HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 14 June 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
17th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

WITNESSES

David Henderson (Convention of Scottish Local Authorities)
John Turner (NHS Confederation in Scotland)
Councillor Rita Miller (Convention of Scottish Local Authorities)
Keith Yates (Convention of Scottish Local Authorities)

CLERK TEAM LEADER

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

LOCATION

Festival Theatre

Scottish Parliament

Health and Community Care Committee

Wednesday 14 June 2000

(*Morning*)

[THE CONVENER *opened the meeting at 10:48*]

Petition

The Convener (Mrs Margaret Smith): Good morning and welcome to the Health and Community Care Committee. Agenda item 1 is a petition from the Scottish Warm Homes Campaign on fuel poverty, which has been referred to us by the Social Inclusion, Housing and Voluntary Sector Committee. The Public Petitions Committee suggested that the petition be passed to the Social Inclusion, Housing and Voluntary Sector Committee and the Transport and the Environment Committee, but the Social Inclusion, Housing and Voluntary Sector Committee suggested that it be referred to us. I think that we can understand the reasons for that.

Members are aware of the link between fuel poverty and poor housing and health in Scotland. Members will also be aware of the timeframe in which we are working until the recess. Could I have some views on how we should deal with the petition?

Malcolm Chisholm (Edinburgh North and Leith) (Lab): It is important that we do something about the petition and that we take up the broad health agenda. We have been asked to consider the health implications of this issue. A lot of work is being done on that, which it would be well worth our while examining—that would enable us to feed into the work by the Social Inclusion, Housing and Voluntary Sector Committee. I suggest that we appoint a reporter to do some work on that over the summer.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I agree—that would certainly demonstrate joined-up thinking with what we are trying to achieve. We should work in partnership with the Social Inclusion, Housing and Voluntary Sector Committee.

The Convener: That committee is undertaking a study of the subject and will produce a report on it, but it would be useful if we had a reporter who was willing to participate in its meetings and do some background work on the health implications.

Dorothy-Grace Elder (Glasgow) (SNP): When does the Social Inclusion, Housing and Voluntary Sector Committee aim to report?

Malcolm Chisholm: Not until after the summer. Its report will be part of its work on the housing bill.

Dorothy-Grace Elder: It is essential that we get our work done over the summer, given the winter story and the number of deaths from hypothermia.

Mary Scanlon (Highlands and Islands) (Con): We do not need to hear evidence at this stage. The link between bad housing and health is well documented; there has been a lot of research into the subject. I support the suggestion that we appoint a reporter. The second option is to examine the steps that the minister has taken to address the issue—I know that the Executive has been considering it. I hope that we will unravel the budget a bit further and understand it a bit more. Putting money into good housing is a health prevention measure—perhaps that will be something for our agenda in future. Malcolm Chisholm would be an excellent reporter, if he is willing to undertake that duty.

The Convener: Are you willing to give up part of your summer recess, Malcolm?

Malcolm Chisholm: Yes.

The Convener: We will appoint Malcolm Chisholm as the reporter to consider this matter on behalf of the Health and Community Care Committee and to work in tandem with the Social Inclusion, Housing and Voluntary Sector Committee. While he is investigating the issue, he can report to us on whether he would like the committee to take evidence. On Mary Scanlon's point, Malcolm Chisholm can write on our behalf to the Minister for Health and Community Care for information on the steps that have been taken to address this issue and on any plans for the future. Is that agreed?

Members: Yes.

Dorothy-Grace Elder: I wish to clarify that we are seeking solutions, as we all accept that the problem exists and do not need much more evidence on that. I want to mention the work force that undertakes improvement work. Sometimes there is a huge logjam and people's homes are not improved because of overwork at certain times of year.

The Convener: If there are issues that members would like Malcolm Chisholm to cover, they can pass their ideas to him.

Witness Expenses

The Convener: Agenda item 2 is on witness expenses, about which a paper has been circulated. As members may recall, we decided some time ago—several months before the Prime Minister, in fact—that, as part of the community care review, it would be a good idea to take evidence from people from Northern Ireland because of the system of joint working and pooled budgets that is in place there. Obviously, expenses arise from taking such evidence because of the travel costs and loss of earnings that will be incurred by the witnesses. Is the committee happy that we ask the Parliament to incur that expense for the committee's community care review?

Malcolm Chisholm: Would it be possible to reduce the number of witnesses from three to two? Half the expenditure would be for the general practitioner—partly for his flight, and partly to pay for his locum. Given that the other two witnesses appear to represent the structures, it may be possible to take evidence only from them.

Ben Wallace (North-East Scotland) (Con): In some of the models in the Sutherland report, the GP is a central issue, so it would be worth while taking evidence from the GP. Some of the future options for community care involve a very GP-centred approach. I would like to know what the GP's experience of joint management in practice has been. I am in favour of taking evidence from all three witnesses.

Dorothy-Grace Elder: We are talking about two, are we not?

The Convener: We have three people at the moment.

Dorothy-Grace Elder: I do not want to add to expense, so I suggest that, as a compromise, we ask in advance whether any of the three can give us information about the Republic.

Margaret Jamieson: But that is the Republic—

Dorothy-Grace Elder: Yes, but they might know about good projects there.

The Convener: We can ask them general questions about best practice, which could touch on other areas. If we do not ask GPs to come, we could ask those who do come to tell us how they see GPs functioning in their system. The other two people will be the chief executive of a multifund health trust and a director of community services—one on the health side and one on the community side.

The clerk tells me that the chief executive of the multifund health trust is also a GP, so we can invite two witnesses and leave the GP witness out of the equation. That makes life a lot easier.

Margaret Jamieson: I hope that this does not set us up for claims for future witnesses. I do not want us to make a rod for our own backs.

The Convener: At the moment, there are discussions about a programme of witness expenses, but that programme has not yet been finalised. That is why we have to arrange this slightly differently. In future, a scheme will be in place.

Ben Wallace: Even then, we will always consider witness expenses case by case. We are not setting any precedents. Members of other committees have expressed the fear that, if we grant expenses to one person, everyone else might demand them.

The Convener: The fact that this visit will involve flights makes it different. Most of the time, we invite witnesses who are coming from mainland Scotland, so the same level of cost is not involved. We shall invite only two witnesses from Northern Ireland, which should reduce the cost by about £350.

Mary Scanlon: I agree with that, but I think that it is important that the chief executive should give us a GP perspective.

The Convener: We shall ensure that that information is relayed to him.

Community Care

The Convener: Agenda item 3 is our continuing inquiry into community care. First, I must apologise to Councillor Miller for the mistake that we have made on her nameplate.

I welcome all our witnesses to the Health and Community Care Committee. Thank you for coming along this morning to speak on behalf of the Convention of Scottish Local Authorities and the NHS Confederation in Scotland. That is a good example of joined-up working. Please begin by making a short statement, after which we will ask you questions.

Councillor Rita Miller (Convention of Scottish Local Authorities): John Turner and I will each make a short statement. As you said, convener, this is joint working at its best. I am Councillor Rita Miller, COSLA's social work and health spokesperson, a post that I have been in for a short time. I am also chair of social work on South Ayrshire Council. John Turner represents the NHS Confederation in Scotland and is the chief executive of Borders Primary Care NHS Trust. Keith Yates is the chief executive of Stirling Council.

