we feel that the provision is not adequate, we can return to the issue.

Kay Ullrich: I agree. We do not want to pre-empt the process.

The Convener: I share the view of many members of the committee. An on-going consultation process is under way. I welcome the fact that the period has been extended after requests from MSPs and the general public. The committee has a good record of taking a strategic view of issues such as this. If we pre-empted the consultation process, we would send completely the wrong message to health boards. Also, we would be inundated with requests from members of the public wanting us to examine other issues while reviews and so on are in progress.

The point that Margaret Jamieson made about tertiary services means that all of us can have an input into the consultation process. However, while there is an on-going process, I do not think that the committee should pre-empt that work. If issues arise at the end of that period—for example, concerning the way in which non-local decisions have been taken—that is the point at which the committee could look at the matter again. Other petitions might come later, but at this point, I suggest that the committee should simply note these ones.

Kay Ullrich: Let us be careful about this: are we noting, or are we rejecting? If we note a petition, we give it credence. We should have a wee think about that.

Dr Simpson: People have to be able to petition Parliament on any topic they want. On the other hand, when they try to use Parliament and its committees to circumvent the procedures for consultation that are in place, that is an abuse of the system. I have raised the point before that noting a petition should be a neutral course of action. We should at least add that, although we note the petitions, we do not accept that we should consider them further because that would circumvent the normal procedures.

Dorothy-Grace Elder: I would do nothing to stop petitions. This Parliament was founded on a petition—the one to the Pope from the supporters of King Robert the Bruce called the Declaration of Arbroath. Mr Harvey is becoming a bit of a national treasure. However, appealing for at least the noting of the petitions, I would like to point out that two particular hospitals in Glasgow have national facilities—the sick kids hospital and the Queen Mother's hospital, which includes the national cardiac unit.

Margaret Jamieson: What about the Southern general?

The Convener: I think that we should note that we will take no action on the petitions because there is an on-going consultation. I agree with Richard Simpson. It would be incompetent for us, when a decision-making process has not been undertaken by Greater Glasgow Health Board, to put forward opinions.

Is the committee happy to say that we will take no action for that reason?

Ben Wallace: I would like to make a procedural point in relation to the Public Petitions Committee. Some of the requests in the petitions in front of us are not within our power or the Parliament's power. I would therefore ask that the Public Petitions Committee reject such petitions and not pass them on to us. We are not in a position to order a public inquiry into the Greater Glasgow Health Board, even if we wanted to. We are not in a position to reject the Greater Glasgow Health Board's proposals—we do not have that competence. The petitions should not be in front of us.

The Convener: That point is well made. The Public Petitions Committee is looking at the way in which it functions and the range of its remit. People write to the Public Petitions Committee on absolutely everything—from the state of the pavements in a particular road, to the siting of telecommunications masts, to health board issues.

Is the committee happy that we should take no action on those petitions and that we should give the reason that we have outlined? We could refer the petitioners to the *Official Report,* so that they can read what we have said on the matter.

Members *indicated agreement.*

The Convener: The final petition—agenda item 5—is from Thomas McKissock, on hepatitis C. We have previously discussed a petition on haemophilia, hepatitis C and the impact on blood transfusions. Members will remember that the minister was undertaking an internal review, and we agreed that we would await the report that would be given to us for comment, at which point we would decide whether to take any further action on the petition.

The local member, Cathy Jamieson, is here to represent her constituent. I invite her to say a few words before we decide what to do with the petition.

Cathy Jamieson (Carrick, Cumnock and Doon Valley) (Lab): Thank you. I appreciate being given the opportunity to make representations on behalf of my constituent, who is not well enough to do so.

Mr McKissock contracted hepatitis C from contaminated blood products. He has pursued this matter over several years, but has not received a satisfactory response. When people have contracted HIV from contaminated blood products, they have received compensation. Mr McKissock is a former miner. Had he contracted an industrial disease such as emphysema or vibration white finger, he would be applying for compensation.

Mr McKissock points out that he has suffered a dramatic loss of quality of life over the years. He has no wish to detract from the inquiry into haemophiliacs, but the Executive's responses so far seem to suggest that the inquiry is concentrating on haemophiliacs who have contracted the virus. He estimates that others might be in a position similar to his own, having contracted the virus through routine operations, and that their views, experiences and concerns are not being taken into account by the present inquiry.

I ask the committee to bring the matter to the attention of the Minister for Health and Community Care, and ask for those concerns to be addressed at a suitable point in the inquiry.