We are grateful to the committee for inviting us to give evidence today and we welcome the opportunity to answer members' questions—provided that they are not too difficult. It is significant that COSLA and the NHS Confederation in Scotland are appearing here together. That sends a clear signal about the extent to which joint working is now a priority for the health service and for local government.

Our joint submission to the committee was made last November and set out a number of things that we wanted to be put in place to deliver more responsive services and to build on the joint work that is already being done. We highlighted a number of issues, including existing funding pressures—that will not surprise members—and our concern about addressing the existing incompatibilities between the national health service and local government.

We set out a number of areas in which we considered that changes were needed and called for a steering group to be set up, involving the key interests, including the Scottish Executive, to oversee a programme for establishing a joint agenda with a clear programme and timetable. We said that the emphasis should be on expanding and developing existing good practice and on maximising the joint impact of all the available resources of local government and the health service. We suggested a number of areas in which we felt progress could be made, including information and communications technologies, community nursing, intensive home care, sharing information to build up a better picture of health problems and perhaps sharing buildings. That would enable nursing staff, for example, to be based in residential units to provide dementia care.

11:00

I am pleased that the Government has responded and that progress is now being made on a range of fronts. In particular, at the start of the year, the Scottish Executive set up the group that we called for in November. The group, of which I am a member, is chaired by the Deputy Minister for Community Care, Iain Gray. I am not at liberty to discuss in detail the progress that the group is making, but I can tell you that it is considering a range of issues, including best practice, charging policies and joint working. It is due to report later this year, partly in June and partly in September.

I do not claim that things are changing as fast as we might want—personally, I would like things to change yesterday—but we are working in the right direction, progress is being made and the pace of progress is increasing. We can develop more of those issues as they arise from members' questions.

John Turner (NHS Confederation in Scotland): Good morning. I have a few brief comments. First, I echo Councillor Miller's statement that COSLA and the NHS Confederation in Scotland are committed to partnership working. We have a shared view about support and care for people who need our services, about care at home or in homely settings and about choice and independence. We take our joint leadership role across our services in this area very seriously.

Our submission made much of our determination to support joint working and to emphasise the importance of a joint, common and strategic approach across Scotland. For example, setting common objectives, common time scales and common training could enhance services. A joint and inclusive systems approach is required, where joint working is designed in at all levels. We recognise that there is much more to be done in joining up our approaches and ways of working.

Our submission to the committee, the first ever piece of work between COSLA and the NHS Confederation in Scotland, helps us to describe past and current limitations. We are trying to create a new tradition of joint working, which applies not only to the health service and to local government relationships, but equally to the voluntary and private sectors, which are key

partners in successful service delivery to our communities. That new tradition requires greater focus on the service users and their carers in the system as a whole.

The seven months that have passed since we made our submission have seen continued progress. In the NHS, the newly configured trusts have developed. In primary care trusts, local health care co-operatives are maturing, with many developing an active partnership with social work services. In addition to the committee's inquiry, there is a national review of the development of LHCCs, which includes social work input. There are now increasing numbers of joint conferences and meetings between health and social work. Very little of that happened in the past.

The management of delayed discharges, by co-operation between the NHS, local authorities and others, has been highlighted as one of the four priorities for additional health resources. Moreover, a national network group on delayed discharge is being created. We await the outcome of the joint futures group, which we understand is considering many of the points raised in our submission.

Although we are aware of current limitations, we know that there are dedicated staff in our services and in the voluntary and private sectors, who provide excellent services and support to many users and carers across Scotland. Some examples of good practice or innovation—a small number of the total that exist—are included in our submission. A major challenge for our services remains the sharing and rolling out of that practice across the country. That alone will bring substantial benefits to our communities.

The Convener: Thank you. I will begin the questioning—we will try to make our questions straightforward. What do you regard as the most problematic issues in community care? Can you highlight two or three that are, in your view, the main sticking points? What needs to be done to address them?

Councillor Miller: I know from previous evidence that the committee has received that an important issue is funding, on which there are increasing pressures because of increasing demands within the system. It is right that the Scottish Executive and the Parliament's committees should ask us to get best value from the money that we spend and to think of best value as being not just about money but about good services.

There is also a demand for additional resources to be put into community care and for a shift in resources towards community care. Additional resources would allow us to effect the shift that is required from residential care to care in the community. The most important problems are funding, the way in which funding is set and how to make it more flexible, so that we can produce a more flexible service.

John Turner: From our perspective, one of the most problematic issues is that of developing a culture of joint working and mature relationships between all levels of those of our services that focus on the needs of the users and their carers. We recognise that we are trying to embrace a new way of working—joint working has not happened much in the past. We are encouraging services to design in opportunities for joint working and partnership at both national and local levels.

The Convener: Should that encouragement come as a diktat, if you like, from Government, or, to pick up Rita Miller's point, should it be left to the flexibility of local working arrangements?

John Turner: There is a clear leadership role for the national level and the 32 councils, 15 health boards and 28 trusts. We all have a key role and, across the services, we must demonstrate our willingness to work together in partnership. Everyone has an important role to play in demonstrating that leadership.

The Convener: You mentioned the idea of common training and the generic careworker—I am always a little worried that the careworker is paid at the bottom end of the generic scale, rather than at the top or even the middle end of that scale. Margaret Jamieson tells me off if I do not mention that. How do you envisage that that common training will assist joint working?

Councillor Miller: Do you want me to start, John?

John Turner: Well, perhaps if I could just—

The Convener: That is one of the problems of joint working—no one knows who should speak first.

John Turner: I refer back to what I just said about common training—senior managers in our organisations are not used to working together or to training together. That issue must be addressed.

A lot of progress in common training is being made among staff on the ground. However, the core issue is to get staff working together in partnership around the needs of the service users. We must bring together training budgets and people with responsibility for training and development across the service sectors, in order to encourage our staff. Our leadership role is imperative, as we must be seen to be working together.

The Convener: Do you envisage that training as on-the-job training as well as training for the

professionals before they start working on the ground?

John Turner: Absolutely.

Margaret Jamieson: I will pick up on the point about management structures and how managers tend to stay in their own territory. While managers are involved in the strategic planning of the delivery of a joined-up service, how will you ensure that a joined-up service happens in the absence of diktat from Government?

Keith Yates (Convention of Scottish Local Authorities): The previous question was about training; one needs understanding in order to get to strategic planning. Health professions and local government, through social work services, have had vertical diktat for many years: "This is what thou shalt do." We have moved significantly over the past year and a half and there has been a great deal of encouragement from the Scottish Parliament and, before that, from the Scottish Office. That diktat—to work together towards a new type of joined-up working—is relatively new. We must remember that much of the guidance that came from the centre previously was about working in different channels. However, change is taking place and, over the past 12 months, working between local authorities, health boards and heath trusts has improved significantly.

The relationship that existed previously between management from, for example, local government, health boards and health trusts was almost insignificant. However, a relationship now occurs in health improvement programmes, through community planning. The level of understanding provides the framework for undertaking the training that John Turner talked about and for spreading strategic planning genuinely across the organisations. To echo John's comments, that strategic planning must have a customer—or service user—focus. If that is at the heart of our work, we will find common ground and a common agenda.

Councillor Miller: Both sets of organisations—health professions and local authorities—are recovering from reorganisation fatigue. For a time we were inward looking while, at the same time, having to keep running the services for which we were responsible. Now that local authorities are set, having sorted out internal matters, they are beginning to examine more closely joint working across authorities. That will be essential if local government is to work with those health boards that work with more than one authority. As well as joint working between local government and health professionals, there should be groups of joint working, or joint working among groups—I do not know if there is a name for that. That joint working is starting to happen.

At the grass-roots level, the local health care co-operatives are among the engines of change, if I may put it that way. In our area, the social work dimension is valued and joint working is beginning to pull together. General practitioners now realise that they can access social work services for which there is a huge demand—that is both good and bad, because of the problem of resources.

Dr Richard Simpson (Ochil) (Lab): I know that my colleagues will come back to local health care co-operatives.

Before I continue, I should make my usual declaration of interests. I am a director of a nursing home company that runs nursing homes in England, a member of the Royal College of General Practitioners, a fellow of the Royal College of Psychiatrists and a member of the British Medical Association. I am sorry about that, but I needed to get it out of the way.

A range of bodies deals with training, such as social work training organisations, training groups for nurses, the boards that are responsible for that training and the Scottish Council for Postgraduate Medical and Dental Education. I see no evidence of joint training at the undergraduate level, little evidence of joint training at postgraduate level within academic institutions and minimal evidence of joint, in-service training in the field. Indeed, I am aware of considerable obstructions that are put in the way of joint training. For example, in order to hold a conference that involves general practitioners in the west of Scotland, one must first find a general practitioner to chair part of one of the conference's sessions. Even if only one or two general practitioners attend the conference, one must pay a fee of more than £100 to the west of Scotland postgraduate medical education board.

It would be interesting to receive a written response that moved beyond the rhetoric that we have heard for 20 years about joint training, detailing how, in practice, that will be developed. As you said in your report—John referred to this as well—the culture and attitudes are the fundamental problem and, without joint in-service training, that situation will never change. I would be interested in your immediate response now, but hope that you would be willing to provide us with a much more detailed analysis of the situation, unless the joint futures group is going to do that anyway.

11:15

The Convener: Richard Simpson has touched on an interesting point. If we are asking our witnesses to provide that information, it would be worth asking all the professional bodies that are involved in training, as well as the academic institutions in Scotland that are involved in health

and social work training, what joint training they are providing, to get beyond the rhetoric.

Margaret Jamieson: I understand what Richard Simpson is saying. As Councillor Miller is aware, Ayrshire was one of the first areas in Scotland to join up with Unison—I declare an interest as a member of Unison—to ensure that home helps, nursing auxiliaries and the people who interface with clients undertake basic training to enable them to go through the Scottish vocational qualification system. That action has worked well in Ayrshire.

Richard Simpson is correct: the minute the professions become involved, those people start to go their separate ways. We must bridge that gap as it is being bridged at the bottom of the scale. Return to learn is being promoted by the minister and the Scottish Executive to ensure that we break that mould; breaking it at a professional level is a big problem.

The Convener: Let us find out what they say they are doing, then try to break it.

John Turner: You are right: the professions train in a very rigid, vertical fashion. We are trying to get people working together horizontally across the service. There are some big structural issues concerning the training, as you have described.

I shall give you a local flavour of how development is being undertaken in the Borders. Virtually all the primary health care teams have a social work representative attached to them, who is regarded as a fundamental member of the team. As part of the planning process, all LHCCs are required to develop primary health care teams with a social work input—and quite often a community input as well—to determine how they are progressing with their joint services.

In several areas, there are pilot schemes for joint assessment. A nurse or physiotherapist can undertake an assessment that is accepted by the social work department for the commitment of resources. In the Borders, we have had to invest in training and development in our pilot areas to bring about that kind of joint working and understanding. The director of social work and I try to carve out opportunities for us to carry out joint development and training. I would be pleased to provide a fuller response, in writing, to the points that you raised in your question.

Councillor Miller: The joint futures group is looking into the professional training part of that. It is nonsense—we were talking about it earlier—that people are training cheek by jowl in universities but there is no cross-fertilisation, although it would not be a huge problem to enable that. That is a professional aspect of the problem.

In Ayrshire, we have concentrated on training for the new tasks—the new way of working, as it were. Training is provided not only for home helps and people on the ground, but for the people who carry out the assessments. Those different professional groups come together to learn about the new jobs that they will all have to undertake. The aim is to provide on-the-job training for the new tasks that everybody must carry out. No single profession has all the answers.

Dorothy-Grace Elder: I was going to ask about the separate structures of local authorities and health boards perhaps getting in the way of community care, but you have already covered that. Instead, I shall ask you about the separate specific budgets getting in the way of community care. Do you know of any examples of that? What could you do to address the situation?

Councillor Miller: How many hours do we have?

The negotiations are always difficult, as budgets are tight. Each organisation is responsible for its budget and there is no use in disputing the fact that problems are encountered when each has to come up with funding for something. As we understand each other's approach more, and as local authorities and health boards devolve their finances to the people at the grass roots who are doing the job, things are becoming easier.

People have the right to join up the budgets, but there are always problems when different people are responsible for different streams of money. When a new stream of money comes in, it is undoubtedly easier for local authorities to make a bid for funding from that new stream.

Dorothy-Grace Elder: Are you finding that a change in attitudes is genuinely taking place, or is the process at an early stage?

Councillor Miller: Respect grows as people work together. The major aspect of the joint training is that people learn about other people's professional backgrounds and understand each other more. As that understanding grows, people are more likely to trust one another. The training is more about people working together than about structures, which can prevent people working together. Putting the right structure in place does not achieve the understanding; that evolves from people working together.

Dorothy-Grace Elder: I was thinking of the change in attitude to bedblocking. If elderly people could be looked after in their own homes, and were happy with that, bedblocking would not be a problem. Are health boards willing to give you any sums directly to ease that?

Councillor Miller: Yes. In South Ayrshire, there is a rapid response team whose job is to prevent inappropriate admissions to hospitals and to get

people out of hospitals quickly. The team has worked very well and was based on a health board-led pilot scheme of augmented care in the home. The rapid response team is in its second year and operates throughout Ayrshire, using the new money that has been received by the health service.

In addition, one of the local health care co-operatives is about to operate in partnership with South Ayrshire Council in a specific geographical area to provide extra support for people at home. It is called North Ayr speedy action and works on the principles of getting what people need into place quickly and cutting out unnecessary bureaucracy.

Dorothy-Grace Elder: We have heard much about the progress that is being made in Ayrshire.

Councillor Miller: I am sorry to bang my own drum all the time.

The Convener: If you are doing good work, you should bang your drum.

Dorothy-Grace Elder: Absolutely.

Councillor Miller: We have taken best practice, developed it, moved it to another sphere and then moved it on again. We are at the third stage of using the idea of a rapid response team.

Dorothy-Grace Elder: Are you getting good feedback—or any feedback—from the rest of the country, through the Convention of Scottish Local Authorities?