The Convener: I would support that action.

Mr Hamilton: So would I. This is an exceptionally serious issue. I suggest that we take three courses of action. First, we should ask the Executive to widen its inquiry to take on the points that Cathy Jamieson has just made. Secondly, we should try to push the Executive to an early resolution on the matter. It was referred to us on 14 December. A long period has passed, and we need to reach some sort of conclusion. Thirdly, we should invite the minister to the committee, at least for a brief discussion on the matter. We should receive all the information well in advance of that meeting, so that we can quiz the minister on the issues.

The Convener: Let me provide more information on the status of our initial request to the minister. We made that request in December. A letter of reminder was sent to the minister's office on 16 May and we have spoken to the health and community care department. The latest estimate for the publication of the report that is to be passed to the committee and to be sent out for consultation is late June. We should therefore receive it soon.

Previously, we said that, when that report was published and re-examined by the committee, we would want to question the minister on it. Committee members might want to pick up on Cathy Jamieson's first point, but the other points have already been covered.

Mr Hamilton: It is useful to have that information. However, if the Executive's report is approaching its conclusion, that presents the committee with a problem. How will the issue be included if the report is almost concluded?

The Convener: The Executive might not be able to include it because of the timetable, but it might be able to address it in a different way. The request will be made that it either include it in the report or address it differently. I anticipate that the committee will be able to extend its questioning when the minister attends, as it is within our remit to ask questions beyond those concerning the report. At the moment, we should keep the petition until we receive a response from the health and community care department on whether it can expand its report or provide information on the issue. When we have received all that information, we can decide what we should do.

Mary Scanlon: I support Cathy Jamieson's point about widening the inquiry, which would be eminently sensible. The letter to the committee from the health and community care department, dated 21 March, states that it

"would not expect to produce a report for the Minister before the end of this month."

That was the end of March. I now hear that the report is not expected until the end of June. We cannot make progress on the issue until we have received that report. It is urgent, and I do not understand why routine operations were not included in the first place. I support what has been said by other members.

Dr Simpson: Haemophilia is incidental to this. I suspect that the inquiry will focus on the acquisition of hepatitis C through blood transfusion products, and I imagine that the report will include the sort of case that has been presented today.

The committee should consider scheduling a time to question the minister in the first week of July. It would concentrate the minds of the minister and civil servants to accept the schedule that they have set this time—although the schedule was not met in March. They have said the end of June, so we expect the report to be in our hands in sufficient time for us to question the minister before the recess.

The Convener: The only problem is that, if we need to extend the report or examine aspects that have not been covered by the report, a July date

would probably be too soon. If those matters are already in the report, no issue would arise.

12:30

Mr Hamilton: It is interesting to contrast the time that we are given to deal with the entire budget with the time that the Executive has for a report.

Cathy Jamieson: I wish to make one simple point. The information outlining the current inquiry, which has also gone to the petitioner, refers consistently to haemophilia and contaminated blood products. Richard Simpson is correct that, in a sense, that is not the issue. The wider issue is about blood products. Unfortunately, the information that has been sent out appears to give the message to my constituent and others in the same situation that their cases are not being taken into account. At the very least, I ask the committee to write to the Executive to make that point.

The Convener: I remind members that it was decided at our previous meeting that we would not meet at the beginning of July, so that members could carry out community care visits. We decided that a small team of committee members would deal with statutory instruments, which have to be dealt with. If you want us to write to the minister and to meet in July, we will be going against our previous decision.

Irene Oldfather: It is important to advise the Executive in advance that we want the answer to this matter included in the inquiry. If we do not do that, there is a danger that the minister or the officials will rightly say that it is outwith the remit of the inquiry but that it is perhaps something for a future investigation.

The Convener: We should write to the Executive this week, drawing its attention to the fact that it is now several months after the time by which we were told that we would have a report. We should say that we are keen for the matter to be brought to a conclusion, but that we ask the Executive to extend the report to take on board the comments on contracting hepatitis C in ways other than those involving haemophiliacs and so on. We should ask the Executive to give us an answer within a week, so that we have on our agenda next week its response on the timetable for the report, on whether the report as it is constituted covers all those matters, and on how long it will be before we can receive an answer if it has to extend the report. We can make a final decision about the petition after we have received that information. Is that acceptable?

Members *indicated agreement.*

Meeting closed at 12:34.

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