Councillor Miller: We have provided you with examples of good practice. There have been many pilot schemes, which have been pump-primed by the money that we received for modernising community care. Such extra funding always helps, as it allows us to focus on new services and there is no argy-bargy about money. Once a new idea has become established, it is easier to get the health board and the local authority to come up with the cash to back it.

Dorothy-Grace Elder: Thank you.

Mary Scanlon: You have talked about common objectives, joint working, joint conferences, shared information and shared buildings. Are we not just tinkering at the edges? Should there be a single point of entry and a single budget, as the evidence that we have heard suggested?

Councillor Miller: I agree that there should be a single point of entry—that is very important—but we do not need both one point of entry and one budget. People want one entry point; they should not face difficulty accessing the services they need.

Mary Scanlon: In response to Dorothy-Grace Elder's question, you acknowledged that funding and budgeting is a problem. Do you not see a single budget alleviating and addressing many of the problems the four of you have faced?

Councillor Miller: I do not see how a single budget would work. Health boards cover certain areas, local authorities operate in others. The lack of coterminosity of boundaries means that a single budget would create more problems than it would solve. It is important that we work jointly and accept that a certain budget is for a certain purpose.

Mary Scanlon: You will not be surprised to know that I am not satisfied by that answer. What do you understand by pooled budgets? Do you think that pooled budgets might be beneficial to the delivery of community care?

Councillor Miller: Do you mean a budget that is held, so that we say that we will put £100,000 into X?

Mary Scanlon *indicated agreement.*

Councillor Miller: That is one way of approaching joint working. The joint investment fund is an example of that. Money is supposed to be held in it, although I have not seen it yet.

The Convener: None of us has seen it.

Councillor Miller: We will jointly bid for that money. That seems to be a good idea.

Mary Scanlon: On the experience of the past year, that does not fill me with great enthusiasm. We have been going through the budget deliberations at national level and at health board level. Are you satisfied that there is adequate transparency in budgeting for community care from the top through to delivery? Is it possible for us to follow it through to ensure that money is going where it should?

John Turner: The answer is no. If there were such transparency, it would not be so much of an issue. I would like to link that back to the bigger picture of financial planning priorities—an issue that we raised in our submission. We suggest that financial planning regimes in the NHS and local government are quite different and we would like to encourage them to come together.

For example, in the NHS we enjoy a high degree of certainty about the resources that will be available over the next few years. I sense that colleagues in local government are not in that position. In the NHS, we are given very clear priorities and planning guidance, which is a wee bit different from the situation in local government. If we could bring those aspects together, we could address the issues of budgeting, transparency, pooling and devolution of budgets within a common strategic context.

Mary Scanlon: I see that you cover that in

paragraph 13 of your submission. Do you think that a single budget would be helpful to the delivery of community care?

11:30

John Turner: I cannot give a straight answer to that. In itself, a single budget is not the solution, although it may be a helpful option in the context of greater transparency and better common understanding of priorities and pressures.

Ben Wallace: I had a meeting in the House of Commons with some of your UK NHS colleagues. I take Rita Miller's point about the potential downsides of a single budget. Health boards have told me that there is an element of squeeze on resource transfer. If the way to protect those resources were to unify the budget, would it not be a good thing? Can you think of another way in which to protect resource transfer in Scotland?

The Convener: Perhaps Richard Simpson can ask his question and we can get answers to both of them.

Dr Simpson: The two things are linked. It is about common cycles of planning. Keith Yates might like to comment on this because Stirling was one of the first places to take on community planning. We have health implementation programmes, trust implementation programmes and partnerships in progress—HIPs, TIPs and PIPs—and I have to wonder what we will get next week. Your submission refers to the harmonisation of timetables, but it is more than that. If we really believe in community planning it should be a joint process anyway. The HIPs and TIPs should subsume that. Could you comment on that? I will come back to resource transfer as a specific issue after that.

John Turner: Yes. Community planning has developed as the umbrella planning mechanism within which all the other plans that you mention—and new ones to come—should operate. The HIP is the strategic public health plan and the TIPs and practice plans are about operational service delivery and development—they are of a much lower order. There is a clear distinction between strategic planning and operational delivery.

Keith Yates: Perhaps I can go back to some of Mary Scanlon's points about transparency, pooling and common budgets. The progress in the past 12 months on sharing information about what budgets are spent by trusts and local authorities is a very important step. When people understand what budgets are available, it is easier to do things such as take steps towards pooled budgets. Many of Sir Stewart Sutherland's recommendations are about creating a common pot; that is a way forward.

However, we cannot separate those elements of community care from the wider range of services that we offer in the community. Good community care is not just about what happens in the hospital, a residential home or through home care, but is about the quality-of-life issues that affect everyone. Those issues might include mobile libraries, lifelong learning and opportunities for better investment in housing and public transport.

One of the great dangers of the discussion about a unified budget is that we forget that, in people's lives, all those things are joined together. In local government, we believe that some of the best developments in community care will not take place in the areas that the committee perceives as community care, but in the other areas that I have just mentioned.

How do we listen to the views of the citizens who, by and large, believe that community care in the wider sense is extremely important, and match that against the other priorities, some of which overlap? I would say yes to transparency and pooled budgets, but I suggest that a single budget would deny the fact that community care must be set in a wider context.

On Richard Simpson's point about community planning, a great deal of progress has been made. Stirling was one of the five pathfinders. We are bringing together all the partner organisations and reaching an understanding of what we all do. We brought in 80 community activists and let them tell us about their vision for the future. They made points about the single-gateway access to community care and working together for greater transparency and asked about how they could put pressure on people such as you to influence the budgets that are available for key priorities.

The Convener: You are right to pick up on the fact that Sir Stewart Sutherland examined the idea of pooling budgets and having a pot of money.

Margaret Jamieson: I want to ask about the resource transfer process, from which we all have battle scars. Is resource transfer still a problem for local authorities?

Keith Yates: A couple of days ago, I examined the situation that we are in. The cost of the resource transfer for 139 people in the Stirling Council area is about £2.6 million. The resource transfer is just more than £2 million, which means that there is a shortfall of about 22 per cent. From reading the evidence that was given to you by the Association of Directors of Social Work, I understand that that is the situation across the rest of Scotland. Councils are seeking to make up that deficit, which has to be done by cutting back on other things. It is therefore no surprise that roads, pavements and schools are in such an appalling state. Things such as education, community care and children and family services in social work

have been kept going while resources have been diminishing.

Transparency is important in dealing with the situation. If we can share the problems with colleagues from the health trusts and health boards, we can find ways to move forward. However, that was not the guidance that we got in the past.

Margaret Jamieson: It is difficult for someone who examines the accounts of a health board to identify the amount of money that is transferred to specific local authorities. If we could identify it, we would find ourselves in further difficulty as local authority accounts do not say how much local authorities get from which health boards. How can we be sure that all the money that goes from the health board to the local authority for community care goes into the social work budget?

Councillor Miller: In my experience, the health board makes sure that that happens. We have to give it an audit trail.

Margaret Jamieson: I am laughing because I find it astounding that a democratically elected council has to provide an audit trail for an organisation that does not have to provide an audit trail to anyone.

Dr Simpson: In the first few years, when the first closures occurred, if resource transfer took place it was done out of good will on the part of the health board, but when guidelines on resource transfer were introduced it was agreed that the health board would remain responsible for the money. The Accounts Commission said that it would be hard to follow such an audit trail. Therefore, Councillor Miller, the evidence across the country would not bear out your experience in Ayrshire, although that area might have a fantastic system of audit trails.

Sutherland said that, in England, £750 million was diverted elsewhere. Are you saying, with your hand on your heart, that, as far as COSLA and the NHS is concerned, no money disappears into other services?

We have heard that there is not a uniform approach to resource transfer. We were given figures of between £8,000 and £22,000 per bed closed. With regard to "The same as you", I raised in the chamber last week the fact that we are going to close a further 2,500 beds by 2005. There will be bridge finance to deal with that, but the point is that money will be released. Should not all of that money be identified? As part of the joint planning process, should not agreement be reached that all that money should be applied to the appropriate service? Since our per capita expenditure on mental health is below that in England and Wales, do you agree that we should guarantee that the resources are transferred into the same service? Should that principle be applied to all long-stay bed closures?

Councillor Miller: On the audit trail, I said that the health board checked to ensure that we used the money correctly. I am not a financial expert, so I cannot tell you how good the process is. The health board has to satisfy itself that the money is spent correctly.

Dr Simpson: That is supposed to happen, but the Accounts Commission says that it does not.

Ben Wallace: Councillor Miller, you said that you provide an audit trail. Is that correct? How detailed is it?

Councillor Miller: I am not a financial expert; I am a councillor. The responsibility for funding sits with the health board. Its financial people must be satisfied that the money is used correctly. I do not know the precise details of that audit trail and I am not the person to ask. I will get information on the process and pass it on to you.

The situation with resource transfer is difficult for local authorities. Care in the community is not, in many cases, cheaper than institutional care. That means that even if all the resource were transferred, the money would not pay for the package of care. The money divvied out in Ayrshire and Arran from the closure of the Royal Scottish National hospital is about £28,000 per head, but the cost of a care package could be about £50,000. That is a funding gap. We have tried to deal with it by not dividing up the money on a per-head basis. We have tried to make the money go with the people, whose care packages vary in cost. That has increased transparency and reduced the chance of a local authority making a little saving on the margins. There are practical examples of joint working that can help in that process.

11:45

Dr Simpson: The example of the RSNH is good. What money from that closure is going to the local health care co-operative for the additional nursing and general practice care that will be required? When the money is transferred, is there a discussion between the groups involved with regard to housing, support work, primary care and mental health work, for example? Are all those groups coming together to agree on costs? If they are not, community care will fail because one or other group in that long series of people who have to be involved will say that they have no more resources. The change fund must help with this. Community care will fail, as it did in England to a large degree, and will be regarded by the public as a failure, unless there is a joined-up movement of funds as part of the resource transfer.

John Turner: In my experience of resource

transfer and services for the elderly, such discussions are under way. Over the years, we have moved from a bed-for-bed replacement dialogue—out of institutions and into community care—to discussion about community packages of care. Perhaps some of those resource transfer moneys can be sensibly applied to nursing and physiotherapy care as much as to social work care. That broadening of the dialogue is beginning to happen.

Dr Simpson: It would be helpful to have some examples of that, as what I am hearing from my background as a GP is that primary care teams are not being given any funds to cope with the transfer, which is now—on your figures—more into the community than into nursing and residential homes. They are not being given additional resources and are extremely stretched.

The Convener: Can you give us more background on that?

John Turner: I would be happy to share information on my local example.

Dorothy-Grace Elder: As witnesses may not be able to answer everything during meetings, it is very valuable if they kindly submit answers later. We cannot possibly put witnesses through a gigantic quiz show in just an hour and a half.

The Convener: But we will try.

Dorothy-Grace Elder: Aren't we wicked?

Mr Yates referred to the common situation of robbing Peter to pay Paul that had been going on for many years. It is councils that bear the brunt of that. While we are talking about budgets and about shifting this, that and the next thing, do you have any estimate of the extra money that you need? We are skirting the issue a bit. There needs to be an extra injection of funds, beyond what you can manage through very cumbersome and time-consuming methods to salvage from here and there. Do you have an estimate of the injection of new money that community care in Scotland really needs in order to work?

Secondly, will you comment on the inequality that arises when clients, especially elderly clients, have to pay? Your submission says that they have to pay to some extent for community care, although they would not have to pay if they were in a national health service hospital.

Councillor Miller: Some of what you asked about is being addressed by the joint futures group. We have drawn that issue to the attention of the Executive. The situation is problematic, as we have been talking about local authority funding and health funding. Local authorities raise at least some of their funding for community care through charging. You are right that many aspects of charging are at the discretion of local authorities—we would like to address the problems that are involved in that.

However, benefits are another aspect. There are benefits that are designed to pay for some of that care. The interface with those benefits makes the situation more complex to deal with. There are allowances that are specifically for people's community care needs, so if a local authority is providing a service that helps people to live in the community, why should it not charge for that service? I am not uncomfortable with the idea of some of that money being used for that purpose. It is a hugely complex situation, which the joint futures group will try to address in some way. We have arrived here through all sorts of historical accidents, but we would prefer not to be starting from here—in the words of the Irish saying, if I were going there, I would not start from here.

Dorothy-Grace Elder: But you need more new money, do you not?

Councillor Miller: Yes, we do. I do not think that we know how much new money we need. You are right that it is complex for councils to know exactly what we are spending. We are now trying to get a handle on exactly what is being spent, on the various routes, and on offsetting against charging and so on. The position for the person trying to access the service—I always come back to the individual—is that although the local authority may begin to charge, if we do a benefits check, people are often better off, because they access all the benefits to which they are entitled. It is not necessarily to people's disadvantage if councils introduce charging. Benefits can be offset against charges, because money is being pulled in from central Government—ultimately, that is still public money.

Dorothy-Grace Elder: I appreciate that, but my concern is about the savings of old people—of the generation that has worked for 50 years or so, as you point out in your submission. I would be grateful if you would come back to us with some idea of the overall sum of new money that is required to really make things work, in addition to the new money that you know that you will receive. Would it be possible to receive such an estimate?

David Henderson (Convention of Scottish Local Authorities): That is quite difficult. Councillor Miller has given you some background. We are talking to councils to try to cost the options of providing some elements free and to find out what would be given up. As well as local government, the private and voluntary sectors are involved. Over the past five years, local government's budget from the Scottish Executive for all the services that it provides has fallen in real terms by £0.5 billion. Between 1996-97 and 2001-02 there has been a reduction of £0.5 billion in real

terms, which is a lot.

Dorothy-Grace Elder: That is terrible.

David Henderson: Also, our share of the Scottish block has dropped from 40 per cent to 36 per cent. Within the amount that we receive, COSLA and the Scottish Executive have agreed on four priority areas. Those are social work, education, police and fire. As we said in our submission, last year, we budgeted to spend 6.5 per cent over the grant-aided expenditure amount on social work, and this year we will spend 6.9 per cent more than the grant-aided expenditure amount. Local government is putting more money into social work than the sums would suggest. Also, complex though the grant-aided expenditure sums may be, they are not particularly accurate, and COSLA and the Executive are re-examining them. There is a shortfall across the piece.

Dorothy-Grace Elder: Where are we losing the £0.5 billion?

The Convener: We will move on to Mary Scanlon. There are a number of questions that have not been asked yet.

Mary Scanlon: I feel that the points that I raised at the beginning have been answered, but I wish to raise a point of clarification on evidence that we received two weeks ago from Sir Stewart Sutherland. He said:

"The Treasury puts headings on various columns for education, pre-nursery schooling, social work, housing benefit and so on and the local authority gets the sum of those columns as a single line budget."—[*Official Report, Health and Community Care Committee,* 31 May 2000; c 962.]

Sir Stewart talked about the £700 million gap between what was pencilled in and what was spent. Is there evidence that the budget for the long-term care of the elderly was raided for another budget? Obviously, the royal commission was based on England and Wales, but is there evidence that what happened there also happened in Scotland?

David Henderson: The way in which Scottish funding is distributed is different from what happens in England. I believe that the figure of £700 million that you cite is an English figure. It is done very differently here. Under the Barnett formula, the block grant goes up or down each year depending on how much each of the English programmes increases or decreases. The Scottish Executive then receives a revised grant, and it is up to the Executive to decide how it distributes that. That is done by a calculation that involves grant-aided expenditure. It is then up to local authorities to decide on their priorities.

Mary Scanlon: I do not know about local government finance. However, are you saying that it is unlikely that there was the equivalent black hole of £70 million in Scotland?

David Henderson: This year, local government is budgeting to spend 6.9 per cent above what the Scottish Executive thinks we should be spending.

Mary Scanlon: The key question is whether that money is going towards long-term care of the elderly.

The Convener: You say that you are spending 6.9 per cent above GAE on social work, but where does community care fit into that? We know that social work consists of many services, including family services, which require considerable expenditure.

David Henderson: In our submission for last year, the figure that we gave for Scotland as a whole was about £20 million below the community care element of social work GAE. That hides considerable differences between councils.

Mary Scanlon: Are you saying that you spent £20 million less than you were pencilled in to spend?

David Henderson: That is not quite the way in which it is done. The GAE figure is arrived at by a hugely complicated method, which is not terribly reliable. I could go through it with you.

Mary Scanlon: But £20 million buys an awful lot of care.

The Convener: Could you provide us with a written explanation of why you think that the figure of £20 million may not be totally reliable? Having spent four years as a councillor, I have heard enough about GAE to last a lifetime. I am still probably no further forward in my understanding of it.

Malcolm Chisholm: I, too, have had my fill of GAE. I was going to ask about services for older people at home. However, paragraph 10 of your submission states that

"councils are planning to spend to within £20,000 of the GAE for community care",

which is significantly different from what you said.

David Henderson: The first draft of our submission contained a misprint, but that was corrected. Perhaps you still have the original draft.

Malcolm Chisholm: I was reassured by that draft, so you are now worrying me greatly. I know that you have undertaken to provide us with a written explanation of the shortfall. If you are spending 6.5 per cent above the GAE figure for social work overall, but are £20 million adrift of the GAE for community care, which constitutes a large part of the social work budget, we would have to draw the conclusion that a great deal of money is being spent on other areas of social work. Is there

an area of social work that is particularly well funded and that would explain the discrepancy?

David Henderson: The bulk of spending goes on children and families.

Malcolm Chisholm: Everybody agrees that one way forward in community care is to support more people at home. Do you think that there is scope for doing that? If so, what would facilitate it?

Councillor Miller: Working within councils would facilitate that. As was said earlier, supporting people at home involves more than care packages. The local authority must get its act together and facilitate work across departments, as well as with health services. Appropriate housing or housing with appropriate adaptations must be easily available to people. We need to pull together whole packages of support for people.

Malcolm Chisholm: I apologise for the fact that I was away to take a phone call. I should not ask questions if I have been out, as you may have answered them already.

Are you implying that funding is the main issue, or are there other issues? If you had the funding, would you be able to support many more people at home? Is that your ideal, or do you think that many people will still require residential care of one kind or another?

12:00

Keith Yates: This is not a black-and-white issue. At one end of the spectrum there is care in the home and at the other there is hospital care, but in between there is a variety of opportunities for providing services. Special needs housing is the sort of area that we might be moving into. In the future, we should consider the possibility of supporting not only individuals in the home or in special needs housing, but carers. A great deal of effort and investment should go into helping people in the community, to ensure that people have a better quality of life in their home environments.

This is not about simply moving someone to a house in the community. It is about the range of support that is available at that house—from primary care, from community nursing, from social work and from the other services that I mentioned, such as libraries and lifelong learning. That mixture will provide the quality of life that we are seeking to achieve. We tend to simplify the issue as one of transferring the costs of keeping someone in hospital to keeping them at home with basic provision. We must also address the add-ons—the things that really make a difference.

Dr Simpson: From the Scottish Federation of Housing Associations we heard evidence on care-and-repair budgets. The problem is that there are different pockets of money, some of which are underspent but which cannot be used to top up other pockets, even though they relate to the same thing, across the different housing sectors—council housing, housing associations and private housing. Would you like to comment on that?

Carers are crucial in the home. One issue that has been highlighted as fundamental is respite, and how that is managed among housing associations, the health service and local authorities. Another is training and stress reduction. This month's edition of *The British Journal of Psychiatry* contains a very good, up-to-date article on the management of stress in carers and how that reduces challenging behaviour in dementia patients. What joint efforts are being made to set up pathfinder or pilot schemes in that area?

Councillor Miller: I agree with what you say about the importance of carer support and reducing hassle for carers. One idea that was suggested in the learning disability review that has just been published is that one person should manage the service. That might allow us to take a one-door approach. If there is a problem, carers should be able to have it dealt with quickly, by contacting one person, who will sort it out.

There should also be an emergency plan for each individual. From speaking to carers of people with learning disability, I know that they are concerned about what will happen when they get older and have to go into hospital. In one such case that I know of, it took four hours for a social worker to work out where the person with learning disability should go when his parent went into hospital. This is about taking a person-centred approach. There must be a sensible plan for dealing with emergencies and with what happens when carers grow old. By and large, we know what will happen, although we do not know when it will happen.

Dr Simpson: What about the care-and-repair budgets? I saw you look heavenwards when I mentioned them.

Councillor Miller: I know. Whenever money is channelled through one route, there is no flexibility. That reduces our ability to use the money as we see fit, which is always problematic. It is one of the arguments against ring-fencing.

Dr Simpson: Will the joint futures group examine that issue?

Councillor Miller: I think so.

Mary Scanlon: Will you describe the ways in which changes associated with best value are—or should be—feeding into the strategic management process associated with community care?

Keith Yates: Best value is an important tool. The key to it is the flexibility and—I am sorry to repeat this—the focus that there must be on the citizen or the customer. That is at the heart of the best value process. In circumstances in which we have started by considering the customer or the service user, we find that we are talking not about the way in which we continue to deliver the service that is being delivered at the moment, but about the way in which we can bring together services across a range of departments and a range of different organisations. Best value can be an important mechanism in changing the way in which we deliver different aspects of community care.

We carried out a home care best value review about 18 months ago; as a result, the way in which we charge for home care services has changed dramatically. The idea was to improve quality and to bring in additional benefits, and we managed to do that. The basic tenets of best value are important. The Minister for Communities made a statement last week regarding the extension of best value across all the public bodies. Legislation on that will go through in 2001. That will be an important step in the direction of putting the citizen at the heart of what we do and of giving public agencies the opportunity to work together to a common agenda.

Mary Scanlon: That sounds impressive. To what extent can linkages be demonstrated between the strategic and operational levels in community care provision? The issue is covered in point 12 of your submission.

The Convener: Is community care planning top-down or bottom-up?

Councillor Miller: Are we talking about an individual's community care plan or the plan for the authority?

Mary Scanlon: We are considering the whole area of community care provision.

Councillor Miller: Changes in community care planning are coming into play. Before I became a councillor, it seemed that the local authority worked out what it thought its community care plan should be, wrote it down, passed it to the health board, the voluntary organisations and so on, and asked them to comment. I do not think that that is the way in which we should do it. All those people should sit down and develop the community care plan together. That is what we should try to do in future. Some authorities have been developing plans in that way. I confess that my authority has been one of the ones that did not develop plans in that way in the past, but we will be doing so in future. That way of planning leads to a shared view of where one is going, which must help when one is developing good joint working.

Mary Scanlon: We have heard today about much good practice in local isolated projects, but we are trying to engender good practice across Scotland. I know that you cannot discuss the joint futures group today, but engendering good practice will be integral to the whole process.

Councillor Miller: You are absolutely right. We have been asked to advise on ways of identifying and sharing good practice across Scotland; that is part of the joint futures group's remit.

Mary Scanlon: Would you be recommending ways of doing that after sitting down and working through the whole process together?

Councillor Miller: Yes. COSLA is aware of examples of good practice in just about everything that we want to do across Scotland. Professor Petch, your adviser, has a database that has information on good practice.

Mary Scanlon: We have to remember that there is also not-so-good practice—that is why we are sitting here today.

Councillor Miller: I agree. COSLA asked for money from the Scottish Executive and has been awarded £100,000 to develop an improvement function. That will involve the exchange of good practice. It will be a case not of people simply saying, "We are doing this and that," but of people saying, "We have done this—and here is where we went wrong." As you rightly suggest, it is important to know that someone has tried something and run into problems, because that can save someone else from going down a blind alley. We are developing such ideas just now, and using high technology to do so.

Dr Simpson: Earlier, you gave examples of what you called the rapid response unit for early discharge and the prevention of discharge. We know that schemes have been tried in Forth Valley and Fife; you also referred to schemes in Ayrshire. If the local authority and the health board do not have a scheme in place, how long is it reasonable to wait before we say that we need to do something—such as hypothecating funding, sending in a task force, or taking some other Machiavellian action?

Waiting for good practice to spread by giving examples—which is what the Government has been doing for three or four years—does not seem to be working. We have agreed that particular examples are definitely good practice—as we have agreed in Ayrshire and in Forth Valley—because they are working and have resulted in people not going into hospital, but how do we hold you responsible? To some extent, we can hold people in the health board responsible under planning guidance and the health board accountability reviews, but how do we hold the local authorities responsible? Or how do we hold

you responsible jointly?

Councillor Miller: It is important that local authorities have local discretion. That is about local accountability of elected members—I am sure that everyone knows the script on that one. Local authorities and health boards are realising that they have to take a step forward. There are things that we know work, and we should be saying to ourselves, "All right, let's just get on and do them."

Dr Simpson: Is there a role for COSLA, for the NHS confederation or for Government in ensuring that good practice is being followed? In evidence to the Finance Committee, COSLA has said that it does not want money to be hypothecated and ring-fenced, and I respect that, because I am very much of that view. However, I would like to make a point that I made to Norman Murray, although I did not receive an answer. A number of local authorities and health boards are not following good practice, with the result that patients are still sitting in hospital at an estimated cost to the taxpayer of between £20 million and £40 million. If we are not going to ring-fence or hypothecate in community care, how do we hold you responsible? What carrots and sticks can we reasonably use within the democratic process?

John Turner: This comes back partly to the leadership issue at all levels in the service. In several areas across Scotland, the local political leaders from the council and their senior directors, along with the chairs and chief executives of health boards and trusts, form, in effect, a steering group to make progress with joint working, of which community care planning is a part. In overseeing that, the group has to ensure that the underlying processes of consultation and involvement, and of joint working at operational level, come to light.

That is a model which you might expect to see across the country. If that model were in place, it would be possible to have a local vehicle for joint leadership of services, which you may then wish to challenge to bring in best practice from elsewhere, while taking account of local circumstances.

12:15

Dorothy-Grace Elder: First, on trust and transparency, is there a need for stronger guidance or for legislation? Secondly, will you review the language that is used? I find that many clients do not understand the jargon—members of the committee do not understand it—and that that tends to distance them from the service.

John Turner: Those are two different issues. Transparency is required. We have discussed how difficult it is for the committee and the Accounts Commission to track resources and utilisation of resources through the system. I am sure that that concerns the committee.

Trust is about relationships between people. It is about confidence, which comes from a common approach, shared leadership—

Dorothy-Grace Elder: And rules.

John Turner: It also comes from engagement and people coming together. I do not know whether we can legislate that people should trust each other, but we should ensure that leadership in the combined services enables partnership and trust to come through.

Dorothy-Grace Elder: I am concerned especially about safeguards for people with mental illness. Will you comment on that?

Councillor Miller: There are advocacy schemes of various sorts for people with mental illness. Many local authorities already have such schemes in place. Are you thinking of some sort of legal safeguard?

Dorothy-Grace Elder: The matter is probably covered by the Adults with Incapacity (Scotland) Bill.

Will you comment on democratic accountability, by which I mean the processes that are associated with strategic management—whatever strategic means? It is gobbledegook, is it not?

Councillor Miller: Strategic management of what?

Dorothy-Grace Elder: Paragraph 19, which is quite substantial, states:

"The success of community care policy and practice will be judged in a number of ways."

It goes on to say that

"Councils, Health Boards and Trusts must understand each other's priorities and constraints".

The paragraph then talks about accountability—we are back to that again. What examples of good practice could be used in relation to accountability? You have a lot of experience in the matter.

Dr Simpson: Perhaps Keith Yates could tell us about Stirling assembly, which I found to be a useful joint mechanism.

Keith Yates: Stirling assembly is a participative assembly in which community councillors, voluntary organisations, business representatives and anyone who wants to give up a Saturday morning can debate an appropriate topic. The assembly chooses the topics for debate. During the past 12 months, it has chosen to focus on what might be perceived as health-related issues and it is evident from Stirling assembly's discussions that it regards health issues as being

of the highest importance.

If we consider the consultations that have taken place during the past two years, we can say that health and community care is probably, after children's services, the second highest priority in the Stirling area. I do not mean education when I mention children's services, although the public do not distinguish between education and other services for children. In the debates, we have had enabling exchanges of views between the users and receivers of services, health professionals and people working in local government. The debates are about common understanding and recognition that we need to work in different ways.

Such debate happens at local level as well. We have area forums—as most local authorities do—in each locality. I attended a forum last night at which the agenda was the acute trust. We talked about hospital changes with six senior managers from the health board and the health trust. It is about making contact and establishing the trust and transparency that Dorothy-Grace Elder asked about and it is about understanding what different organisations do.

Service users often ask, "What happens to my mother or my father" and, "Can you explain why this did not happen?" It has been an important step forward to hear about reality in the debates with service users. The debates take us out of a sterile environment. Somebody asked about community care plans. Such plans were often produced at a high level and were just part of a planning process. The plans were strategic and they gave all the figures, but they lacked input relating to the reality of what they meant for people's lives.

In answer to Richard Simpson's question, we believe that we are driving forward many agendas by having debates that are less intellectually rigorous, or that are couched less in the sort of language that Dorothy-Grace Elder mentioned. They are on the issues that people want to know about.

Everybody who attends the forums is humbled, because they take us back to the reality of what public services are about. They help us to make connections and to decide how to reverse the pyramid that we have had for much of the post-war period, which has the professions at the top and the customer at the bottom.

Dr Simpson: A similar thing happens in Clackmannanshire, but it also has a civic jury that discusses issues; recently it discussed health. The civic jury is made up of randomly selected people from the community who are presented with evidence by experts over two days and who feed back to a public forum meeting. I cover both Stirling and Clackmannan, and I found that to be a useful mechanism.

The Convener: I move back to Malcolm Chisholm, as we have only 10 minutes left for questioning.

Malcolm Chisholm: What impact could local health care co-operatives have? What could be done to ensure that they are an effective mechanism for driving forward the agenda? To what extent are social work departments involved in LHCCs? Does that vary throughout Scotland?

John Turner: My impression is that it varies. LHCCs are new bodies within new trusts and a wide variety of mechanisms and ways of working are coming through in the LHCCs in Scotland. One of the reasons the national network group—on which there is a social work representative—has been established is to review the progress of LHCCs. LHCCs provide a huge opportunity. Their constituents are the primary health care teams, so it is important not only that partnership with them is evident around the LHCC board table, but that social work services are encouraged to become part of the local primary health care teams in communities.

Anecdotally, my impression is that that is happening quite a lot and that significant barriers are coming down in primary care and in our relationship with social work services

Malcolm Chisholm: Are you happy generally with the way things are going, or would you prefer more central direction? The decision was made two years ago to have little—if any—central direction. Was that the right decision, or would you have preferred a more prescriptive approach to drive things forward? Would that be appropriate now?

John Turner: We should wait to hear what the network group says. I am sure that it will come back with suggestions about good practice and that it will encourage us along the road of partnership.

It is difficult to say surely but, with hindsight, I sense that there has been a positive growth in primary care. The champions who are coming through deliver, perhaps, far more than they could have if there had been too much central prescription. That is because they have the freedom to take matters forward in a way that is appropriate to local circumstances.

Councillor Miller: The amount of social work services' involvement does vary; some local health care co-operatives are quite fragile because they are just getting themselves together. There is a huge amount of energy for setting up LHCCs. That is very beneficial, because it involves a group of people coming together. In our area, social work services are involved from the start in setting up

LHCCs and that is certainly moving the agenda forward. The situation varies throughout Scotland because it depends on who the champions are, who takes the lead role in the LHCC and the energy of the chairperson. I think that LHCCs are an important step forward and I have great expectations about how they will work to produce good quality services at grass-roots level.

Dr Simpson: The LHCC group might like to revisit the Mitchell report, which, I suppose, few people have heard of. In 1979, it recommended joint working mainly with primary care teams but also with hospital teams. It also recommended that there should be one of a number of forms of attachment to primary care. I was delighted to hear John Turner mention social work's attachment to primary care teams. Without such attachment of social work to the primary care teams—as opposed to their incorporation into the teams—the chances of developing joint working on the ground are extremely limited.

Much research has been done that illustrates how important it is that social work services become aware early of needs in all sorts of matters; Councillor Miller referred to the committee's inquiry, child abuse and early crisis warning problems. Those needs tend to emerge most quickly through primary care teams. Although the divorce of social work services from health services had many benefits, the main disbenefit was the loss of interaction with the primary care teams. I am interested to hear witnesses' comments on community care. Do LHCCs universally accept community care as a model that they should work through with the local authorities?

John Turner: That varies. Some LHCCs are moving forward, but others are not. It is difficult to discern a pattern throughout Scotland.

Dr Simpson: Is enough evaluation being done on the connection between primary care and social work? For example, has that connection been evaluated as being valuable in the Borders? Every time social work services are confronted with a resource problem, they withdraw from that connection. On five occasions spanning 12 out of 30 years, I had social work attachment to my surgery, but that attachment was withdrawn every time there was any pressure on social work. Because such attachments were withdrawn, they could never be developed.

John Turner: In the Borders, the trust obviously evaluates that, but social work staff, GPs and primary health care teams feel that there has been a substantial improvement in the way in which working relationships are moving forward.

Dr Simpson: It might be that joint evaluation is what is needed, so that both parties agree that that is one of the solutions to the problems of joint working, which we talked about at the beginning of this meeting.

Councillor Miller: Evaluation is important, but it is often used as an excuse for not doing anything and for delaying the process further. My concern about our LHCCs is that they wanted things to happen while we were asking them to wait until we had evaluated the rapid response team. The primary care trust asked them to wait until evaluation had been done prior to a decision on the next stage being made. The moment can be lost—when a new group is formed it must be allowed to do something.

12:30

Ben Wallace: I will comment on the joint investment fund. We have been discussing LHCCs. I agree with Rita Miller that the JIF was intended to give flexibility to LHCCs. It was designed to be accessed by the management of the LHCC to concentrate social services. The concept of the JIF seems to be shifting away from health boards and primary care trusts. Will COSLA protect the original concept of the JIF? That is key to helping to solve community care problems. The responses that I have received from primary care trusts on the JIF indicate that it is, as a concept, seen as a murky idea.

Councillor Miller: The JIF seems to be a moving target. In our area, it has not worked out—as I thought it would and as I was led to believe it should work—according to the Government's proposals. That is not COSLA's view; it is my view.

Ben Wallace: Do you see the JIF as an integral part of the way in which the LHCCs move forward in relation to community care?

Councillor Miller: Yes, but that is not a COSLA view, because COSLA has not discussed the matter yet.

John Turner: It will be interesting to watch how the additional allocations—which have been made available to the service recently—are used in that context. The LHCCs are to be given a key role in determining how we develop primary care in the context of better management of delayed discharges and peaks in demand.

Ben Wallace: Are you referring to the new funds that were announced? I have nine health boards' detailed responses to the Executive; only one of them mentions that.

The Convener: I was in the Borders on Monday. The JIF there seems to work better than those in some other areas. It is patchy.

I must bring questioning to a close. I thank the witnesses for coming to the committee and

answering our questions and for their written submission and I thank them in advance for the extra information that they will provide in writing on issues that cropped up during today's meeting.

Meeting closed at 12:33.

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